EFFECTS OF CHILD-CENTERED PLAY THERAPY AND CURRICULUM-BASED SMALL-GROUP GUIDANCE ON THE BEHAVIORS OF CHILDREN REFERRED FOR AGGRESSION IN AN ELEMENTARY SCHOOL SETTING

Brandy R. Schumann, BS, MS

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APPROVED:

Garry Landreth, Major Professor
Sue Bratton, Committee Member
Bob Berg, Committee Member
Dee Ray, Committee Member
Michael Altekruse, Department Chair
Jan Holden, Coordinator of Counseling Program
M. Jean Keller, Dean of the College of Education
Sandra L. Terrell, Dean of the Robert B. Toulouse School of Graduate Studies

The purpose of this study was to determine the effectiveness of child-centered play therapy and curriculum-based small-group guidance on the behaviors of aggressive children in an elementary school as determined by (a) the reduction of aggressive behaviors, (b) the decrease in internalizing problems, and (c) the decrease in externalizing problems of aggressive children.

Two types of behavioral instruments, the Behavioral Assessment System for Children-Teacher Rating Scale/Parent Rating Scale and the Child Behavior Checklist-Caregiver/Teacher Report Form, were used to provide multiple measures of the same construct in this matched pretest-posttest comparison group experimental designed study. Qualitative data was also collected. The population studied was comprised of 37 volunteer children identified as aggressive in kindergarten through fourth grade, ages 5-12, who qualified for counseling services at a Title I public elementary school in North Texas. Children who were referred by teachers and parents, and met the required criteria, were matched in pairs on grade level and randomly assigned to one of the two real-world setting interventions; play therapy treatment group (n=20), which received 12-15 individual child-centered play therapy sessions, or the curriculum-based small-group guidance group (n=17), consisting of 12-19 lessons.

Major strengths of the study included utilizing students referred for counseling due to behavioral difficulties (students demonstrating at-risk and clinically significant
aggressive behaviors) and servicing them at school, a real-world setting. Another strength was the use of 30-minute play therapy and guidance sessions, which conform to typical school practice.

Twelve hypotheses were tested using two-factor mixed repeated measures and eta squared. The data of this study tentatively support the effectiveness of both modalities in decreasing the aggressive behaviors, internalizing problems, and externalizing problems of aggressive children. The data seems to indicate that school-based child-centered play therapy is as effective at improving the behaviors of aggressive children as a nationally recognized guidance curriculum program. Qualitative data from the parents and teachers of the children demonstrated clinical significance, suggesting that school-based child-centered play therapy is more noticeably effective in reducing the aggressive behaviors of children. A control group is needed to determine conclusive results and discern possible effects of maturation.
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## TABLE OF CONTENTS

ACKNOWLEDGEMENTS ........................................................................ iii

LIST OF TABLES ...................................................................................... v

Chapter

1. INTRODUCTION ............................................................................. 1
   - Purpose of the Study ................................................................. 3
   - Review of Related Literature .................................................. 4
     - Aggression in Children ......................................................... 4
     - Therapy With Aggressive Children and Treatment Considerations ........................... 6
     - History and Guiding Principles in Child-Centered Play Therapy .................................... 10
     - Play Therapy With Aggressive Children .................................. 12
     - Aggression in Schools ............................................................. 25
     - Counseling in Elementary Schools ....................................... 27
     - Counseling Aggressive Children in Elementary Schools ........................................... 31
   - Summary ................................................................................. 36

2. METHODS AND PROCEDURES .................................................. 37
   - Definition of Terms ................................................................ 37
   - Hypothesis .............................................................................. 39
   - Instruments ............................................................................ 42
   - Selection of Subjects ............................................................. 46
   - Collection of Data .................................................................. 50
   - Treatment .............................................................................. 52
   - Statistical Analysis ............................................................... 55

3. RESULTS AND DISCUSSION .................................................... 56
   - Results .................................................................................. 56
   - Discussion ............................................................................. 81
   - Summary ............................................................................... 92
   - Limitations ............................................................................ 93
   - Contributions and Strengths of Study .................................... 95
   - Recommendations ............................................................... 96

APPENDICES .................................................................................. 97

REFERENCES .................................................................................. 122
LIST OF TABLES

Page

1. Demographic Information for the Students who Participated in the Study........ 49
2. Mean Total Scores for the Aggressive Subscale on the Behavioral Assessment System for Children-Teacher Rating Scale (BASC-TRS/C) ................................. 58
3. Two-Factor Mixed Repeated Measures Results for the Aggressive Subscale Score on the Behavioral Assessment System for Children-Teacher Rating Scale ........................................................................................................................................ 58
4. Mean Total Scores for the Internalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale (BASC-TRS/C) ........................................................................................................................................ 59
5. Two-Factor Mixed Repeated Measures Results for the Internalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale ........................................................................................................................................ 60
6. Mean Total Scores for the Externalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale (BASC-TRS/C) ........................................................................................................................................ 61
7. Two-Factor Mixed Repeated Measures Results for the Externalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale ........................................................................................................................................ 62
8. Mean Total Scores for the Aggressive Subscale on the Behavioral Assessment System for Children-Parent Rating Scale (BASC-PRS-C/P) ........................................... 63
9. Two-Factor Mixed Repeated Measures Results for the Aggressive Subscale Score on the Behavioral Assessment System for Children-Parent Rating Scale ........................................................................................................................................ 63
10. Mean Total Scores for the Internalizing Problems Composite Score on the Behavioral Assessment System for Children-Parent Rating Scale (BASC-PRS-C/P) ........................................................................................................................................ 64
11. Two-Factor Mixed Repeated Measures Results for the Internalizing Problems Composite Score on the Behavioral Assessment System for Children-Parent Rating Scale ........................................................................................................................................ 65
12. Mean Total Scores for the Externalizing Problems Composite Score on the Behavioral Assessment System for Children-Parent Rating Scale (BASC-PRS-C/P) ........................................................................................................................................ 66
13. Two-Factor Mixed Repeated Measures Results for Externalizing Problems Composite Score on the Behavioral Assessment System for Children-Parent Rating Scale ......................................................................................................... 67
14. Mean Total Scores for the Aggressive Subscale on the Child Behavior Checklist-Teacher Report Form (CBC-TRF) ........................................................................................................... 68
15. Two-Factor Mixed Repeated Measures Results for Aggressive Subscale Score on the Child Behavior Checklist-Teacher Report Form ................................................................. 68
16. Mean Total Scores for the Internalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form (CBC-TRF) ................................................................. 69
17. Two-Factor Mixed Repeated Measures Results for Internalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form ........................................ 70
18. Mean Total Scores for the Externalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form (CBC-TRF) ......................................................... 71
19. Two-Factor Mixed Repeated Measures Results for Externalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form ........................................ 71
20. Mean Total Scores for the Aggressive Subscale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) ................................................................. 72
21. Two-Factor Mixed Repeated Measures Results for Aggressive Subscale Score on the Child Behavior Checklist-Parent Report Form ......................................................... 73
22. Mean Total Scores for the Internalizing Problems Composite Score on the Child Behavior Checklist-Parent Report Form (CBC-PRF) ......................................................... 74
23. Two-Factor Mixed Repeated Measures Results for Internalizing Problems Composite Score on the Child Behavior Checklist-Parent Report Form ........................................ 74
24. Mean Total Scores for the Externalizing Problems Composite Score on the Child Behavior Checklist-Parent Report Form (CBC-PRF) ......................................................... 75
25. Two-Factor Mixed Repeated Measures Results for Externalizing Problems Composite Score on the Child Behavior Checklist-Parent Report Form ........................................ 75
26. Parental Observations of Their Children ................................................................................................. 78
27. Teacher Observations of Their Children ................................................................................................. 79
28. Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of Kindergarten Group Guidance Sessions Led by Leader 1 .......................................................... 85

vi
29. Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of First-grade Group Guidance Sessions Led by Leader 2 .......................................................... 86

30. Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of Second-grade Group Guidance Sessions Led by Leader 3 ............................................................................................................. 87

31. Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of Third-grade Group Guidance Sessions Led by Leader 4 ............................................................................................................. 88
CHAPTER 1
INTRODUCTION

With youth violence in the United States increasing at an alarming rate, aggression among children has become a growing concern (Elders, 1994). School violence, such as the shootings in Columbine, Colorado, in 1999, has brought attention to the dire consequences of ignoring the social-emotional needs of children. The Surgeon General’s report described the shortage of children’s mental health services as a national health crisis. “Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met” (U.S. Public Health Service, 2001, p. 3). Trotter, Eshelman, and Landreth (2004) suggested that aggressive, acting-out behaviors of children are among the most common causes for child therapeutic referrals. Ironically, these same children are also considered to be among the most difficult to work with in therapy. The number of violent crimes committed by children is escalating, while the age of child offenders is decreasing (Frost & Jacobs, 1995). Consequently, adults are increasingly seeking therapeutic interventions for aggressive children, demonstrating a need for earlier interventions.

Approximately 34 million children are enrolled in elementary schools across the United States, many of which are dealing with emotional issues and significant behavioral problems that are interfering with their ability to meet their academic potential (Mash & Dozois, 1996; U.S. Census Bureau, 2000).

Schools are currently the primary providers of mental health services, as 70% of children who receive mental health services receive them from school counselors (U.S. Public Health Service, 2001). Thus, educators continually search for interventions to
assist children because psychological problems can inhibit a child’s ability to learn and lead to academic failure (Cowen, 1973; Pianta, 1997). A recent increase in school systems referrals indicates a need to expand services (U.S. Public Health Service, 2001).

Research performed by The Children’s Hospital of Philadelphia compared existing school-based aggression prevention programs across the nation. They found that targeting programs to kindergarten and young elementary school students, focusing on aggression in girls as well as boys and conducting programs in naturalistic settings like playgrounds are key factors in the success of aggression prevention in schools (Leff et al., 2001).

A meta-analysis performed by Ray, Bratton, Rhine, and Jones (2001) provided empirical evidence demonstrating therapeutic effectiveness of play therapy for children’s emotional needs, but few of the studies included in the meta-analysis focused on aggression. Thus, further research exploring therapeutic modalities that meet the emotional needs of aggressive children is needed. Although the few studies that did address aggressive children indicated support for play therapy as an effective intervention with aggressive children, the absence of current research weakens the ability to generalize their results (Bratton & Ray, 2000).

Landreth, Homeyer, Glover, and Sweeney (1996) noted a significant impact on children when mental health professionals provide understanding and acceptable opportunities to express unfulfilled feelings, wants, and needs. Play therapists have suggested play as the medium of choice to achieve this task (Axline, 1969; Klein, 1955; Landreth, 2002, Moustakas, 1997; Ray et al., 2001). The importance of play in the lives
of children is well documented, demonstrating that play serves as a means for children to express negative emotions and to work through conflicts in a safe environment (Axline, 1969; Klein, 1955; Landreth, 2002; Schaefer & O'Connor, 1983). Frost and Jacobs (1995) proposed that play deprivation, along with societal and familial factors, may be a contributor in increased juvenile aggression.

Some play therapists express concern related to the behavioral latitude permitted in child-centered play therapy, particularly with regard to aggressive children. The view sometimes expressed is that such children need a controlled environment rather than a permissive one (Drewes, 2001; Knell, 2003; Seeman, Barry, & Ellinwood, 1964; Stone, 2000). A controversy exists among play therapy mental health professionals as to the most effective means to decrease aggressive behaviors in children. Play therapists disagree on the issue of whether to facilitate the release of aggression or inhibit the expression of aggression in order to diminish future occurrences of aggression in children (Drewes, 2001; Landreth, 2002; Seeman et al., 1964; Stone, 2000; Trotter, Eshelman, & Landreth, 2003). Contradicting literature, along with weak and inconsistent research, contributes to inconclusive arguments in relation to decreasing aggression in children. Little empirical evidence exists for either argument.

**Purpose of the Study**

The purpose of this study was to determine the effectiveness of child-centered play therapy and curriculum-based small-group guidance on the behaviors of aggressive children in an elementary school as determined by (a) the reduction of aggressive behaviors of children, (b) the decrease in internalizing problems of
aggressive children, and (c) the decrease in externalizing problems of aggressive children.

Review of the Literature

The following review is a synthesis of literature and research related to four major areas: (a) aggression in children, (b) therapy with aggressive children and treatment considerations, (c) history and guiding principles in child-centered play therapy, (d) play therapy with aggressive children (e) aggression in schools, (f) counseling in elementary schools, and (g) counseling aggressive children in elementary schools.

Aggression in Children

Defining aggression, the aggressive acting-out child, and the process of aggression, appears to be difficult, because definitions in the literature differ. Mueller (2000) defined aggression as “an action intending to physically harm someone else” (p. 663). He further noted that aggression could also be displaced onto physical objects. For example, he considered behaviors such as biting, thumping, throwing things, snatching a jump rope from others, threatening to do harm, smacking, hitting, and aggression by a child’s fantasy monster to be aggressive. Lebo and Lebo (1957) and Moustakas (1959) noted that aggressive behaviors appear in various manners and that the manner of aggressive behavior depends on the child. They reported that individual differences of expression seemed to be a result of previous living conditions, problems involving the mother-child relationship, and the individual character of the child.

Bierman, Smoot, and Aumiller (1993) and Dodge and Coie (1987) reported aggression to be strongly correlated with peer rejection throughout childhood and adolescence, noting, however, that some aggressive children were not rejected. They
further noted that aggressive boys who were accepted by their peers were more likely than aggressive-rejected boys to use aggression in an instrumental manner (e.g., to defend their turf or authority, to obtain something), and were less likely than aggressive-rejected children to exhibit other negative behaviors such as tantrums, cheating, or verbal insults.

Wehby, Symons, and Shores (1995) studied 28 elementary school-aged children with emotional/behavioral disorders and found that low rates of positive social interactions characterized the daily classroom ecology of students displaying aggressive behavior. The combination of both aggressive behaviors and peer rejection appears to put children at particular risk for serious, chronic adjustment difficulties. The sociometric status of aggressive-rejected boys is more stable than the status of other groups and more predictive of later aggressive behavior (Bierman & Wargo, 1995; Coie, Terry, Lenox, Lochman, & Hyman, 1996; Dodge, 1993).

According to Oaklander (1988), children in American culture receive conflicting messages about anger. They experience adults acting out their anger on them or on others, yet at other times they are instructed that it is not permissible or “nice” for them to express their own anger. When a child does act on feelings of anger, adults quickly respond in attempts to discontinue the behavior (Trotter et al., 2003). Oaklander (1988) proposed that to avoid punishment, children might refrain from any expression of anger. She suggested this might be harmful to the child in that it may leave the child feeling guilty or shameful for even having such feelings. She stressed that children need to express these feelings to avoid the devastating consequences to their psyche that result from repressing them.
Peterson-Johnson and Clark (2001) suggested that the aggressive, acting-out behaviors of a child might in actuality be an attempt by the child to shield him or herself against feeling unwanted, unimportant, unloved, or unlovable. Such children may also be stuck at a developmental level in which some traumatic event occurred. Traumatic experiences, loss of security or protection, abuse or neglect, divorce, depression, or the birth of another sibling, may be precursors for aggression.

Willock (1983) contended that the aggression a child displays might serve as a defense mechanism, assisting the child in self-protection and coping with the world. A child may need this mechanism due to the lack of feelings of safety offered by the child’s parents. Underlying the child’s aggression exists a vulnerability from feeling unloved and unwanted, possibly as a result of inadequate parenting. Willock (1983) suggested that two aspects, a devalued self and a disregarded self, compose an aggressive child’s self-structure. Children who experience themselves as devalued or disregarded may adopt an angry, alienated view of life to defend against feelings of anxiety, anger, or depression.

Neibauer (1988) posited that aggressive behavior is the result of an intense internal conflict and self-doubt. Children demonstrate this internal conflict via offensive interactions with the environment in an attempt to be recognized and to declare the self. Ironically, aggressive behaviors used by the child to gain recognition actually produce isolation and rejection.

*Therapy With Aggressive Children and Treatment Considerations*

The American Psychological Association’s *Diagnostic and Statistical Manual of Mental Disorders, 4th-TR* (DSM-IV-TR) (APA, 2000) classified overtly aggressive and
acting-out behavior as criteria for the diagnosis of conduct disorder or disruptive behavior disorder not otherwise specified. The diagnosis of conduct disorder is considered appropriate when a child demonstrates a “repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (DSM-IV-TR, 2000, p. 98). The child must also present three or more of the following criteria within the last 12 months, with at least one manifesting within the last 6 months: displayed aggression to people and animals, destruction of property, deceitfulness or theft, or serious violations of rules (DSM-IV-TR, 2000).

There are many different theories to explain why children behave aggressively and how to decrease subsequent aggression. The catharsis theory of aggression states that aggressive impulses build up and need to be released in order to decrease (Freud, 1963). Berkowitz (1964) suggested that catharsis could be achieved either instrumentally (direct physical or verbal aggression) or symbolically (vicarious or displaced aggression). Once catharsis occurs, the aggressor may experience tension reduction or a decrease in the tendency to aggress again. Berkowitz further noted that aggressive behavior can initiate feelings of satisfaction or a reduction in anxiety without the likelihood of subsequent aggressive behavior.

Results of studies attempting to validate this theory of aggression are mixed and limited in availability because many are dated. Research by Konecni and Ebbesen (1976) and Konecni and Doob (1972) supported the catharsis theory, indicating that the expression of physical or verbal aggression results in a decrease of subsequent aggression. However, other studies have demonstrated that cathartic release leads to
an increase in subsequent aggression (Green, Stonner, & Shope, 1975; Siegman & Dintzer, 1977).

Murray and Feshbach (1978) investigated whether engaging in fantasy or behavioral aggression decreased the likelihood of subsequent aggressive behavior. In their study they limited the amount of physical activity the children engaged in and aroused the children’s’ anger before they participated in a play situation. They found that participants who participated in an aggressive motoric activity and those who participated in a nonaggressive sedentary activity (symbolic aggression condition) experienced a decrease in fantasy aggression. Contrarily, subjects who participated in the nonaggressive motoric activity increased in fantasy aggression.

Sandler and Joffe (1965) noted that aggression may be functional and lead to adaptation, or it may remain undischarged and lead to passive resignation and depression. Frommer (1968) and Lesse (1974) concurred and suggested that in children, anger and hostility precede, rather than follow, the experience of depression. Moustakas (1959) stated that aggressive behavior that appears during therapy is of significance. He further discussed the process of aggression from a relationship therapy perspective, noting that it involved (a) vague anxiety and hostility, (b) fluctuation of anxiety and hostility, (c) focused hostile attitudes, (d) mixture of negative and positive attitudes, and (e) real separation of negative and positive attitudes.

According to social learning theory, behavior is learned and maintained through observation, imitation of others, and positive consequences (Bandura, Ross, & Ross, 1961, 1963). Thus, social learning theorists propose that aggression in children is learned through modeling and is maintained through practice and reinforcement of
aggressive responses. Social learning research has consistently demonstrated that participation in aggressive acts increases aggressive behavior, with numerous studies indicating that children exposed to aggressive acts demonstrate a significantly greater amount of aggressive behavior than children not exposed to such acts (Puleo, 1978; Walters & Willows, 1968). Social learning theorists maintain that this results because a new way of behaving was learned (Bandura et al., 1961, 1963) or because stimuli have become associated with aggressive behavior and serve as cues to trigger subsequent behavior (Berkowitz, 1964).

Bandura et al. (1961) investigated this theory, finding that children who had observed someone pound a plastic figure with a mallet spent more time pounding other items with the mallet, opposed to children who were not exposed to this modeling. Bandura and Walters (1963) found similar results, noting that children who had been taught to press a lever to deliver an electric shock or forcefully hit a bobo doll (airfilled punching bag) later demonstrated more physically aggressive behavior in a nonaggressive situation. The results of social learning research on aggression indicate that aggressive play may lead to an increase in subsequent aggression (Bandura, 1973).

Sarnoff (1987) described aggressive behaviors from a psychoanalytic perspective, stating that some children find it difficult to control and inhibit sexual and aggressive drives due to extreme levels of stress or excitement caused by excessive aggressive or sexual stimulation. Fukaka (1971) defined the process of aggression in play therapy as a movement between periods. Fukaka outlined this process as beginning with a period of anxiety and searching, followed by a period of beginning of
aggressive behavior, a period of expansion of aggressive behaviors, a period of creative reorganization, and ending with a period of adaptation outside of the playroom.

**History and Guiding Principles in Child-Centered Play Therapy**

Children’s problems are often compounded by the inability of adults to understand or respond effectively to what children are experiencing (Landreth, 2002). This communication gap is magnified as a result of adults’ demand that children adopt adult or verbal means of communication. Children’s language development lags behind their cognitive development. Thus, efforts to communicate with children solely on a verbal level will result in awkward and unnecessary miscommunications (Landreth, 2002).

Play has long been recognized as important in the lives of children. Play is to the child what verbalization is to the adult (Landreth, 2002). Play is a developmentally natural means of communication for children, permitting the expression of feelings, the exploration of relationship, the description of experience, the disclosing of wishes, and the fulfillment of self.

In 1909, Sigmund Freud published the first case, “Little Hans,” a 5-year-old boy with a phobia, depicting the therapeutic use of play as a psychological approach to working with children. In this classic case, Freud conducted treatment by advising Hans’s father of ways to respond to Hans based on the father's notes about Hans’s play. Play therapy developed from efforts to apply psychoanalytic therapy to children. Hug-Hellmuth (1921) was one of the first therapists to categorize play as essential in providing therapy to children, including play materials in session to promote the expression of self.
Melanie Klein (1955) proposed that play proved direct access to a child’s unconscious. Using play with children to mimic free associations techniques used adults, Klein was able to analyze children under the age of six. During this same period Anna Freud (1946) began to use play as a means to build a therapeutic alliance with child patients. She emphasized the importance of developing the emotional relationship between the child and the therapist before interpreting the unconscious motivation behind a child’s drawings and play. These initial pioneers prompted major developments for the use of play in various theoretical schools. These collective movements contributed to the establishment and acceptance of play therapy as an accepted modality for treating children.

Carl Rogers (1942) developed nondirective therapy, which is known today as person-centered therapy. Virginia Axline (1969) was a major developer of nondirective play therapy, later to be known as child-centered play therapy, successfully applying nondirective therapy principles to children in play therapy. Since her initial efforts, many have expanded on her work in play therapy, including Moustakas (1953), Guerney (2001), and Landreth (2002). These theorists emphasized a child-centered play therapist makes no attempt to control or change the child. The child-centered theory is based on the belief that a child’s behavior is at all times caused by the drive for complete self-realization. Objectives in child-centered play therapy include self-awareness and self-direction by the child, which is facilitated by a fully stocked playroom, with freedom extended to the child to play as desired. In this approach the therapist actively reflects the child’s thought and feelings, believing that offering
genuineness, unconditional positive regard, and empathetic understand will free the child to accept self (Axline, 1969; Landreth, 2002)

Axline (1969) proposed eight basic principles to guide a therapist in developing a Play Therapy with Aggressive Children: (a) develop a warm, friendly relationship with the child; (b) accept the child exactly as he/she is; (c) develop a feeling of permissiveness so the child feels free to express feelings completely; (d) recognize and reflect the child’s feelings in a manner that promotes insight into his/her behaviors; (e) maintain a deep respect for the child’s ability to solve his/her own problems and believe the responsibility to make choices and to instigate change is the child’s; (f) allow the child to lead, the therapist follows; (g) understand that therapy is a gradual process and does not rush the child; and (h) set only limitations that are necessary (p. 73).

Play Therapy With Aggressive Children

In play therapy, the therapist’s task is to provide a safe therapeutic environment where a child can explore feelings, behaviors, and consider other ways of being (Carroll, 1995). Several leading play therapy authorities have emphasized that the relationship between therapist and child is of utmost importance for the child’s healing and growth (Axline, 1969; Guerney, 1983; Landreth, 2002; Moustakas, 1959). The therapeutic relationship is essential in that it assures the child that neither he/she nor the therapist will be harmed as a child explores his or her most frightening and destructive thoughts and feelings. An aggressive child may feel threatened by the intimacy of such a relationship and thus be resistant to the therapist (Peterson-Johnson & Clark, 2001). The therapist must be able to first accept the child’s need to be negative or rejecting, because the aggressive, acting-out child may feel as though the therapist
wants to change him or her. In a safe and unconditionally accepting environment and relationship, the child is free to accept his or her self (Landreth, 2002).

Moustakas (1955) examined the expression of negative attitudes between adjusted and maladjusted children. He found that maladjusted children demonstrated a significantly greater number of negative attitudes with a greater average severity of feeling. He also found no difference in the kinds of negative attitudes expressed between adjusted and maladjusted children, thus supporting the hypothesis that anger is a natural and healthy emotion. Axline (1969) stressed that the therapist should facilitate the expression of all feelings experienced by a child. The therapist’s complete acceptance of the child’s inner feelings, combined with the appropriate reflections of these feelings, facilitates the clarification of feelings for the child and insight into the child’s own behavior.

Whether a cathartic release of aggression in the playroom is therapeutic is not well established (Sloan, 1997). Amster (1964) suggested that play has a cathartic purpose. In the playroom the unconscious material that has built up in the child can be expressed, and the accompanying tensions and feelings can be cathartically released. Thus, in play therapy, feelings that are manifested by aggressive behaviors are expressed openly and resolved in a fully accepting therapeutic relationship. Nickerson (1973) concurred that play may facilitate a child’s communication while also allowing for a cathartic release of negative feelings. This may in turn help the child learn to cope with his/her environment.

Some play therapists have expressed concern for the behavior latitude permitted in child-centered play therapy, particularly with regard to aggressive children. Stone
(2000) expressed concern for including aggressive toys such as the Bobo in a play therapy room to facilitate a child’s expression of emotions. He questioned the therapeutic value and the resulting effects of such items, suggesting that they may invite aggressive behavior in children and possibly teach children to be violent. Drewes (2001) reported on a personal experience in which she viewed the aggressive behaviors of a child in the playroom to be related to aggressive acts outside of the playroom. She reported that the use of aggressive toys in the playroom is not sufficient in helping children learn how to handle aggressive feelings and impulsive actions and recommended the use of alternative expressive materials such as clay, water, drawings, and stories.

Other play therapists recommend that aggressive toys be included in the playroom. They address the comments by Stone (2000) and Drewes (2001) by stressing the importance of considering the developmental level of children. They note that children lack the verbal skills and the sophistication necessary to adequately express many emotions. (Guerney, 1983; Landreth, 2002, Trotter et al., 2003).

Feshbach (1956) examined the differential effects of aggressive and nonaggressive play objects on the play activity of high- and low-aggressive children. Results from this study indicated that children who utilized aggressive play objects consequently expressed more inappropriate aggression than when they played with neutral toys. It was also found that both high- and low-aggressive children who played with either the aggressive or neutral toys showed decreases in aggression as rated by their teachers.
Trotter et al. (2004) conducted an informal survey on the play therapy session case notes and session summary scales of 15 master’s and doctoral degree play therapists to determine how children played with the Bobo in their current play therapy sessions. The informal survey included 205 play therapy sessions for 20 children with play therapists of various theoretical orientations. They found that aggressive play with the Bobo was reported in only 22% of the sessions and 65% of the sessions did not include Bobo play.

Trotter et al. (2003) stressed that, although toys may break or the supply of paper and paints may run out, the most important element in the therapeutic process is the caring, consistent, and compassionate presence of the therapist. Moustakas (1997) noted that children who feel accepted, cherished, and respected experience a sense of inner power and confidence by which anger, pain, or sorrow are permitted free release. The expression of these feelings, in the presence of a caring play therapist, facilitates the child’s healing.

Landreth (2002) suggested that the playroom be equipped with toys and materials that allow children the opportunity to express aggressive feelings, including a bop bag, toy soldiers, aggressive puppets, aggressive animals, guns, and rubber knives. He also recommended that materials such as an egg carton, popsicle sticks, clay, and paper be included as alternative items that a child can destroy. In child-centered play therapy, the child is free within acceptable boundaries to express anger, hostility, and frustration, with the aforementioned items (Landreth, 2002).

O’Connor (1986) classified hostile (aggressive) behaviors to include firing a toy gun which shot rubber-tipped darts; striking an object in the playroom; throwing any
object; acting out others’ deaths (burying cars or dolls in the sandbox; conducting wars with toy soldiers; shooting a doll or toy soldier with the dart gun); commanding the therapist to perform some behavior; discussing or expressing hurting another person in reality or fantasy; discussing any behavior in which he/she engaged, and for which he/she was later punished; and verbalizations that become noticeably louder than the immediately preceding verbalizations.

Trostle (1984) suggested that a child’s aggressive behaviors reflect the child’s internal feelings of isolation, loneliness, insecurity, anger, incompetence, and rebellion. Through the process of play, a child is able to express these feelings, because play and activity are the natural medium of communication for children (Landreth, 2002). Through the modality of play therapy the mental health professional provides the child the opportunity to recreate and work through past traumas (Smith & Herman, 1994).

Allowing the externalization of a traumatic event onto play materials provides an emotional safe distance for the child to work without retraumatization (Mills & Allan, 1992). Trotter et al. (2003) suggested that “in play therapy, feelings that are masked by aggressive behaviors are expressed openly and resolved in an understanding accepting therapeutic relationship” (p. 120). Peterson-Johnson (2001) similarly stated that an aggressive child will feel the freedom to experiment with more socially effective behaviors if provided an opportunity to express negative feelings or needs and still be accepted by the therapist.

According to Carroll (1995), a child’s aggressive behavior in the playroom is the expression of a need in that moment. Furthermore, the child masks feelings of fear and vulnerability by projecting these undesired feelings outward. The child is unable to
change until he or she feels the need. Peterson-Johnson and Clark (2001) suggested that it is “through symbolic representation that a child gains a sense of control over events that seem uncontrollable in reality” (p. 240).

Peterson-Johnson and Clark (2001) suggested that an aggressive child may initially reject the play therapist as a means to protect his or her self. This occurs because aggressive children may feel incapable of attracting the genuine interest or caring of others. Peterson-Johnson and Clark stressed that the therapist should look beyond this rejection, remaining sensitive to the child and the underlying feelings. To understand a child’s external reaction to the world, they suggested that the therapist identify the child’s internal frame of reference.

Willock (1983) shared his personal experience with an aggressive child client who utilized masked dependency in therapy, a style of forcing close caretaking while acting as if that were the last thing the child wanted. His client enjoyed playing out and drawing explosive battle scenes and army battles, and shot people not to kill them, but to make them suffer. The child also climbed on top of cabinets, overturned chairs, threatened to break valuable objects, picked up the telephone to curse at whoever was on the line, made huge messes, ran out of the therapy room, turned off the lights, spit into the room, and yelled obscenities in attempts to force Willock to physically take care of him. Willock noted that the chaos, violence, and defiance were not without meaning. The aggressiveness led to a better place and would not have been possible if the child’s vulnerabilities were not therapeutically engaged and worked through.

Aggressive children often exhibit aggressive behavior in therapeutic settings and thus, necessitate the setting of limits. Bixler (1949) and Landreth (2002) reported on the
therapeutic impact of limits and their necessity in the play therapy relationship. Limits provide physical and emotional security; facilitate the development of self-control, decision-making, and self-responsibility; promote the therapist’s acceptance of the child; anchor the play session to reality and emphasize the here and now; promote consistency of the environment; preserve the professional, ethical, and socially acceptable relationship; and protect the play therapy materials and room (Bixler, 1949; Landreth, 2002). Solomon (1948) noted that it might be necessary for the therapist to show a degree of firmness. He suggested that it might become a therapeutic necessity to set limits as to how far children can go to express their aggressions. He further supported the play approach, in that it permitted physical aggression to be expressed, needing few limits to items such as a doll, noting that some rubber dolls can take a considerable beating without danger of destruction.

Through limit setting, the play therapist is able to offer a warm, accepting, and empathetic environment to the aggressive, acting-out child (Landreth, 2002; Peterson-Johnson & Clark, 2001). Landreth’s ACT model of therapeutic limit setting is commonly used in child-centered play therapy (see Appendix C). Landreth suggested that a therapist remember to “act” when a limit is needed: “A, Acknowledge the child’s feeling, wish or want; C, Communicate the limit; and T, Target acceptable alternatives” (Landreth, 2002, p. 261). Limits set in this manner provide an aggressive child with multiple alternatives to express and release aggression, while more importantly create an atmosphere of safety and security, promoting predictability in the therapeutic relationship and setting.
Multiple investigators have attempted to discover the effectiveness of play-based intervention services of children. Limited is the number of studies that have attempted to measure their effectiveness on aggressive children. After an exhaustive search of the literature, the following studies are presented as support for utilizing this modality with this population.

Beers (1985) investigated the effectiveness of play therapy with oppositionally defiant children. She compared 20 intact families, with at least one child diagnosed as oppositionally defiant, aged 4 to 9 years. The families were randomly assigned to participate in one of three groups: (a) play therapy and parent counseling, (b) focused videotape feedback group (child received a videotaped play period with each parent and then tape was reviewed by therapist with parents), or (c) a control group. Utilizing two measures, the Eyberg Child Behavior Inventory and the Interpersonal Behavior Constructs Scale, Beers found that all groups demonstrated a decrease in perceived problems and intensity of problems. She further reported that nonacceptance behavior in parent-child interactions decreased significantly for play therapy groups after 8 weeks of treatment although some of this positive gain was lost at the 16 weeks and follow-up period. The videotape feedback group had a statistically significant increase in non-acceptance behavior at both midtreatment and follow-up. Beers further found that the play therapy group increased at statistically significant levels in the amount of time a parent and child worked together as compared to a video group. Shared conversations significantly increased in the videotaped feedback group, while play therapy group showed a slight decrease.
Hannah (1986) studied 10 children, aged 4 to 6 years, in a time-series experimental design lasting 11 weeks. Nine children were identified as intervention subjects, receiving play therapy, and 1 was identified as a nonintervention comparison subject. Eight of the 9 intervention subjects exhibited a significant positive change in their targeted behavior (verbal social interactions, patterns of peer interaction, off-task behavior, and aggressive acts), whereas the comparison subject showed a significant increase in undesirable behavior.

Kaczmarek (1983) investigated 38 children exhibiting behavioral excesses. In mother-child dyads, children were assigned to one of three groups for 7 weeks: (a) play technology (with mothers receiving training in a group format to act as play facilitators for their own children, at home), (b) individual play therapy with a counselor, or (c) unstructured play sessions between the mother and the child at home. Kaczmarek found that the individual play therapy and the unstructured play sessions groups significantly reduced the number of daily group total behavioral counts. Individual play therapy also appeared to produce positive results when the child had a need to release anger and negative emotion.

Sloan (1997) examined the effects of spontaneous aggressive play on 22 elementary students. In this study, 11 children participated in 10 aggressive-charged play therapy sessions (sessions in which the therapist suggested and demonstrated aggressive activities to the child) and 11 children participated in 10 traditional (unspecified) play therapy sessions. Data collected included initial behavior ratings and follow-up ratings completed at the 2nd, 4th, and 6th week of the intervention period by parents, teachers, peers, and students, along with recorded observation of spontaneous
aggression in play sessions. The Devereux Behavior Rating Scale was used as an initial screening instrument. A modified version of the same scale was utilized as a repeated measure of home and school aggression. Contrary to predictions, the children who participated in the aggressive-charged play therapy sessions did not exhibit more aggression in the playroom as compared to the children who received traditional (unspecified) play therapy. Furthermore, the data provided support that participation in play therapy is effective in reducing aggressive behaviors and implied that play therapy may be an effective school-based intervention for elementary students.

Dogra and Veeraraghavan (1994) studied 20 children diagnosed with aggressive conduct disorder and their parents in a pre-post control group experimental design. Utilizing the Picture-Frustration Test and Child Behavior Rating scale, the investigators found that, compared to the control group which received no treatment, children who received 16 sessions of nondirective play therapy and parental counseling demonstrated significantly fewer extrapunitive responses as well as significantly higher impunitive and need-persisitence responses. They noted that the treatment group showed significant positive change on adjustment to self, home, school, social, physical, and personality total adjustment. They further found that the play therapy, parent counseling group demonstrated a decrease in aggression, including fighting and bullying, violence against adults, and temper tantrums. Parental use of corporal punishment, parental neglect, and a child’s strong dislike for school also decreased in the experimental group after 16 sessions of treatment.

Seeman et al. (1964) conducted a study on 16 children rated lowest in adjustment of 150 children on the Tuddenham Reputations Test. The pre-post design
study consisted of an 8 member control group and an 8 member experimental group that experienced play therapy once per week. The researchers were able to compare the two groups with respect to changes in aggression scores because the two groups remained intact throughout the study. Prior to the application of the treatment, all 16 of the children had positive aggression Z scores, indicating that each were more aggressive than the class average. At posttesting, the children in the experimental group had lower aggression scores than the average child in the class. All the children in the control group still had higher than average aggression scores.

Wakaba (1983) studied the effect of 21 group play therapy sessions on 3 children who stuttered in an attempt to improve the children’s stuttering and to promote their development in social adaptation. As therapy progressed, change was observed in each child in terms of aggression: from periods of anxiety, appearance of aggressive behavior, and frequent occurrence of aggressive behavior, to a decrease in aggressive behavior. After the appearance of aggressive behavior, Wakaba noticed that as cooperative play with other children began, a fluctuation in stuttering occurred. This was later followed by a decrease in stuttering. The researcher noted that the appearance of aggressive behavior during therapy is thought to be of major significance for the disappearance of stuttering and for interpersonal relationships. Follow-up surveys were made 6 months and 5 years after therapy, showing that both stuttering and social adjustment had improved, indicating the effectiveness of therapy.

Lebo and Lebo (1957) reported on the close relationship between the appearance of aggressive behavior and the establishment of interpersonal relationships. They stressed that children who frequently demonstrated aggressive
behavior were successful in establishing an interpersonal relationship with the therapist. This study continues to serve as foundational support for the use of mental health modalities that utilize a therapeutic relationship as a base for healing.

Kot, Landreth, and Giordano (1998) conducted a pretest-posttest control group designed study in which they hypothesized that child abuse might be one of the traumatic precursors that lead to aggressive behaviors in children. Children who witness domestic violence experience loss, isolation, low self-esteem, lack of impulse control, and emotional turmoil, and they tend to imitate the violent behaviors of the parents. The study compared 11 children who witnessed domestic violence and received 12 individual child-centered play therapy sessions to a control group, also composed of 11 children who witnessed domestic violence. They found that the treatment group exhibited less aggression following play therapy than the control group.

According to Cohn (1962), children could use dolls as a projective technique in eliciting fantasy aggression. He argued that for the child, doing something in play is like doing it in reality. Cohn stated that dolls provide children an opportunity to create a world in which their thoughts and motives dictate occurrences. Cohn further reported that children are less inhibited to produce fantasy aggression with dolls than under other conditions. With dolls, a child is free to engage in spontaneous aggressive behaviors (Peterson-Johnson & Clark, 2001). Sears (1950) observed 42 preschool-aged children in doll play to study the relationship between aggression and punishment in the home. Sears found that the severely punished group was the most aggressive in fantasy play.

The use of art materials can provide children opportunities to express on paper the emotions they are incapable of verbalizing. Neibauer (1988) reported that the use
of art in play therapy may provide the aggressive, acting-out child a symbolic container in which to place his or her feelings. Manning (1987) studied abused children and children from violent homes and found that aggression was depicted in children’s drawings most often by exaggerated figures and as objects falling and/or hanging over a child’s head. Hammer (1980) noted that oversized open arm and hands in art are signs of aggression. According to Neibauer (1988), aggressive acting-out children may approach an art experience with caution manifested in behaviors like hesitation, distractibility, or oppositionalism. They may avoid authentic self-expression and lose self-control due to increased anxiety. These children may also use abstract art modalities, such as clay, because of its ambiguous nature, allowing them to be distanced from characterizing self or their environment. Neibauer (1988) argues that the angry child will cling to the symbolic level, avoiding responsibility for his or her actions in an attempt to protect self from further injury or loss. Art offers this same child a means to express emotion while maintaining a distance from the fear and threat of reality.

According to Peterson-Johnson and Clark (2001), art materials and engaging in artwork may elicit either enthusiasm or fear from an aggressive, acting-out child. Aggressive children possess a need to assert themselves and to be recognized as valued persons. Creativity-expressed outlets such as art test a child’s ability and willingness to assert the self and integrate internal impulses with external realities (Neibauer, 1988).

Peterson-Johnson and Clark (2001) also noted games to be an effective therapeutic technique for working with older, aggressive, acting-out children. Through the game process, the child may learn and practice social skills necessary to interact
with others. By adhering to rules of a game, a child learns what consequences exist for inappropriate behaviors and thus begins to understand how to constructively deal with anger, frustration, or hostility in a socially acceptable manner (Peterson-Johnson & Clark, 2001). This translates to learning self-control over the basic aggressive impulses that the child is accustomed to exhibiting freely.

Johnson and Nelson (1978) noted that games provide children with positive and constructive social actions and attitudes. They studied 14 male juvenile delinquents, aged 12-15, by randomly assigning them to either an experimental group that received five counseling sessions involving the use of the role-playing simulation game or to a control group that received counseling without the game. They found that the experimental group demonstrated an increased willingness to communicate in general, as well as with either counselor. In contrast, communication from the control group worsened, accompanied with a decreased willingness to communicate.

Willock (1983) suggested that a child may feel safer participating in a structured activity because it is less likely to trigger intense drives or feelings. Willock cautioned game users that children might use games as a mean to avoid building a real relationship with the therapist and possibly limit creative expression. Reid (1993) suggested that board and card games led by an adult might be more successful at decreasing aggressive behaviors than cognitive or behavioral techniques because they provide a child a sense of safety in an anxiety-provoking environment.

Aggression in Schools

Many attempts have been made to document the increasing presence of violence and aggression in the school system. Carlsson-Paige and Levin (1991)
conducted a national survey in which 91% of the responding teachers reported increased violence among children in their classrooms. In 1992, Zero to Three, a national nonprofit organization that promotes the healthy development of babies and toddlers, performed a survey of New Orleans fifth graders. More than half of the fifth graders reported they had been victims of some type of violence; 70% had witnessed weapons being used.

School-age children often reject physically aggressive children because of their inappropriate behavior (Hann & Borek, n.d.; Reiss & Roth, 1993). The mixture of rejection and aggressiveness intensifies behavior problems, increasing the difficulty for aggressive children to build positive relationships with other children. Recent research indicates that children who are both aggressive and rejected show poorer adjustment in elementary school than children who are aggressive, rejected, or neither (Hann & Borek, n.d.).

Longitudinal research has consistently demonstrated that aggressive, peer-rejected children in first grade are at increased risk for participating in delinquent, violent behavior in adolescence (Hawkins et al., 2000; Loeber & Farrington, 1998; Tolan & Gorman-Smith, 1998) and for becoming antisocial adults (Eron & Huesmann, 1990). Promising studies exist suggesting that the developmental path of youth violence may be altered (CPPRG, 1999; Dahlberg, 1998; Stoolmiller et al., 2000). Several studies have demonstrated that aggressive behavior can be reduced by altering the social environments at school (Farrell & Meyer, 1997; Gottfredson, 1997; Reid et al., 1999; Stoolmiller et al., 2000).
Stressors from children’s home environments may contribute to the development of adjustment difficulties and create an inner turmoil that may preoccupy the thoughts of children, distracting them during classroom instruction (Adelman & Taylor, 1991). The National Association for the Education of Young Children [NAEYC] (1993) stressed the need to break the cycle of violence that children and families exist in for fear that children’s learning in schools will be hindered, noting that “children need to be safe at school to successfully learn” (p. 1). They further stressed that our entire society must assume some responsibility for the problem of increased violence. They suggested that new policies should be designed that target the “greatest number of resources toward children in the preschool and elementary years when children are most vulnerable to developmental damage as a result of exposure to violence” (p. 1). Chaloner (2001) noted that, because of the increase of violence present, teachers and school counselors are forced to handle violent children, frequently without the resources to intervene successfully.

Counseling in Elementary Schools

Approximately 34 million children are enrolled in elementary schools across the United States (U.S. Census Bureau, 2000). Thousands of these children are dealing with emotional issues, including withdrawal, hyperactivity, impulsiveness, aggression, and significant behavioral problems that are interfering with their ability to develop and maximize their academic potential. Mash and Dozois (1996) estimated that 14-22 percent of all children experience developmental, emotional, and behavioral disorders. Many of these children never reach services offered by the mental health system (U.S. Public Health Service, 2001).
Schools are currently the primary providers of mental health services because most children who experience difficulties are referred to school counselors (U.S. Public Health Service, 2001). Approximately 70% of children who receive mental health services receive them from school counselors. Elementary schools are of critical importance because they provide both educational and psychological foundations for youth (Gibson, Mitchell, & Basile, 1993). Educators continually search for interventions to assist children because psychological problems can inhibit a child's ability to learn and lead to academic failure (Cowen, 1973; Pianta, 1997).

Elementary school counseling programs, which began in the 1960s and 1970s, have been based on the rationalization that, if school counselors aid children at a young age to appropriately socialize and develop a positive attitude toward learning, they will become productive, well-adjusted students (White & Flynt, 1999). Thus, elementary school counselors work largely from a preventive model. Elementary school counselors deliver a variety of services. They do not work in isolation, valuing consultation with teachers and parents and educating them on classroom management skills, models for understating children, discipline, and parenting skills respectively (Alexander, 1964). Warm, nurturing relationships with teachers and positive early school experiences are known to be critical components in children's ability to cope with stress and trauma (NAEYC, 1993).

A recent increase in school systems referrals of children for counseling, along with a lack of resources, resulting in an inability to meet current counseling demands, indicates a need to expand services (U.S. Public Health Service, 2001). The Surgeon General stressed a need for an increase in school-based counseling services, noting
that greater access to services could facilitate a reduction in barriers to academic success and serve as prevention against the development of future mental health problems (U.S. Public Health Service, 2001).

In 2003, the American School Counselor Association (ASCA) implemented a national model to correct historical criticisms of the school counseling profession, including lack of consistent identity, variation in roles from school to school, and non-school counselor responsibilities (ASCA, 2003; Gysbers & Henderson, 2001). This model increased the focus on treatment goals and the effectiveness of the school counseling services provided, by proposing an organizational framework that formulates a comprehensive school guidance program. ASCA’s national model for school counseling programs incorporated Gysbers and Henderson’s (2001) four components, guidance curriculum, responsive services, individual planning, and system support, into the primary delivery system for counseling services in schools.

Guidance curriculum, Gysbers and Henderson’s first component, is designed to prevent problems that may develop in a student’s future. When providing guidance, a counselor attempts to promote awareness, assist in skill development, and improve application of skills to everyday life (Ray, Muro, & Schumann, 2004). Typically this demand for guidance services is met by providing large-group classroom guidance activities with topics directly related to the developmental level of the child audience. For example, a kindergarten classroom guidance curriculum might focus on following school rules and introducing positive character qualities. A fifth-grade classroom guidance curriculum might entail an activity promoting the understanding and identification of peer pressure (White & Flynt, 1999). Classroom guidance is the most efficient use of the
counselor’s time, because it builds specific resilient attributes and increases appropriate socialization for a large number of children at the same time (Gibson et al., 1993; White & Flynt, 1999). A guidance curriculum is generally used in a preventative manner, but it can also be utilized as a direct intervention (Pedersen & Carey, 2003; Worzbyt & O’Rourke, 1989).

Response services, Gysbers and Henderson’s second component, addresses the immediate concerns of students, concentrating on intervention (Gysbers & Henderson, 2001). Of the four, this component is most closely associated with the role of counseling. Offered in individual and group formats, school counselors provide response services when they use remedial interventions with students struggling to make healthy choices and struggling to cope with difficult situations (Cobia & Henderson, 2003).

A key element in these first two components is group membership. This quality can carry terrific benefits, including the promotion of insight. Berg and Landreth (1998) implied the importance of group membership, noting that children in groups discover that their peers have problems too, thus diminishing barriers of loneliness. Feelings of belonging follow this decrease in loneliness and the child may begin to experiment with new interpersonal skills. According to Ginott (1982), group therapy is based on the assumption that children will modify behavior in exchange for acceptance. Landreth and Sweeney (1999) outlined multiple benefits that the presence of another child or several children can bring to the therapeutic environment, including a relaxed setting with less tension and anxiety, increased spontaneity and self-awareness, providing a tangible
social setting for discovering and experimenting with new and more satisfying modes of relating to peers and vicarious and directed learning.

Individual planning is Gysbers and Henderson’s third component of school counseling in which a counselor assists students in monitoring and planning their educational and occupations values, goals, abilities, aptitudes, and interests. For elementary school settings, individual planning involves monitoring academic achievement through the management of standardized testing and tutoring (Gysbers & Henderson, 2001). An example of individual planning may involve encouraging a fifth-grade student who demonstrates low self-esteem to become a mentor for a kindergarten student, while exploring options with the student’s teacher to provide more opportunities for responsibility in the classroom.

Gysbers and Henderson’s final component is system support, an essential to the success of the other three components (2001). System support indirectly services students; by impacting the system, students are impacted. System support can consist of staff development, community relations and outreach, advisor boards, program management, accountability, research and development, and program time are foundations to program balance and function.

Counseling Aggressive Children in the Schools

Leff et al. (2001) compared existing school-based aggression prevention programs across the nation and found that targeting programs to kindergarten and young elementary school students, focusing on aggression in girls as well as boys, and conducting programs in naturalistic settings like playgrounds are key factors in the success of aggression prevention in schools. Leff et al. (2001) reported that as many
as 30% of school-age children are repeatedly teased, threatened, or attacked by their peers.

Guidance curriculum. Second Step®: A Violence Prevention Curriculum is a “universal prevention program that proactively teaches critical social and emotional skills to all children. The curriculum goals are focused on reducing aggressive and disruptive behavior while promoting social-emotional competence” (Committee for Children, 2002b, p. 4). The Second Step units are based primarily on cognitive-behavioral theory, which grew out of Bandura’s social learning theory, and are designed to improve children’s skills in three general areas: empathy, impulse control and problem solving, and anger management. Utilized in a classroom guidance format, the Second Step program has been found to be successful and decreasing aggression and increasing positive behaviors (Frey, Nolen, Van Schoiack-Edstrom, & Hirschstein, 2001; Grossman et al., 1997; McMahon et al., 2000; Taub, 2002).

Grossman et al., (1997) examined the impact of the Second Step program on aggression and positive social behavior among elementary students. The study consisted of dividing 12 schools into six pairs that consisted of similar student body make up in relation to socioeconomic status and ethnicity. One school in each pair was randomly assigned to the control group, not exposed to the Second Step program, or an experimental group, where second- and third-grade classroom teachers taught the Second Step program to participants. Trained coders, unaware of experimental assignment, observed the participants in their classrooms, lunchrooms, and on the playground for a total of 45-60 minutes of observations per child on three occasions; prior to the intervention, 2 weeks following the intervention, and 6 months after the
intervention. Results demonstrated that second- and third-grade students who were exposed to the Second Step curriculum became less physically aggressive and increased their positive social interactions. In contrast, the behavior of the control group children not exposed to the curriculum worsened. Measures of the experimental group’s higher levels of positive interaction were maintained at the 6-month follow up period.

McMahon et al. (2000) investigated the effectiveness of the Second Step Preschool-Kindergarten program with 109, predominantly Africa American and Latino 3- to 7-year-old children from low income urban families. In this pre/post evaluation, all children participated in the Second Step program. The researchers found that following the completion of the Second Step lessons, the children demonstrated an increased conceptual knowledge of social skills and a decrease in observed levels of physical aggression, verbal aggression, and disruptive behavior.

Using an experimental-control group design, Taub (2002) examined the effects of the Second Step curriculum on 54, third- to fifth-grade students. In this study, ratings of children’s social competences and antisocial behavior were collected from teachers along with researcher observations of children’s prosocial behavior (engaging appropriately with peers, follows directions, follows classroom rules) and antisocial behaviors (bothers others, fights/argues with others). Compared to the control group students, students who received exposure to the Second Step lessons increased in social competence and followed more directions. They also demonstrated a slight decline in antisocial behaviors, while the control group increased in antisocial behavior.

A study of over a thousand second-through fifth-grade students indicated improved social competence in the intervention schools versus the control schools.
Investigators found that Second Step participants displayed less hostility, required less adult intervention, and were more likely to choose goals that led to fair outcomes for others as well as themselves (Frey et al., 2001).

Child-centered play therapy. White and Flynt (1999) reported, “School counselors facilitate cognitive development and school success as well as emotional adjustment, and they do this by combining verbal and nonverbal play experiences in developmentally appropriate counseling experiences for children” (p. 339). They further emphasized that elementary school counselors should be aware of the developmental needs of their students and understand that play is a natural activity of children through which a child communicates, tests, incorporates, and masters his or her world. Landreth (1987) encouraged school counselors to use play therapy to meet the developmental needs of children. Berg (1971) stressed that play therapy skills should be equally utilized by a school’s counselor as the use of verbalization and behavior modification. The Elementary School Guidance and Counseling journal publicly recognized this need and dedicated an entire special issue to play therapy (Gerler, 1993).

Landreth (2002) recommended careful planning when developing and implementing a play therapy program in a school, stressing that many teachers and administrators fail to understand play therapy and its purposes. He has encouraged school counselors to educate staff on the guiding principles of play therapy and facilitate their understanding of the process. Landreth (1993) outlined four factors believed to be inhibiting the growth of play therapy programs in elementary schools; (a) the infancy of the field of play therapy; (b) the infancy of the school counseling position, existing only
since the 1960s; (c) lack of play therapy knowledge among school personnel; and (d) the lack of play therapy training programs.

Ray et al. (2004) noted the potential benefits of implementing a play therapy program in an elementary school and the challenges of collecting data. During their yearlong pilot study they collected qualitative data from school administrators and teachers that suggested a decrease in office referrals, an increase in academic performance, and an improvement in classroom behavior. They found that conclusive quantitative data completed by the teachers were difficult to collect due to high turnover in staff. Ray et al. explained that play therapy fits into the ASCA (2003) national model, serving the student population as a responsive service and appearing to be a valuable school intervention.

Bleck and Bleck (1982) studied third-grade children who were considered disruptive to the classroom (shouting, hitting, teasing, tripping others, kicking, running around, throwing objects, hurting others, etc.). In this randomized pre-and post-control group experimental design, children were randomly assigned to either an experimental group or a control group. The experimental group attended bi-weekly structured playgroup sessions with 5 other children, led by elementary school counselors for 5 weeks, and the control group received no treatment. Their findings implied that counselors using structured play can have positive effects on the attitudes of disruptive children, including increased self-concept.

In a meta-analysis of play therapy outcome research across 6 decades, play therapy was found to be an effective therapeutic modality for treating children’s problems. The analysis revealed that children receiving play therapy services performed
.8 standard deviations above nontreatment groups, a recognized large effect size. Of the 96 studies analyzed in the meta-analysis, 36 were performed in a school setting, indicating that the school setting is an appropriate location to implement play therapy interventions (Ray et al., 2001).

Summary

With the recent increase in school systems referrals, schools are currently in need of effective interventions to assist aggressive children with psychological problems. Current literature suggests that child-centered play therapy is suited to meet these treatment demands. Current research supports the use of Second Step, a curriculum-based guidance program, to meets these demands. Comparative studies are needed to determine the most appropriate means of meeting these demands.
CHAPTER 2
METHODS AND PROCEDURES

This chapter presents the methods and procedures utilized for this study. Included in the chapter are the definition of terms, hypotheses, descriptions of the instruments utilized for the collection of data, a discussion of the selection of participants, specific methods of data collection, a description of the treatment, and an explanation of the data analysis procedures.

Definition of Terms

*Aggression* was defined as the child’s tendency to do physical harm to him or herself, therapist, room or materials or emotional harm to self or others. Aggression was operationally defined for the purposes of this study as the score on the Aggressive subscale of the Behavioral Assessment System for Children (BASC) (Reynolds & Kamphaus, 1992).

*Externalizing behavior problems* refers to behaviors, which are outward manifestations of inner conflict. These behaviors can include aggression, hyperactivity, and conduct problems. For the purpose of this study, externalizing behavior problems was operationally defined as the score on the “Externalizing Problems” domain of the Behavioral Assessment System for Children (BASC) (Reynolds & Kamphaus, 1992).

*Internalizing behavior problems* refers to behavioral characteristics that are symptomatic of an attempt to cope with internal difficulties. Often emotions are prevented from expression and are instead directed internally. Behavioral characteristics include withdrawal, anxiety, depression, and suicidal ideation. For the purpose of this study, internalizing behavior problems was operationally defined as the...

*Child-centered Play Therapy* was defined as a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development. (Landreth, 2002, p. 16)

*Child-centered Play Therapy Skills* According to Axline (1969), Guerney (1983), Landreth (2002), and as listed by Ray (in press), effective child-centered play therapy nonverbal skills consist of the following: (a) leaning forward and maintaining an open posture; (b) appearing interested; (c) seeming comfortable and relaxed; (d) voicing a tone and expression that is congruent with the child’s affect; (e) voicing a tone and expression that is congruent with the play therapist’s responses. Effective child-centered play therapy verbal communication includes the following: (a) tracking behavior, verbally reflecting the child’s behaviors; (b) reflecting content, paraphrasing the child's verbal expressions; (c) reflecting feelings, voicing the child’s emotions; (d) facilitating decision making and responsibility, empowering the child to decide or do for himself or herself; (e) facilitating creativity and spontaneity, freeing the child from rules or burdens that are not present in the play therapy room; (f) building self-esteem and using encouragement, facilitating the child to feel capable and worthy; (g) facilitating the relationship, encouraging a positive, healthy therapeutic relationship between the child
and the play therapist; (h) enlarging the meaning and the facilitation of understanding, verbalizing connections between the child’s play and experiences; and (i) limit setting, providing structure within the permissive play therapy environment. These child-centered play therapy skills are individually defined in Appendix C. For the purpose of this study, child-centered play therapy skills were operationally defined as those skills listed by Axline (1969), Guerney (1983), and Landreth (2002).

Curriculum-based small-group guidance was defined as a small-group guidance modality in which a counselor provided developmentally appropriate violence-prevention education for aggressive children. The curriculum used for this study, titled Second Step®: A Violence Prevention Program, is a “universal prevention program that proactively teaches critical social and emotional skills to all children. The curriculum goals are focused on reducing aggressive and disruptive behavior while promoting social-emotional competence” (Committee for Children, 2002b, p. 4). The Second Step program is designed to improve children’s skills in three general areas: empathy, impulse control and problem solving, and anger management. In this study, the Second Step curriculum was utilized in a manner similar to a responsive service, one of the four components as defined by the National Model according to the American School Counselors Association. For the purpose of this study, curriculum-based small-group guidance was operationally defined the Second Step program.

Hypotheses

To carry out the purpose of this study, the following hypotheses were presented:

Hypothesis 1: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Behavioral Assessment System for
Hypothesis 2: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Behavioral Assessment System for Children-Teacher Rating Scale posttest than will the curriculum-based small-group guidance group children.

Hypothesis 3: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Behavioral Assessment System for Children-Teacher Rating Scale posttest than will the curriculum-based small-group guidance group children.

Hypothesis 4: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Behavioral Assessment System for Children-Parent Rating Scale posttest than will the curriculum-based small-group guidance group children.

Hypothesis 5: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Behavioral Assessment System for Children-Parent Rating Scale posttest than will the curriculum-based small-group guidance group children.

Hypothesis 6: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Behavioral Assessment System for Children-Parent Rating Scale posttest than will the curriculum-based small-group guidance group children.
Hypothesis 7: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Child Behavior Checklist-Teacher Report Form posttest than will the curriculum-based small-group guidance group children.

Hypothesis 8: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Child Behavior Checklist-Teacher Report Form posttest than will the curriculum-based small-group guidance group children.

Hypothesis 9: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Child Behavior Checklist-Teacher Report Form posttest than will the curriculum-based small-group guidance group children.

Hypothesis 10: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Child Behavior Checklist-Parent Report Form posttest than will the curriculum-based small-group guidance group children.

Hypothesis 11: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Child Behavior Checklist-Parent Report Form posttest than will the curriculum-based small-group guidance group children.

Hypothesis 12: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Child Behavior Checklist-Parent Report Form posttest than will the curriculum-based small-group guidance group children.
Instruments

Two types of behavioral instruments were used to provide multiple measures of the same construct, ensuring accuracy and consistency among the rater’s perceptions. *Behavioral Assessment System for Children- Teacher Rating Scale/Parent Rating Scale*

The Behavioral Assessment System for Children- Teacher Rating Scale (BASC-TRS)/ Parent Rating Scale (BASC-PRS) were developed in 1992 by Reynolds and Kamphaus. They are categorized as self-administered test for teachers, parents, or caregivers, available in Spanish and in English and requiring approximately 20 minutes to complete. They are comprehensive measures of both adaptive and problem behaviors in the school, community, and home setting. The BASC-TRS/PRS have three forms with items targeted at three age levels: preschool (2 ½ -5), child (6-11), and adolescent (12-18). The forms contain descriptors of behaviors that the participant rates on a 4-point scale of frequency, ranging from *Never* to *Almost Always*.

The BASC-TRS/PRS assess both verbal and physical aggression in a combined score. Verbal aggression includes arguing, name-calling, criticizing, blaming, and verbally threatening others. Physical aggression includes breaking others’ possessions, hitting others, and being cruel to animals. The Aggression subscale gives greater weight to verbal aggression because verbal demonstrations of aggression are more frequent. Further, the BASC-TRS/PRS calculates clinical problems in the broad composites of Externalizing Problems and Internalizing Problems. Although these composite scores contribute to establishing a clinical scales overview or Behavioral Symptom Index (BSI), for the purpose of this study it was not included. Scales and composites with the same name contain the similar content at all age levels (Reynolds & Kamphaus, 1992).
Strong reliability has been established for the BASC-TRS instrument. The internal consistency, correlation, or degree, to which the items of this scale are measuring the same domain of behavior, averaged above 0.80. The test-retest reliability, meaning the consistency of ratings by the same parent over a brief time interval, averaged above 0.82. Interrater reliability, the level of agreement among independent ratings of the same child by two parents, averaged 0.83 for the first and 0.7 to 0.9 for the second ratings (Reynolds & Kamphaus, 1992).

Many of the TRS scales and composites, particularly those measuring externalizing and school problem behaviors, correlate as high as .92 with corresponding scores on other instruments (Reynolds & Kamphaus, 1992). These results support the construct validity of those BASC-TRS dimensions. Further validity studies have been conducted on the BASC-TRS, establishing factorial and discriminate validity.

Several types of reliability have been established for the BASC-PRS instrument. The internal consistency was established to be in the middle 0.80’s to low 0.90’s. The test-retest reliability yielded values of 0.85, 0.88, and 0.70 for the three levels. Interrater reliability was found to have a mean correlation of about 0.6 (Reynolds & Kamphaus, 1992). The BASC-PRS has been correlated with four other instruments. As was found for the BASC-TRS, results support construct validity. Further validity studies have been conducted on the BASC-TRS, establishing factorial and discriminate validity.

Child Behavior Checklist-Caregiver/Teacher Report Form

The Child Behavior Checklist (CBCL) and (Caregiver) Teacher Report Form (C-TRF, TRF), originally developed by Achenbach and Edelbrock in 1986, are the newest versions of a well-established and recognized family of instruments for the identification
of behavior and emotional difficulties in children. The checklist, written at a fifth-grade reading level, was designed to record, in a standardized format, behavioral symptoms of children that parents, guardians, or teachers perceive as competencies or limitations. The CBCL/TRF can also be used to measure a child’s change in behavior over time or following a treatment. It is available in Spanish and English and can be completed in approximately 20 minutes used as a self-administered test.

The 2001 revised version of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBCL/C-TRF), (Achenbach, 2002) was used in this study. Two age-specific versions of the CBCL/C-TRF exist: CBCL and C-TRF for children ages 1 ½-5, and another CBCL and TRF for ages 6-18. The first section of each questionnaire consists of 20 competence items, and the second section consists of 118 items on behavior or emotional problems. The participant on a 3-point scale of frequency, ranging from Not true to Very true or Often true, rates behavioral symptoms and emotional descriptors. The 118 items have been factor analyzed into the eight subscales including Aggressive Behavior. Performing a second-order factor analysis of the Behavior Problem Scale yields two primary composites termed Internalizing Problems and Externalizing Problems. Each subscale and factor score can be computed to determine T-scores and percentiles. This study primarily focused on the Aggressive Behaviors subscale and the Internalizing and Externalizing domains of the behavior scales. Within this family of instruments, scales and composites with the same name contain similar content at all age levels (Achenbach, 2002).

Inter-interviewer and test-retest reliabilities of the CBCL age 6 to 18 item scores were supported by intraclass correlations ranging from .90 to 1.00 for the mean item
scores obtained by different interviewers and for reports by parents on two occasions 7 days apart. The test-retest of scale scores was supported by a reliability of .90 for the CBCL age 6 to 18 competence and empirically-based problem scales and the TRF adaptive and problem scales, .85 for the CBCL preschool age scales, and .81 for the C-TRF scales. Internal consistency of competence scales was supported by alpha coefficients of .623 to .79 on the CBCL and .90 on the TRF Total Adaptive scale. For the empirically-based problem scales, alphas ranged from .78 to .97 on the CBCL and .72 to .95 on the TRF. Cross-informant correlations between scale scores were higher for mothers versus fathers and for parents versus youths than has been found in meta-analyses of many rating forms. Cross-informant correlations between parents and teachers, between pairs of teachers, and between youths and teachers were commensurate with correlations found in meta-analyses.

The content validity of the competence, adaptive, and problem item scores has been supported by 4 decades of research, consultation, feedback, and revision, as well as by findings that all items discriminated significantly (p < .01) between demographically matched referred and nonreferred children. The criterion-related validity of the CBCL and TRF scales was supported by multiple regressions, odds ratios, and discriminant analyses, all of which showed significant (p < .01) discrimination between referred and nonreferred children. The construct validity of the scales has been supported in many ways, such as evidence for significant associations with analogous scales or other instruments and with DSM criteria; by cross-cultural replications of syndromes; by genetic and biochemical findings; and by predictions of long-term outcomes. The validity of these tools has been documented in empirical research. Therefore, Achenbach and
Rescorla (2000, 2001) advised that they be used as an integrative unit where appropriate for the age of the individual.

Selection of Subjects

Human subjects approval was obtained from the University of North Texas Internal Review Board prior to the recruitment of subjects for this study. The population studied was comprised of volunteer children identified as aggressive in kindergarten through fourth grade, ages 5-12, who qualified for counseling services at a Title I public elementary school in North Texas. In Texas, a school is categorized “Title I” if over 50% of the school population receives reduced cost or free lunch. Over 56 children qualified for these services.

The selected school had a population that was approximately 56% Hispanic, 28% Caucasian, and 15% African American, with the remaining percentage of the population represented by other ethnicities. In order to be eligible for participation, the children were required to meet the following criteria: (a) had parental or guardian consent (Appendix A); (b) agreed to participate in 15 weeks of individual play therapy or group guidance (Appendix B); (c) spoke English; (d) were referred for school counseling services through their school by their parents, teacher, or from the student discipline board; (e) were not currently receiving play therapy services or any other form of psychotherapy; and (f) were rated as at risk or clinically significantly aggressive, as measured by the BASC-PRS or BASC-TRS by a parent, guardian, or teacher.

Children who were referred by teachers and parents and met the aforementioned criteria were then matched in pairs on grade level and randomly assigned to one of the two real-world setting interventions. One of each pair was assigned to either the play
therapy treatment group, which received 12-15 individual child-centered play therapy sessions, or the curriculum-based small-group guidance group, which received 8-15 group guidance sessions, consisting of 12-19 lessons. Of the 56 children who volunteered to participate in the study, 19 were excluded from the analyses. Eight of the 19 children were unable to complete participation in the study because they moved to a new campus. Two of 8 eight children were required to relocate due to school policy in response to their high needs behavior. One of these 2 children suffered from a seizure disorder that resulted in up to 50 seizure episodes a day, lasting several seconds, followed by a postdictal phase of sleepiness. These episodes increasingly interfered with the child’s academic progress, and the child was relocated to a new campus after 10 play therapy sessions. It was also noted that prior to the 10th session, the child had experienced a seizure, causing him to sleep through the entire session and requiring the school nurse to become involved. The 2nd child, also a member of the play therapy treatment group, was expelled from the school campus for multiple episodes of acting out behaviors that endangered the safety of other students.

Six children moved due to personal environmental circumstances. One of the 19 children was excluded because it was found that he was receiving weekly mental health services in a community setting. Five of the children in the play therapy treatment group and 3 of the children in the group guidance group were absent multiple times and, therefore, did not meet the stated criteria. Two of the children were excluded from the group guidance group because it was determined that their therapist did not meet the criteria to offer services for this study. It should also be noted that, 9 of the parents failed to complete posttesting in the time frame allotted. Thus, their scores were
excluded from parent score analysis, but because posttesting scores were collected from the teachers for these same children, the children are still included in the teacher score analyses.

The demographic information for the 37 students completing the study, play therapy treatment group (n=20) and group guidance group (n=17), is given in Table 1.
Table 1

Demographic Information for the Students who Participated in the Study

<table>
<thead>
<tr>
<th></th>
<th>Play therapy group n=20</th>
<th>Group guidance group n=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Ethnic Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>First</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Second</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Third</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Fourth</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Average number of sessions</td>
<td>14.25</td>
<td>11.76</td>
</tr>
<tr>
<td>Average number of lessons</td>
<td>N/A</td>
<td>15.65</td>
</tr>
</tbody>
</table>

Table 1 categorically presents the number of participants who were randomly assigned and successfully completed participation in the study. Although initially matched on grade level, attrition resulted in a lack of balance in final calculations. Random assignment resulted in 17 males assigned to the play therapy treatment and
15 males assigned to the small-group guidance group. The numbers of females who were assigned to the play therapy treatment and small-group guidance groups were 3 and 2, respectively. In regard to ethnic group membership, the play therapy group consisted of 10 Hispanic, 6 Caucasian, and 4 African American children. The curriculum-based small-group guidance group was comprised of 4 Hispanic, 8 Caucasian, and 5 African American children. The play therapy group was composed of 3 kindergarten children, 3 first-grade children, 4 second-grade children, 4 third-grade children, and 6 fourth-grade children. The group guidance group was composed of 3 kindergarten children, 6 first-grade children, 5 second-grade children, and 3 third-grade children. Although 3 additional fourth-graders were originally randomly assigned to the curriculum-based small-group guidance group, their data were, as noted previously, excluded from analyses because the participation criteria were not met. Students who had lost their initial matched pair, due to uncontrollable circumstances, were rematched to the best extent possible, with new incoming participants during the initial period of the study. Also, conscious effort on the part of the investigator was made to keep an overall balance of the number of children in each of the treatment groups. Thus, toward the end of group placement, some children were placed in a service regardless of having a matched constituent in the opposing treatment.

Collection of Data

This quantitative study utilized a matched pretest, posttest comparison group experimental design (Vogt, 1999). Initially, parents and guardians received a full explanation of the procedures and any risks involved in participating in this study. After they signed consent forms, each parent and guardian was asked to complete the
Behavioral Assessment System for Children-Parent Rating Scale (BASC-PRS) and the Child Behavior Checklist (CBCL). Teachers were asked to complete the Behavioral Assessment System for Children- Teacher Rating Scale (BASC-TRS) and the Teacher Report Form (C-TRF, TRF) for each identified child. Substitute teachers were provided for the teachers in the classroom to provide them time to fill out the instrument during the school day without distractions. Less control over the pretest environment was exercised for the parent raters, as parents received the instruments in an envelope sent home with the child.

The BASC-PRS and BASC-TRS were used as screening devices to determine whether, according to the instrument, the children were at-risk or clinically aggressive. All pretesting was completed by the 3rd week in January. Children whose scores qualified them for participation were assigned to groups. Both treatment groups' sessions began after all pretest information was collected. Posttesting occurred the 2nd week in May, at which time parents and teachers completed the BASC-PRS and TRS and CBCL/C-TRF. Posttesting was completed by the last week of June.

Qualitative data in reference to children’s behaviors were obtained from comments from the parents and teachers to determine clinical implications of the study. To document significant verbalizations and happenings, the therapists completed a play therapy session summary form (Appendix D) or a group guidance session summary form (Appendix E) immediately following each session. Additional qualitative data were gathered from parents through face-to-face feedback sessions with their child’s therapist.
All information was kept confidential. Names of parents and children were not and will not be disclosed in any publications or discussion of this material. Information obtained from the instruments was recorded with a code number. Only the investigator had a list of the participants’ names. At the conclusion of this study, the list of participant’s names will be destroyed.

Treatment

The 20 children who participated in the play therapy treatment group of this study received individual child-centered play therapy once a week, for 30 minutes, for a minimum of 12 sessions. The modified session length of 30 minutes was selected to match the typical length of counseling sessions in a school environment and to meet scheduling demands. All sessions were conducted in the play therapy room at the participants’ school. This room was located in the main school office area, next to the principal’s office. The room was equipped with the following toys, which conform to Landreth’s (2002) recommendations:

<table>
<thead>
<tr>
<th>Sand</th>
<th>Puppets</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoops/shovel/bucket</td>
<td>Puppet theatre</td>
<td>Plastic domestic animals</td>
</tr>
<tr>
<td>Dramatic play clothes</td>
<td>Vehicles/planes</td>
<td>Plastic zoo animals</td>
</tr>
<tr>
<td>Masks and hats</td>
<td>Riding car</td>
<td>Medical kit</td>
</tr>
<tr>
<td>Plastic dinosaurs</td>
<td>Baby dolls/clothes</td>
<td>Punching or Bop bag</td>
</tr>
<tr>
<td>Toy guns/knife/sword</td>
<td>Pacifiers</td>
<td>Rope</td>
</tr>
<tr>
<td>Handcuffs</td>
<td>Pillow/blanket</td>
<td>Gumby® figure</td>
</tr>
<tr>
<td>Toy soldiers</td>
<td>Nursing Bottles</td>
<td>Cash register/money</td>
</tr>
<tr>
<td>Toy car</td>
<td>Scotch® tape</td>
<td>Play kitchen/food</td>
</tr>
</tbody>
</table>
The playroom was also equipped with culturally sensitive items such as multicultural toys that capture elements of the Hispanic culture, including Hispanic dolls, plastic food, and musical instruments.

The play therapists responded to the children by using basic and advanced nonverbal and verbal child-centered play therapy responsive skills. The child-centered play therapist responds verbally at an appropriate rate with succinct and interactive responses (Landreth, 2002; Ray, in press).

The 17 children who participated in the curriculum-based small-group guidance group of this study attended grade-level group guidance lessons based on the violence prevention curriculum of the Second Step program once a week for 30 minutes for minimum of 12 lessons. The 30-minute session length was selected based on a recommendation from the Second Step program instruction and conveniently matched the length structure of the play therapy treatment group.

Second Step was designed to develop students’ social and emotional skills, while teaching them to change behaviors and attitudes that contribute to violence. The curriculum teaches students skills central to healthy social and emotional development: empathy, impulse control, and problem solving. Although designed as a prevention program, in this study the Second Step curriculum was utilized as an intervention rather than a classroom guidance curriculum and was presented to children already identified...
as aggressive, in a small-group setting led by a counselor. Although authors of the Second Step curriculum recommended that classroom teachers conduct the lessons in a “universal” classroom format, they noted that it is not required (Committee for Children, 2002b). Thus, counselors were utilized as leaders of small-groups, to maintain a response service format typically provided by school counselors. The program also strongly recommended that the teachers be present for the presentations of the lessons if they were not the curriculum presenter. This aspect of the program was unachievable with the resources available to this study.

The Second Step program is affirmed by research and national award-granting agencies such as the U.S. Departments of Education and Health and Human Services as well as the Collaborative for Academic, Social, and Emotional Learning (CASEL). The program was designated a “CASEL Select” program by CASEL and was designated a “Model” program by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program was also designated as an “Exemplary” program by the U.S. Department of Education (USED). Multiple studies have examined the effectiveness of the Second Step program, finding beneficial results (Frey et al., 2001; Grossman et al., 1997; McMahon et al., 2000; Schick & Cierpka, 2003; Taub, 2002).

The eight therapists for the individual child-centered play therapy group and four therapists for the curriculum-based small-group guidance group were University of North Texas graduate-level counseling students who were experienced in play therapy. Each therapist must have completed two play therapy courses and a counseling practicum with an emphasis on play therapy. The therapists for the curriculum-based
small-group guidance group had also received training in school guidance. Guidance training consisted of attending a seminar, taught by a university faculty member whose specialty was school counseling, on providing guidance in the school setting. Further, group guidance therapists were required to attend training conducted by the investigator on the Second Step program.

Statistical Analysis

Following the completion of the study, pretest and posttest data were scored by a research assistant using the computer scoring software available for the Behavior Assessment System for Children (BASC) and the Child Behavior Checklist (CBC). In order to determine whether the means of the play therapy treatment and curriculum-based small-group guidance groups were statistically equal, independent sample t-tests were performed on each of the pretest scores on each dependent variable. Due to small sample size, a potential lack of power exists. A Cohen’s d effect size was computed for each independent sample t-test to determine the practical significance of the t-test results (Thompson, 2002). A two-factor mixed repeated measure (treatment group X time) was computed on each of the dependent variables to determine whether the play therapy treatment and curriculum-based small-group guidance groups behaved differently across time, using SPSS for Windows Release 12 (Hinkle, Wiersma, & Jurs, 2003). A level of $p \leq .05$ was established as the criterion for either retaining or rejecting the hypotheses. An eta squared statistic was computed for each two-factor mixed repeated measures to determine the practical significance of the results (Thompson, 2002). Additional qualitative data generated from feedback from subjects’ teachers and parents are also presented.
CHAPTER 3
RESULTS AND DISCUSSION

This chapter presents the results of each hypothesis tested in the study and a description of the statistical and practical analyses performed. Also included are the analysis of qualitative data, a discussion of the possible meaning of the results, implications of the findings, and recommendations for further research.

Results

Quantitative Results

Independent sample t-tests were performed on each of the pretest scores for the play therapy treatment and curriculum-based small-group guidance groups on each dependent variable and are reported in Appendix F and G. The independent sample t-tests confirmed that the pretest means for both the play therapy treatment and curriculum-based small-group guidance groups were statistically equal for each of the 12 dependent variables. As a consequence of small sample size, a potential lack of power exists. Thus, a Cohen’s d effect size was computed for each independent sample t-test to determine the practical significance of the t-test results (Thompson, 2002).

Cohen (1988) provided general suggestions for interpreting these indices. He suggested that a standardized difference of about 1.2 is “small,” whereas values of 1.5 and 1.8 are “medium” and “large,” respectively. As indicated in Appendix F and G, all the Cohen’s d effect sizes were small, ranging from .004 to .353, indicating no to small practical significant difference between pretest means. The results of both the independent sample t-test and Cohen’s d effect size demonstrate both that the means of the play therapy treatment and curriculum-based small-group guidance groups are
equal and permit further statistical analysis to be performed and that differences documented on the posttest can tentatively be attributed to the treatment.

The results of this study are presented in the order in which the hypotheses were tested. Pre- and posttest means and standard deviations for each hypothesis are reported. A two-factor mixed repeated measure (treatment group X time) was computed on each of the dependent variables to determine whether the play therapy treatment and curriculum-based small-group guidance groups behaved differently across time. An a priori of .05 was established as the criterion for either retaining or rejecting the hypotheses. Eta squared effect size was computed for each two-factor mixed repeated measures to determine the practical significance of the results (Thompson, 2002). Each calculation was interpreted using Cohen’s (1988) suggested strength indices listed previously.

Hypothesis 1: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Behavioral Assessment System for Children-Teacher Rating Scale posttest than will the curriculum-based small-group guidance group children.

Table 2 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.
Table 2

Mean Total Scores for the Aggressive Subscale on the Behavioral Assessment System for Children-Teacher Rating Scale (BASC-TRS/C)

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>71.25</td>
<td>65.90</td>
</tr>
<tr>
<td>SD</td>
<td>14.736</td>
<td>13.669</td>
</tr>
</tbody>
</table>

Total Cases = 37

Note. A decrease in the mean score indicates a decrease in Aggressive behavior.

Table 3 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and small-group guidance groups’ mean scores and the effect size.

Table 3

Two-Factor Mixed Repeated Measures Results for the Aggressive Subscale Score on the Behavioral Assessment System for Children-Teacher Rating Scale

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>687.491</td>
<td>1</td>
<td>687.491</td>
<td>8.448</td>
<td>.006</td>
<td>.041</td>
</tr>
<tr>
<td>Group * Time</td>
<td>10.789</td>
<td>1</td>
<td>10.789</td>
<td>.133</td>
<td>.718</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>2848.157</td>
<td>35</td>
<td>81.376</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>12.959</td>
<td>1</td>
<td>12.959</td>
<td>.034</td>
<td>.854</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>13269.393</td>
<td>35</td>
<td>379.126</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16828.789</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 3, there was a
significant main effect of condition \[F(1,37) = 8.448, p < .05\]. There was not a significant interaction effect \[F(1,37) = .133, p > .05\]. On the basis of these data, hypothesis 1 was rejected. The eta squared for the main effect was .041, and the eta squared for the interaction effect was .001, indicating little practical significance for either as measured by the BASC-TRS (Thompson, 2002).

Hypothesis 2: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Behavioral Assessment System for Children-Teacher Rating Scale posttest than will the curriculum-based small-group guidance group children.

Table 4 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 4

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>53.70</td>
<td>49.55</td>
</tr>
<tr>
<td>SD</td>
<td>9.102</td>
<td>7.577</td>
</tr>
<tr>
<td>Total Cases = 37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* A decrease in the mean score indicates a decrease in Internalizing Problems.

Table 5 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.
Table 5
Two-Factor Mixed Repeated Measures Results for the Internalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>589.436</td>
<td>1</td>
<td>589.436</td>
<td>13.712</td>
<td>.001</td>
<td>.073</td>
</tr>
<tr>
<td>Group * Time Interaction</td>
<td>42.084</td>
<td>1</td>
<td>42.084</td>
<td>.979</td>
<td>.329</td>
<td>.005</td>
</tr>
<tr>
<td>Error</td>
<td>1504.510</td>
<td>35</td>
<td>42.986</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>114.190</td>
<td>1</td>
<td>114.190</td>
<td>.687</td>
<td>.413</td>
<td>.014</td>
</tr>
<tr>
<td>Error</td>
<td>5816.404</td>
<td>35</td>
<td>166.183</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8066.624</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 5, there was a significant main effect of condition \([F(1,37) = 13.712, p < .05]\). There was not a significant interaction effect \([F(1,37) = .979, p > .05]\). On the basis of these data, hypothesis 2 was rejected. The eta squared for the main effect was .073, and the eta squared for the interaction effect was .005, indicating little practical significance as measured by the BASC-TRS (Thompson, 2002).

Hypothesis 3: play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Behavioral Assessment System for Children-Teacher Rating Scale posttest than will the curriculum-based small-group guidance group children.
Table 6 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 6

*Mean Total Scores for the Externalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale (BASC-TRS/C)*

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>70.45</td>
<td>65.80</td>
</tr>
<tr>
<td>SD</td>
<td>13.751</td>
<td>12.996</td>
</tr>
</tbody>
</table>

Total Cases = 37

*Note.* A decrease in the mean score indicates a decrease in Externalizing Problems.

Table 7 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.
Table 7

**Two-Factor Mixed Repeated Measures Results for the Externalizing Problems Composite Score on the Behavioral Assessment System for Children-Teacher Rating Scale**

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>735.239</td>
<td>1</td>
<td>735.239</td>
<td>11.072</td>
<td>.002</td>
<td>.054</td>
</tr>
<tr>
<td>Group * Time Interaction</td>
<td>51.563</td>
<td>1</td>
<td>51.563</td>
<td>.776</td>
<td>.384</td>
<td>.004</td>
</tr>
<tr>
<td>Error</td>
<td>2324.275</td>
<td>35</td>
<td>66.408</td>
<td>.123</td>
<td>.728</td>
<td>.003</td>
</tr>
<tr>
<td>Group</td>
<td>37.012</td>
<td>1</td>
<td>37.012</td>
<td>.123</td>
<td>.728</td>
<td>.003</td>
</tr>
<tr>
<td>Error</td>
<td>10550.934</td>
<td>35</td>
<td>301.455</td>
<td>.384</td>
<td>.384</td>
<td>.004</td>
</tr>
<tr>
<td>Total</td>
<td>13699.023</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 7, there was a significant main effect of condition \[F(1,37) = 11.072, p < .05\]. There was not a significant interaction effect \[F(1,37) = .776, p > .05\]. On the basis of these data, hypothesis 3 was rejected. The eta squared for the main effect was .054, and the eta squared for the interaction effect was .004, indicating little practical significance as measured by the BASC-TRS (Thompson, 2002).

Hypothesis 4: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Behavioral Assessment System for Children-Parent Rating Scale posttest than will the curriculum-based small-group guidance group children.
Table 8 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 8

Mean Total Scores for the Aggressive Subscale on the Behavioral Assessment System for Children-Parent Rating Scale (BASC-PRS-C/P)

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group</th>
<th>Small-group guidance group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=20) Pretest</td>
<td>(n=17) Pretest</td>
</tr>
<tr>
<td></td>
<td>Posttest</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>58.63</td>
<td>59.92</td>
</tr>
<tr>
<td>SD</td>
<td>22.262</td>
<td>16.935</td>
</tr>
<tr>
<td></td>
<td>16.634</td>
<td>13.614</td>
</tr>
<tr>
<td>Total Cases</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in Aggressive behavior.

Table 9 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 9

Two-Factor Mixed Repeated Measures Results for the Aggressive Subscale Score on the Behavioral Assessment System for Children-Parent Rating Scale

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>279.001</td>
<td>1</td>
<td>279.001</td>
<td>5.465</td>
<td>.027</td>
<td>.016</td>
</tr>
<tr>
<td>Group * Time</td>
<td>.073</td>
<td>1</td>
<td>.073</td>
<td>.001</td>
<td>.970</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>1327.427</td>
<td>26</td>
<td>51.055</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>20.371</td>
<td>1</td>
<td>20.371</td>
<td>.034</td>
<td>.855</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>15450.344</td>
<td>26</td>
<td>594.244</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>17077.216</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 9, there was a significant main effect of condition \[ F(1,28) = 5.465, p < .05 \]. There was not a significant interaction effect \[ F(1,28) = .001, p > .05 \]. On the basis of these data, hypothesis 4 was rejected. The eta squared for the main effect was .016, and the eta squared for the interaction effect was .000, indicating little practical significance as measured by the BASC-PRS (Thompson, 2002).

Hypothesis 5: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Behavioral Assessment System for Children-Parent Rating Scale posttest than will the curriculum-based small-group guidance group children.

Table 10 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 10

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>49.31</td>
<td>42.56</td>
</tr>
<tr>
<td>SD</td>
<td>9.965</td>
<td>6.613</td>
</tr>
<tr>
<td>Total Cases</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in Internalizing Problems.
Table 11 presents the two-factor mixed repeated measures data, showing the
level of significance of the differences between the play therapy treatment and
curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 11

Two-Factor Mixed Repeated Measures Results for the Internalizing Problems

Composite Score on the Behavioral Assessment System for Children-Parent Rating

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>507.524</td>
<td>1</td>
<td>507.524</td>
<td>13.604</td>
<td>.001</td>
<td>.093</td>
</tr>
<tr>
<td>Group * Time</td>
<td>6.095</td>
<td>1</td>
<td>6.095</td>
<td>.163</td>
<td>.689</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>969.958</td>
<td>26</td>
<td>37.306</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>139.339</td>
<td>1</td>
<td>139.339</td>
<td>.948</td>
<td>.339</td>
<td>.026</td>
</tr>
<tr>
<td>Error</td>
<td>3820.000</td>
<td>26</td>
<td>146.923</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5442.916</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group
guidance groups were entered into a two-factor repeated measures analysis of variance
with two levels (play therapy and group guidance). As shown in Table 11, there was a
significant main effect of condition \([F(1,28) = 13.604, p < .05]\). There was not a
significant interaction effect \([F(1,28) = .163, p > .05]\). On the basis of these data,
hypothesis 5 was rejected. The eta squared for the main effect was .093, and the eta
squared for the interaction effect was .001, indicating little practical significance as
measured by the BASC-PRS (Thompson, 2002).
Hypothesis 6: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Behavioral Assessment System for Children-Parent Rating Scale posttest than will the curriculum-based small-group guidance group children.

Table 12 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 12

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>59.81</td>
<td>53.94</td>
</tr>
<tr>
<td>SD</td>
<td>21.230</td>
<td>15.708</td>
</tr>
</tbody>
</table>

Total Cases = 28

*Note. A decrease in the mean score indicates a decrease in Externalizing Problems.*

Table 13 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.
The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 13, there was a significant main effect of condition \([F(1,28) = 8.925, p < .05]\). There was not a significant interaction effect \([F(1,28) = .059, p > .05]\). On the basis of these data, hypothesis 6 was rejected. The eta squared for the main effect was .036, and the eta squared for the interaction effect was .000, indicating little to no practical significance as measured by the BASC-PRS (Thompson, 2002).

Hypothesis 7: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Child Behavior Checklist-Teacher Report Form posttest than will the curriculum-based small-group guidance group children.

Table 14 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.
Table 14

**Mean Total Scores for the Aggressive Subscale on the Child Behavior Checklist-Teacher Report Form (CBC-TRF)**

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>71.30</td>
<td>69.10</td>
<td>71.65</td>
<td>64.29</td>
</tr>
<tr>
<td>SD</td>
<td>10.849</td>
<td>11.285</td>
<td>9.727</td>
<td>10.687</td>
</tr>
</tbody>
</table>

Total Cases = 37

*Note.* A decrease in the mean score indicates a decrease in Aggressive behavior.

Table 15 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 15

**Two-Factor Mixed Repeated Measures Results for Aggressive Subscale Score on the Child Behavior Checklist-Teacher Report Form**

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>419.297</td>
<td>1</td>
<td>419.297</td>
<td>8.712</td>
<td>.006</td>
<td>.049</td>
</tr>
<tr>
<td>Group * Time</td>
<td>121.999</td>
<td>1</td>
<td>121.999</td>
<td>2.535</td>
<td>.120</td>
<td>.014</td>
</tr>
<tr>
<td>Error</td>
<td>1684.541</td>
<td>35</td>
<td>48.130</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>91.346</td>
<td>1</td>
<td>91.346</td>
<td>.506</td>
<td>.481</td>
<td>.011</td>
</tr>
<tr>
<td>Error</td>
<td>6312.871</td>
<td>35</td>
<td>180.368</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8630.054</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance.
with two levels (play therapy and group guidance). As shown in Table 15, there was a significant main effect of condition \([F(1,37) = 8.712, p < .05]\). There was not a significant interaction effect \([F(1,37) = 2.535, p > .05]\). On the basis of these data, hypothesis 7 was rejected. The eta squared for the main effect was .049, and the eta squared for the interaction effect was .014, indicating a small practical significance as measured by the CBC-TRF (Thompson, 2002).

Hypothesis 8: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Child Behavior Checklist-Teacher Report Form posttest than will the curriculum-based small-group guidance group children.

Table 16 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

**Table 16**

_Mean Total Scores for the Internalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form (CBC-TRF)_

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>57.80</td>
<td>53.80</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>9.731</td>
<td>9.174</td>
</tr>
<tr>
<td>Total Cases</td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

_Note_. A decrease in the mean score indicates a decrease in Internalizing Problems.
Table 17 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 17

Two-Factor Mixed Repeated Measures Results for Internalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>417.234</td>
<td>1</td>
<td>417.234</td>
<td>8.791</td>
<td>.005</td>
<td>.056</td>
</tr>
<tr>
<td>Group * Time Interaction</td>
<td>10.747</td>
<td>1</td>
<td>10.747</td>
<td>.226</td>
<td>.637</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>1661.118</td>
<td>35</td>
<td>47.461</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>62.700</td>
<td>1</td>
<td>62.700</td>
<td>.415</td>
<td>.523</td>
<td>.008</td>
</tr>
<tr>
<td>Error</td>
<td>5283.165</td>
<td>35</td>
<td>150.948</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7434.964</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 17, there was a significant main effect of condition \( [F(1,37) = 8.791, p < .05] \). There was not a significant interaction effect \( [F(1,37) = .226, p > .05] \). On the basis of these data, hypothesis 8 was rejected. The eta squared for the main effect was .056, and the eta squared for the interaction effect was .001, indicating little practical significance as measured by the CBC-TRF (Thompson, 2002).

Hypothesis 9: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Child Behavior Checklist-Teacher Report Form.
Table 18 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 18

*Mean Total Scores for the Externalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form (CBC-TRF)*

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>69.85</td>
<td>67.35</td>
</tr>
<tr>
<td>SD</td>
<td>9.270</td>
<td>9.477</td>
</tr>
</tbody>
</table>

Total Cases = 37

*Note.* A decrease in the mean score indicates a decrease in Externalizing Problems.

Table 19 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 19

*Two-Factor Mixed Repeated Measures Results for Externalizing Problems Composite Score on the Child Behavior Checklist-Teacher Report Form*

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>379.495</td>
<td>1</td>
<td>379.495</td>
<td>11.073</td>
<td>.002</td>
<td>.057</td>
</tr>
<tr>
<td>Group * Time Interaction</td>
<td>76.793</td>
<td>1</td>
<td>76.793</td>
<td>2.241</td>
<td>.143</td>
<td>.012</td>
</tr>
<tr>
<td>Error</td>
<td>1199.559</td>
<td>35</td>
<td>34.273</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>65.936</td>
<td>1</td>
<td>65.936</td>
<td>.466</td>
<td>.499</td>
<td>.010</td>
</tr>
<tr>
<td>Error</td>
<td>4951.659</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6673.442</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 19, there was a significant main effect of condition \([F(1,37) = 11.073, p < .05]\). There was not a significant interaction effect \([F(1,37) = 2.241, p > .05]\). On the basis of these data, hypothesis 9 was rejected. The eta squared for the main effect was .057, and the eta squared for the interaction effect was .012, indicating a small practical significance as measured by the CBC-TRF (Thompson, 2002).

Hypothesis 10: The play therapy treatment group children will attain a significantly lower mean Aggressive subscale score on the Child Behavior Checklist-Parent Report Form posttest than will the curriculum-based small-group guidance group children.

Table 20 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 20

*Mean Total Scores for the Aggressive Subscale on the Child Behavior Checklist- Parent Report Form (CBC-PRF)*

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>64.69</td>
<td>61.13</td>
</tr>
<tr>
<td>SD</td>
<td>13.325</td>
<td>11.248</td>
</tr>
<tr>
<td>Total Cases = 28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. A decrease in the mean score indicates a decrease in Aggressive behavior.*
Table 21 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 21

Two-Factor Mixed Repeated Measures Results for Aggressive Subscale Score on the Child Behavior Checklist-Parent Report Form

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>232.180</td>
<td>1</td>
<td>232.180</td>
<td>5.624</td>
<td>.025</td>
<td>.036</td>
</tr>
<tr>
<td>Group * Time</td>
<td>4.180</td>
<td>1</td>
<td>4.180</td>
<td>.101</td>
<td>.753</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>1073.302</td>
<td>26</td>
<td>41.281</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2.501</td>
<td>1</td>
<td>2.501</td>
<td>.012</td>
<td>.912</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>5204.552</td>
<td>26</td>
<td>200.175</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6516.715</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 21, there was a significant main effect of condition \([F(1,28) = 5.264, p < .05]\). There was not a significant interaction effect \([F(1,28) = .101, p > .05]\). On the basis of these data, hypothesis 10 was rejected. The eta squared for the main effect was .036, and the eta squared for the interaction effect was .001, indicating little practical significance as measured by the CBC (Thompson, 2002).
Hypothesis 11: The play therapy treatment group children will attain a significantly lower mean Internalizing Problems composite score on the Child Behavior Checklist-Parent Report Form posttest than will the curriculum-based small-group guidance group children.

Table 22 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.

Table 22

Mean Total Scores for the Internalizing Problems Composite Score on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>57.13</td>
<td>54.50</td>
</tr>
<tr>
<td>SD</td>
<td>9.681</td>
<td>7.933</td>
</tr>
</tbody>
</table>

Total Cases = 28

*Note.* A decrease in the mean score indicates a decrease in Internalizing Problems.

Table 23 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.
The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance with two levels (play therapy and group guidance). As shown in Table 23, there was a significant main effect of condition \[ F(1,28) = 4.239, p < .05 \]. There was not a significant interaction effect \[ F(1,28) = .200, p > .05 \]. On the basis of these data, hypothesis 11 was rejected. The eta squared for the main effect was .036, and the eta squared for the interaction effect was .002, indicating negligible practical significance as measured by the CBC (Thompson, 2002).

Hypothesis 12: The play therapy treatment group children will attain a significantly lower mean Externalizing Problems composite score on the Child Behavior Checklist-Parent Report Form posttest than will the curriculum-based small-group guidance group children.

Table 24 presents the pre- and posttest means and standard deviations for the play therapy treatment and curriculum-based small-group guidance group.
Table 24

Mean Total Scores for the Externalizing Problems Composite Score on the Child

Behavior Checklist-Parent Report Form (CBC-PRF)

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment group (n=20)</th>
<th>Small-group guidance group (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>62.13</td>
<td>59.00</td>
</tr>
</tbody>
</table>

Total Cases = 28

Note. A decrease in the mean score indicates a decrease in Externalizing Problems.

Table 25 presents the two-factor mixed repeated measures data, showing the level of significance of the differences between the play therapy treatment and curriculum-based small-group guidance groups’ mean scores and the effect size.

Table 25

Two-Factor Mixed Repeated Measures Results for Externalizing Problems Composite Score on the Child Behavior Checklist- Parent Report Form

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F Ratio</th>
<th>Significance of F</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>203.720</td>
<td>1</td>
<td>203.720</td>
<td>4.316</td>
<td>.048</td>
<td>.042</td>
</tr>
<tr>
<td>Group * Time Interaction</td>
<td>7.292</td>
<td>1</td>
<td>7.292</td>
<td>.154</td>
<td>.698</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>1227.333</td>
<td>26</td>
<td>47.205</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>37.149</td>
<td>1</td>
<td>37.149</td>
<td>.282</td>
<td>.600</td>
<td>.008</td>
</tr>
<tr>
<td>Error</td>
<td>3428.333</td>
<td>26</td>
<td>131.859</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4903.827</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data for the play therapy treatment and curriculum-based small-group guidance groups were entered into a two-factor repeated measures analysis of variance.
with two levels (play therapy and group guidance). As shown in Table 25, there was a significant main effect of condition \[F(1,28) = 4.316, p < .05\]. There was not a significant interaction effect \[F(1,28) = .154, p > .05\]. On the basis of these data, hypothesis 12 was rejected. The eta squared for the main effect was .042, and the eta squared for the interaction effect was .001, indicating little practical significance as measured by the CBC (Thompson, 2002).

**Qualitative Results**

Kazdin (1999) noted the importance of qualitative data in his description of clinical significance as the “practical or applied value or importance of the effect of the intervention-that is, whether the intervention makes a real (e.g., genuine, palpable, practical, noticeable) difference in everyday life” (p. 332). Clinical significance differs from practical significance in that practical significance is said to be a research finding that one can put to use, that can change practice. Interventions that yield no effects may still be clinically significant (Kazdin, 1999). In an attempt to establish whether a clinically significant difference was present between the play therapy treatment and small-group guidance group, any comments made by parents or by teachers about the participants throughout the study and posttesting were recorded.

Of the 28 children whose parents participated in posttesting, 17 of the children’s parents reported observations during the posttesting session. The general characters of their observations regarding their children are presented in Table 26. Ten parents of children who received play therapy services reported an improvement in some aspect of their child’s life, including increased frustration tolerance levels, increased
independence, increased self-esteem, and improvement academically and behaviorally at school.

Table 26

*Parental Observations of Their Children*

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment</th>
<th>Group guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=16</td>
<td></td>
<td>n=12</td>
</tr>
<tr>
<td>Noted improvement</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Noted a worsening</td>
<td>None Noted</td>
<td>1</td>
</tr>
<tr>
<td>No change noted</td>
<td>None Noted</td>
<td>1</td>
</tr>
</tbody>
</table>

During posttesting, parents of children who received play therapy commented, “He is more independent and confident. He is more assertive and courageous.” Another parent noted that her son’s, “self-esteem increased . . . he’s more easy going.” A 3rd parent reported that her son was, “more willing to do homework without crying . . . he seems less sensitive.” A 4th parent reported that her child seemed to have improved self-esteem: “She seems happier and shows more smiles.” A 5th parent was relieved to report that her son was “getting into trouble less with his teacher at school and getting less angry at home.” A 6th parent noted her son was “not as clingy,” and was “more of a self starter.” A 7th parent excitedly stated, “She listens a whole lot better and she has improved two levels in reading.” This child was now reading at the second-grade level and is in the first grade. Another parent reported that his son initially “would not do homework, and his teacher was at a loss as to what she should do with him. Since this (play therapy) began he is now doing well in the classroom. He does his homework and
is not going to have to take summer school as originally planned because his grades improved.” The parent further noted that his son seems a lot more positive and happy at school and home. All of the remarks listed are from parents whose children were members of the play therapy treatment group.

Ten of the children’s teachers reported unsolicited observations to the investigator throughout the term of the study. In the teachers’ absences the observations were matched to the appropriate study group. The overall characters of their observations are presented in Table 27.

Table 27

Teacher Observations of Their Children

<table>
<thead>
<tr>
<th></th>
<th>Play therapy treatment</th>
<th>Group guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=20</td>
<td></td>
<td>n=17</td>
</tr>
<tr>
<td>Noted improvement</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Noted a worsening</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No change noted</td>
<td>None noted</td>
<td>None noted</td>
</tr>
</tbody>
</table>

Six teachers noted improved behavior for their students who received play therapy services. For example, one teacher of a child who was a member of the play therapy treatment group reported, “I saw a lot of improvement on academic performance, and behavior at school.” She also noted that the child’s performance improved to such a degree that she had recently referred him to be tested in the expo (gifted and talented) program for the campus. Two teachers made positive anonymous observations, reporting, “My student really enjoyed going with his person, I could tell it helped with his self-confidence,” and “I definitely saw an improvement in my students.
This program is very beneficial.” Due to the lack of identifying information they could not be matched to either of the intervention groups.

Discussion

The quantitative results of this study, along with teachers’ and parents’ qualitative feedback, provide information regarding the effectiveness of child-centered play therapy and curriculum-based small-group guidance with children displaying aggressive behaviors at home and school. An interpretation of the results for the 12 hypotheses is presented below.

For the 12 dependent variables of aggression, internalizing problems, and externalizing problems, as measured by both the BASC and CBC, a significant main effect was found for each variable. These results document, while ignoring group membership, that the children of this study significantly improved their behavior over time on all 12 of the hypothesized variables. These results tentatively meet the purpose of this study—to determine the effectiveness of child-centered play therapy and curriculum-based small-group guidance on the behaviors of aggressive children in an elementary school. Hence, these results suggest that both child-centered play therapy and curriculum-based small-group guidance in the school setting decrease the aggressive behaviors of children, decrease the internalizing problems of aggressive children, and decrease the externalizing problems of aggressive children. Thus, the data seems to indicate that school-based child-centered play therapy is as effective at improving the behaviors of aggressive children as the nationally recognized guidance curriculum program Second Step®: A Violence Prevention Curriculum. Further
research, including the use of a control group, is necessary to determine conclusive results and discern possible effects of maturation.

When statistically analyzing whether or not the play therapy treatment and curriculum-based small-group guidance groups behaved differently over the course of the study, no statistical significant difference was found; thus, all 12 hypotheses were rejected. These results indicated that no statistical difference exists between the play therapy treatment and curriculum-based small-group guidance group. Practical significance calculations further support the findings, with eta squared calculations on the 12 variables ranging from low values of .000 to .014. Hence, the difference between the play therapy treatment and curriculum-based small-group guidance groups holds little practical significance.

Twice as many parents (10 to 5) and six times as many teachers (6 to 1) reported observable improvement of behavior among the children assigned to the play therapy group compared to children assigned to the curriculum-based small-group guidance group. It was also noted that no parents reported an increase in behavioral problems from their children from the play therapy treatment group, whereas 1 parent noted an increase in problems from the group guidance group. Similarly, 1 teacher reported increases in behavioral problems from a member of the play therapy treatment group, and 2 teachers reported an increase among the group guidance group. These result demonstrate clinical significance that supports the effectiveness of child-centered play therapy in improving the behaviors of aggressive children over that of curriculum based, group guidance.
One likely explanation for the nonsignificant statistical results between the play therapy group and the group guidance group is the training of the therapists leading the curriculum-based small-group guidance group. As with the play therapy treatment group therapists, the curriculum-based small-group guidance group therapists were experienced in play therapy, having completed at least two play therapy courses and a practicum focused on play therapy. The curriculum-based small-group guidance group therapists were instructed during their guidance training not to utilize their verbal and nonverbal child-centered play therapy communication skills during their group guidance sessions. The purpose of this instruction was to isolate the modalities to the designated sessions, providing the foundation of the study to compare play therapy to group guidance. It was not anticipated that the play therapists would have difficulty refraining from utilizing their play therapy skills while leading the guidance groups.

To determine whether or not the play therapists utilized their play therapy skills in the guidance groups, the investigator interviewed each of the four group guidance therapists and surveyed a randomly selected single videotaped session from each of the four grade-level guidance groups. Results from the interviews indicated a wide use of play therapy communication skills. Two of the four group guidance therapists verbally indicated that they utilized their child-centered play therapy skills over 50% of the time they spent with their participants. One group guidance therapist reported using her child-centered play therapy skills over 75% of the time. Another therapist reported spending only 30% of the available group time on the group guidance curriculum because of the need to contain the children’s behaviors. When asked if child-centered play therapy skills were used during the group guidance sessions, one therapist
responded, “Totally, I couldn’t not do it (use child-centered play therapy skills).” As one therapist noted, she knew she had been unable to keep her child-centered play therapy skills out of her group sessions when the children in her group began to use child-centered play therapy-type responses to each other, an indication that they had learned these responses from the group leader. She reported an experience of one child setting a child-centered play therapy worded limit on another child.

All four of the therapists reported that they responded with Landreth’s (2002) ACT model of therapeutic limit setting (see Appendix C), a recognized play therapy skill, to all of their group members who subjectively required a limit on their behavior. Ginott (1982) commented on the occurrence of this phenomenon. He explained that the group setting provides children with a concrete social matrix in which they may test reality and the reaction of the counselor and the other children. One therapist said during the interview, “I tried not to use them (play therapy skills) but I couldn’t avoid using them.” The therapist went on to say that she tried to use the “rewards” suggested by the Second Step group guidance curriculum, “but they (rewards, used to promote curriculum) didn’t matter when they (children) got aggressive so I had to use limit setting.” Remarks such as these suggest that the therapists, when attempting to use group guidance, may have had a tendency to switch to play therapy skills to subjectively improve the immediate result rather than continue with what appeared to be failing or inadequately progressing. It is not known how many of the Second Step suggestions for “Handling Disruptive Behavior” (redirecting, transitional comments, reminding to use listening skills, introducing ways to calm down, taking a break, and ending the lesson)
(Committee for Children, 2002c) were utilized by each of the therapists before attempting child-centered play therapy limit setting.

The therapists for the group guidance group continually reported discomfort, uneasiness, and worry about the children’s disruptive behavior in their groups. One therapist, crying after a session, reported, “I just wish we were in a playroom so I wouldn’t have to set so many limits.” She continued, sharing an experience that a child threatened to call 911 on the working phone in the classroom space being used for the group guidance session. After multiple play therapy type limits were set, by which the therapist felt she struggled to send a message of acceptance, the child followed through with his threat. The therapist then had to address the operator on the phone, then the teacher and an administrator. This therapist’s comment suggests that the group guidance environment with aggressive and acting out children may have contributed to taxing effects on the therapists. It should be noted that the room utilized for the small-group guidance lessons met Second Step suggested criteria to encourage good listening and cooperative learning, including open space, no enticing toys within reach on open shelves, and visually blocked from “comings and goings in other parts of the school” (Committee for Children, 2002c, p. 40).

The therapists’ struggle to avoid the use of their play therapy skills was also evident in the tabulation of number and length of time that play therapy skills were used in the four randomly selected videotaped sessions. Table 28 presents the tabulated results of the number of times play therapy skills were used by leader 1, as well as the length and percentage of time spent using play therapy skills for a randomly selected
videotaped kindergarten group guidance session. The 82.8% of session time spent using play therapy skills greatly exceeded the therapist’s report of 50%.

Table 28

*Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of Kindergarten Group Guidance Sessions Led by Leader 1*

<table>
<thead>
<tr>
<th>Number of times play therapy skills were used</th>
<th>Minutes spent using play therapy skills</th>
<th>% of time spent on play therapy skills</th>
<th>Minutes spent in transition</th>
<th>% of time spent in transition</th>
<th>Minutes spent on curriculum</th>
<th>% of time spent on curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>24.84</td>
<td>82.8%</td>
<td>4.66</td>
<td>15.53%</td>
<td>.5</td>
<td>1.67%</td>
</tr>
</tbody>
</table>

Number of children present this particular session = 3

*Note.* The number of children present in this randomly selected session does not necessarily represent the number of children assigned to this classification. Also, timed use of play therapy skills was tabulated only if it led to a deviation from the group guidance curriculum.

Table 29 presents the tabulated results of the number of times play therapy skills were used, as well as the length and percentage of time spent using play therapy skills for a randomly selected videotaped first-grade group guidance session. The 21.7% of play therapy skill use recorded denotes the great degree to which the therapist utilized play therapy skills throughout the session.
Table 29

**Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of First-grade Group Guidance Sessions Led by Leader 2**

<table>
<thead>
<tr>
<th>Number of times play therapy skills were used</th>
<th>Minutes spent using play therapy skills</th>
<th>% of time spent on play therapy skills</th>
<th>Minutes spent in transition</th>
<th>% of time spent in transition</th>
<th>Minutes spent on curriculum</th>
<th>% of time spent on curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>6.51</td>
<td>21.7%</td>
<td>N/A</td>
<td>N/A</td>
<td>23.49</td>
<td>78.3%</td>
</tr>
</tbody>
</table>

Number of children present this particular session = 5

*Note.* The number of children present in this randomly selected session does not necessarily represent the number of children assigned to this classification. Also, timed use of play therapy skills was tabulated only if it led to a deviation from the group guidance curriculum.

Table 30 presents the tabulated results of the number of times play therapy skills were used, as well as the length and percentage of time spent using play therapy skills for a randomly selected videotaped second-grade group guidance session. The 22 times of identified play therapy skill use denotes the great degree to which the therapist utilized play therapy skills throughout the session. For this session, the interjected use of play therapy skills made it impractical to measure time spent solely on curriculum versus play therapy skills.
Table 30

Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session
Sampling of Second-grade Group Guidance Sessions Led by Leader 3

<table>
<thead>
<tr>
<th>Number of times play therapy skills were used</th>
<th>Minutes spent using play therapy skills</th>
<th>% of time spent on play therapy skills</th>
<th>Minutes spent in transition</th>
<th>% of time spent in transition</th>
<th>Minutes spent on curriculum</th>
<th>% of time spent on curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 Used intertwined with curriculum</td>
<td>Cannot be calculated</td>
<td>N/A</td>
<td>N/A</td>
<td>Used intertwined with play therapy skills</td>
<td>Cannot be calculated</td>
<td></td>
</tr>
</tbody>
</table>

Number of children present this particular session = 5

Note. The number of children present in this randomly selected session does not necessarily represent the number of children assigned to this classification. Also, timed use of play therapy skills was tabulated only if it led to a deviation from the group guidance curriculum.

Table 31 presents the tabulated results of the number of times play therapy skills were used, as well as the length and percentage of time spent using play therapy skills for a randomly selected videotaped third-grade group guidance session. The 23 times of identified play skill use denotes the great degree to which the therapist utilized play therapy skills throughout the session. For this session, the interjected use of play therapy skills made it impractical to measure time spent solely on curriculum versus play therapy skills. It should also be noted that the curriculum designated for this particular session required the children to watch a video for the majority of the session which was occasionally paused for discussion. This may have contributed to the small number of play therapy skills used because the interaction between the therapist and children was lessened.
Table 31

Descriptive Data of Use of Play Therapy Skills During a Single 30-minute Session Sampling of Third-grade Group Guidance Sessions Led by Leader 4

<table>
<thead>
<tr>
<th>Number of times play therapy skills were used</th>
<th>Minutes spent using play therapy skills</th>
<th>% of time spent on play therapy skills</th>
<th>Minutes spent in transition</th>
<th>% of time spent in transition</th>
<th>Minutes spent on curriculum</th>
<th>% of time spent on curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Used intertwined with curriculum</td>
<td>Cannot be calculated</td>
<td>N/A</td>
<td>N/A</td>
<td>Used intertwined with play therapy skills</td>
<td>Cannot be calculated</td>
</tr>
</tbody>
</table>

Number of children present this particular session = 2

Note. The number of children present in this randomly selected session does not necessarily represent the number of children assigned to this classification. Also, timed use of play therapy skills was tabulated only if it led to a deviation from the group guidance curriculum.

The findings suggest that the Second Step guidance curriculum was not followed in most group guidance sessions and may have significantly affected the results of this intervention. If the curriculum had been followed more rigorously, different results may have been produced. Because the results of this study tentatively support the use of group guidance in schools to decrease the aggressive behaviors of children, it is important to address the characteristics of the group guidance provided. Upon investigation, a high use of child-centered play therapy skills throughout the group guidance sessions became evident. Largely, the types of child-centered play therapy skills utilized by the therapists were the reflection of feeling, the reflection of content, and limit setting. These skills are considered to be basic and essential in play therapy sessions (Axline, 1969; Landreth, 2002). Thus, to achieve similar results it is recommended that counselors who utilize small-group guidance should or an
intervention with aggressive children in a school setting be adequately trained in play therapy skills.

Another consideration for the nonsignificant results between treatments is the potential contribution made by group versus individual therapies. Landreth and Sweeney (1999) outlined the benefits the presence of another child or several children brings to the therapeutic relationship,

1) It is less threatening for the child to enter the new experience in the company of 2 or 3 other children. 2) The presence of several children facilitates the establishment of a desired relationship between the therapist and each child. 3) The presence of other children diminishes tension and stimulates activity and participation. 4) The presence of other children increases spontaneity. 5) The therapeutic process is enhanced by the fact that every child can be a giver and not only a receiver of help. 6) The group accelerates the child’s awareness of the permissiveness of the setting. 7) Children are forced to reevaluate their behavior in the light of peer reactions. 8) Group play therapy provides a tangible social setting for discovering and experimenting with new and more satisfying modes of relating to peers. 9) The presence of several children serves to tie the therapy experience to the world of reality. 10) The group provides opportunity for vicarious and directed learning (problem solving, alternative behaviors, and so on). And 11) the therapist is provided insight into how the child may be in the real word. (p. 53)

The possible importance of the group was evidenced by one of the therapist’s comments: “Having the other members (in the group) was very important to them (the
children). They (the present members) would ask where the other members were when they were absent,” seemingly disappointed by their absence. Berg and Landreth (1998) stressed the importance of group membership:

In group counseling relationships, children experience the therapeutic releasing qualities of discovering that their peers have problems too, and a diminishing of the barriers of feeling all alone. A feeling of belonging develops and new interpersonal skills are attempted in a “real life” encounter where children learn more effective ways of relating to people through the process of trial and error.

(p. 312)

The therapist for the small-group guidance group referred to in the previous paragraph further reported that the children seemed to benefit from witnessing the same limits set on the other children equally. In groups, children can benefit from socially appropriate behaviors that other children model, have an opportunity to try new behaviors in a social setting, and learn that inappropriate behaviors fail to get desired results (Axline, 1969). Bierman et al. (1993) and Dodge and Coie (1987) found aggression to be strongly correlated with peer rejection throughout childhood and adolescence. Ginott (1982) commented, “Group therapy is based on the assumption that children will modify behavior in exchange for acceptance” (p. 327).

The group atmosphere may have also acted as a catalyst, making it easier for each child to act out and bring forth anxieties (Slavson, 1948). Slavson believed that, alone, a child tends to repeat activities, whereas group experiences facilitate the exploration of new behaviors. White and Flynt (1999) noted that expanded interpersonal
growth might encourage new ways of thinking, awareness of new options, and problem solving skills, later transferring to the classroom.

Some authors caution against the application of group therapy for aggressive or acting out children (Ginott 1998; Slavson, 1948). Multiple references can be found cautioning play therapists to exclude excessively aggressive or acting out children from group play therapy (Ginott, 1994; Slavson, 1948; Sweeney & Homeyer, 1999). The results from this study suggest that further investigation is needed to determine whether these recommendations are soundly based and are not eliminating a beneficial modality for aggressive children.

Summary

The data of this study tentatively meet the purpose of this study—to determine the effectiveness of child-centered play therapy and curriculum-based small-group guidance on the behaviors of aggressive children in an elementary school. They also support the effectiveness of both modalities in decreasing the aggressive behaviors, internalizing problems, and externalizing problems of aggressive children. Thus, the data seems to indicate that school-based child-centered play therapy is as effective at improving the behaviors of aggressive children as the nationally recognized guidance curriculum program Second Step. Qualitative data from the parents and teachers of the children demonstrated clinical significance, suggesting that school-based child-centered play therapy is more noticeably effective in reducing the aggressive behaviors of children. Differences between the two groups were not statistically significant at the p < .05 level, or practically significant. Factors inherent to the design of the study, including the internalization/use of play therapy skills among the group guidance group therapists,
lack of control for the effects of group dynamics in the small-group guidance group, and lack of adherence to the small-group guidance curriculum, may have hindered the investigator from accessing the differences between the effectiveness of group guidance and play therapy with this population.

A significant main effect was found for all 12 dependent variables of aggression, internalizing problems, and externalizing. Hence, while ignoring group membership, the children of this study, as a whole, significantly improved their behavior over time on all 12 of the hypothesized variables. The practical significance calculations of these same data fail to demonstrate strong support for this finding. A control group is needed to determine conclusive results and discern possible effects of maturation.

Limitations

Limitations inherent to the procedure of this study follow:

1. A convenience sample was used rather than a random sample and was not fully matched. This may inhibit the generalizibility of the conclusions.

2. The absence of fourth graders in the group guidance group potentially affected the outcome of this study.

3. The motivation for support services for children is externally, rather than internally, based. Rather than self-referral, a parent or teacher typically refers a child for counseling services. This adds another variable to this study, possibly confounding the results.

4. The internal validity of this study is threatened by the possible effect of maturation. Inherent to the design of this study is the potential for the children’s
developmental changes in physical and emotional areas to impact the outcome, irrespective of the treatment administered.

5. The internal validity of this study is further threatened by the possibility of a Hawthorne Effect, the tendency for subjects of research to change their behavior simply because they are being studied.

6. Because the group guidance therapists collected all of the children together from their classrooms before conducting the sessions, it is possible that the teachers knew which children were receiving the group guidance versus the individual play therapy, thus potentially biasing the raters’ scores.

7. Participants’ environmental occurrences, including divorce of parents, death of a loved one, incarceration of parent, and home move, were not controlled for and were not assessed by the investigator. These occurrences may have impacted or altered the teachers’ and children’s emotional state during the course of the study.

8. Environmental occurrences that existed on the school campus at the time of the study, including campuswide construction and end of the school year term, produced subjectively evident stress on the part of the students and staff. For example, the 23 teachers who participated in the study were required to be out of their classrooms for the summer by the last day of school. Posttesting occurred 2 days prior to this event. These occurrences were not controlled for and may have impacted or altered the participants’ emotional state during the course of the study.

9. Nine of the 37 parents who consented to participate in this study failed to complete posttesting. The end of the school year timing of posttesting may have contributed to this attrition.
10. Small sample size affected the power of the statistical procedures, thus compromising the probability of obtained significance.

11. Lack of adherence to the Second Step protocol added an additional variable to the study, possibly confounding the results.

Contributions and Strengths of Study

Although there are limitations that affect the generalizability and interpretation of some of the findings, this study has added to the play therapy literature and contributed to the fields of guidance and counseling. One of the major strengths of the present study is that it utilized students referred for counseling due to behavioral difficulties (students demonstrating at-risk and clinically significant aggressive behaviors) and serviced them at school, a real-world setting. In addition, the use of 30-minute play therapy and guidance sessions conformed to typical school practice.

This study differed from previous play therapy research in several ways. First, this study utilized multiple measures of the same variable from multiple sources (parent and teacher) and with multiple measures (BASC and CBC) in addition to qualitative observations collected. Secondly, data were collected across an average of 14.25 play therapy sessions, whereas previous studies investigating the effects of play therapy on aggression have utilized typically 10 or fewer sessions. Third, this study compared play therapy to a nationally recognized and empirically supported guidance program, finding equality in their effectiveness. Lastly, this study was unique in that it utilized a violence prevention curriculum as an intervention or response service format with a population already identified as aggressive.
Based on the results of this study, the following recommendations for further research are offered:

Recommendations for Further Research

1. Conduct a replication of this study using counselors who have not been trained in play therapy to lead the curriculum-based small-group guidance group or monitor/supervise guidance sessions through duration of study. This will protect the validity of the study by isolating the variable of play therapy to the play therapy treatment group.

2. Conduct a replication of this study with the addition of a control group. This addition will enhance the research design and permit additional conclusions to be drawn as to the effectiveness of play therapy on the aggressive behaviors of children.

3. Conduct a replication of this study extending the length of time the services are provided. Mapping change across an extended length of time may provide valuable field-enhancing information to determine the length of time necessary to measure change.

4. Conduct a replication of this study using a larger sample size, including increasing the size of the group guidance groups to actual classroom proportions, as intended. This will increase the power of statistical measures.

5. Conduct a replication of this study earlier in the school year. This will protect the integrity of the study by removing the impact of stress that accompanies a school staff, student body, and parents at the end of a school year. This may potentially allow teachers increased sensitivity to change.
6. Perform research that investigates the integration of play therapy skills into the personhood of the therapist. Little research exists investigating this phenomenon, which was expressed during this study.

7. Conduct a well-controlled study that investigates the effectiveness of group play therapy with aggressive children.

8. In a replicated study, utilize an assessment tool that measures variables from the child’s point of view, thus reducing the reliance upon outside observation and the effects of rater bias such as a self-report version of the BASC or CBC.

9. Conduct a follow-up study of the children in this study to determine the long-term effectiveness and generalizability of improved behavior.

10. Explore the variability that may exist between parent and teacher ratings of the same child, being sure to control confounding variables, such as distractions or time constraints, that may affect the accuracy of measures.

11. Conduct a study that compares the effectiveness of play therapy on the aggressive behaviors of children at different grade levels or by developmental grouping (ages 4-7, 8-10, etc.).
APPENDIX A

INFORMED CONSENT FORM
RESEARCH CONSENT FORM

Subject Name:_____________________________________ Date:______________

Title of the study: Effects of Child-Centered Play Therapy and Curriculum-based small-group guidance in an Elementary School Setting on the Behaviors of Children Referred for Aggression

Principal Investigator: Brandy Schumann, University of North Texas, Counseling Department Doctoral Candidate.

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks and discomforts of the study. It is important for you to understand that no guarantees or assurances can be made as to the results of this study.

Your participation is voluntary and you and/or your child may choose to withdraw at any time during the study without penalty of any kind. Your signature indicates that you meet all of the requirements for participation and have decided to participate and you have been told that you will receive a signed copy of this consent form.

Your decision whether or not to participate will not affect your child’s standing at school. At the conclusion of the study, a summary of results will be made available to all interested parents and teachers.

Purpose of the study and how long it will last:
The study involves 30 minute counseling sessions for your child, one time per week for approximately 15 weeks. You will also be asked to complete two questionnaires at the beginning and at the end of your child’s counseling. Each questionnaire will take approximately 20 minutes to complete.

Description of the study including the procedures to be used:
If you allow your child to participate, first, your child will be assigned to receive either individual play therapy or group skills counseling. Both counseling procedures will be for 30 minutes, one time per week for approximately 15 weeks.

In the group skills counseling, the counselor will conduct a variety of activities that have been approved by the principal including: 1) read stories and ask children questions about the stories 2) show children pictures of different emotions such as anger and happiness and ask them to identify the emotion and 3) ask them to practice social skills such as how to solve disagreements with other children and how to make socially acceptable choices.

In individual play therapy, your child will be in a playroom at school equipped with toys such as art supplies, dress up clothes, cars, boats, planes, toy animals, dishes, and plastic food. This will be a nonstructured playtime for your child to direct his or her own play.
Secondly, you and your child’s teacher will also be asked to complete questionnaires, two at the beginning and two at the end of the study. The questionnaires are scored by computer and puts behaviors into categories as well as giving important information about your child’s behaviors. Both the parent and teacher questionnaires take approximately 20 minutes to complete each. The Behavior Assessment System for Children and the Child Behavior Checklist are questionnaires used here at Lee Elementary and for research purposes. The Principal Investigator will record the results and compare results.

The researcher is also interested in the children’s patterns of play (example: number of limits needed). For this reason the researcher will videotape individual play sessions. Videotapes will be coded and only the researcher will know to whom the tape belongs. The tapes will be kept in a locked cabinet in the researcher’s office. Only the researcher and her employed associate will review the tapes for coding play patterns. After the child’s patterns of play are coded, the researcher will keep the videotapes for future study.

**Description of procedures/elements that may result in discomfort or inconvenience:**
There is no personal risk or discomfort directly involved with this study other than the normal expression of anger, sadness or frustration associated with expressing emotions through play. You and/or your child may choose to withdraw at any time without penalty or prejudice.

**Description of the procedures/elements that are associated with foreseeable risks:**
There are no foreseeable risks involved with this study other than those associated with normal daily activities.

**Benefits to the subjects or others:**
The play times are based on the fact that play is the way children talk. Selected play materials are utilized to help young children express feelings, thoughts, experiences, and behaviors. The toys are the children’s words and play is the way they talk. This interaction between children, selected play materials, and the trained play therapist may help enhance your child’s self esteem, self-control, and self-confidence. There may be times after the play sessions when your child may behave a little differently (more quiet or more active). The counselor for your child will be available to help you understand what is going on with your child and give you ideas about responding to your child.

Elementary school is a time when students develop attitudes concerning self, peers, social groups and family. Those children selected to receive group skills counseling will attend small-group counseling sessions that teach skills that may help to improve their academic, personal/social and career development. Most elementary schools use group skills counseling as a regular part of counseling services for children.

**Confidentiality of research records:**
The information you provide when you answer the questionnaire will be kept confidential, and will not be disclosed in any publication or discussion of this material. All information will be recorded with code numbers to preserve confidentiality. Only the researcher, Brandy Schumann, the group skills counselor and the children’s teachers and administrators will know the participants names. At the end of the study the list of names will be destroyed.
The only exceptions to confidentiality are if a) a child disclosed abuse, neglect or exploitation, b) the child is a danger to oneself or to someone else, c) a court orders disclosure of information, or d) the parent or legal guardian requests release of information.

**Review for protection of participants:**
This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

**Research Subjects’ Rights:**
I have read or have had read to me all of the above.

Brandy Schumann has explained the study to me and answered all of my questions. I have been told the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case there are problems or questions, I have been told I can call Brandy Schumann or Dr. Sue Bratton or Dr. Dee Ray at telephone number 940-565-2066.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

_______________________________________________________________________
Signature of Parent or Guardian    Date

_______________________________________________________________________
Signature of Witness      Date

The researchers may wish to present some of the tapes from this study at scientific conventions or as demonstrations in classrooms. Please sign below if you are willing to allow us to do so with the tapes of your child’s participation.

I hereby give permission for the videotape made for this research study to be also used for educational purposes.

_______________________________________________________________________
Signature of Parent or Guardian    Date
For the Investigator or Designee:
I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

______________________________   ________________
Signature of the Principal Investigator      Date
APPENDIX B

CHILD ASSENT FORM
PLAY THERAPY-RESEARCH INFORMATION FOR CHILDREN

(To be read to child subjects age four to 11, selecting the appropriate terms in “( )” when noted. Questions will be allowed and responded to immediately during the reading of this statement.)

My name is ________. I am a counselor for children. That means I play and talk with children about things that are important to children. Sometimes children feel sad. Sometimes children feel scared and sometimes children like to tell stories to adults.

(If assigned to counseling group)  
If you want to, you can talk with a counselor like me. You will talk with a counselor like me about stories the counselor will read.

(If assigned to Play Therapy)  
If you want to, you can play in a playroom with a counselor like me.

If you decide you want to (talk/play) with someone like me in a special time, you can say yes or if you don’t want to (talk/play) with someone like me you can say no. The special talk or play time will be one time each week for 30 minutes. Which do you choose? Allow the child to respond and confirm his or her response.) Also, I would like you to know that you can always change your mind and you can tell your parent (guardian) that you do not want to go to the special (talk/play) time anymore.

What you say or do in counseling is private. I will not tell your parent or teacher what you say or do in the (talk/play) time. This rule will only be broken if I think you are not safe and need to be protected. If you want to tell your parent or teacher about what you do during your (talk/play) time, you can.

Thank you for your help.

Sincerely,

Brandy Schumann, MS, NCC, RPT, LPCI, MFTI  
Nationally Certified Counselor, Registered Play Therapist  
Licensed Professional Counseling Intern, Marriage and Family Therapist Intern  
Doctoral Student Counseling Intern, University of North Texas
ASSENT OF CHILD

**Title of Study:** THE EFFECT OF A PERMISSIVE THERAPEUTIC CLIMATE ON THE AGGRESSIVE BEHAVIORS OF CHILDREN

**Principal Investigator** Brandy Schumann  
**Committee Chair** Dr. Garry Landreth

_________________________(name of child) has agreed to participate in research

Title of Project

__________________________________

Signature of the Subject. Signature of the Parent or Guardian must be substituted if waiver of assent is required.

WAIVER OF ASSENT

The assent of ________________________________________________(name of child) was waived because of

_____ Age

_____ Maturity

_____ Psychological state of the child

__________________________ ____________________________
Signature of Subject, Parent, or Guardian Date
APPENDIX C

OPERATIONAL DEFINITIONS OF PLAY THERAPY SKILLS EXCERPTED FROM RAY (IN PRESS)
Non-verbal Skills

Play therapy is heavily reliant on non-verbal skills. Because play therapists believe that play is the language of children, the verbal world becomes less important in a play therapy session. Non-verbal skills are critical to any therapy, but especially to play therapy.

**Leaning forward/Open stance.** The play therapist is physically directed toward the child at all times. The play therapist moves in the chair as the child moves so that the therapist is always squarely facing the child. Arms and legs are positioned to convey a sense of openness to the child.

**Appearing interested.** The therapist looks as if she is interested in the child throughout the session. The therapist does not appear preoccupied with other thoughts or matters.

**Seems comfortable.** The therapist seems comfortable with the child and the situation. The therapist remains relaxed throughout the session.

**Therapist’s tone/Expression congruent with child’s affect.** The therapist matches the level of affect displayed by the child. Often, new play therapists will present themselves as overly animated to the child. This is generally the way that many adults relate to children. Therapists new to working with children often carry the idea that their role is to make the child happy and therefore use their tone of voice toward this end. As with counseling adults, the therapist should strive to be congruent with how the child expresses himself.

**Therapist’s tone/Expression congruent with therapist’s responses.** The therapist should not only match the child’s affect but should also convey a sense of genuineness. The skill of matching verbal response with non-verbal response is symptomatic of the therapist's level of genuineness with the child. Specifically speaking, the therapist would not flatly present the response, “You’re excited by how you made the bubbles.” In this example, the therapist would need to add the affect of excitement to the response. In addition, this skill also addresses the tendency of some therapists to end their responses in a higher tone, indicating a question. When making definitive responses, therapists should avoid this habit, which is confusing to the child. The child is left to figure out how to respond to the therapist, “Should I answer or not?”

Verbal Skills

The delivery of verbal responses by a play therapist to the child is almost as impact as the words chosen. Two delivery skills are observed specifically in the supervision of play therapists, succinct/interactive responses and rate of responses. Because play therapy is offered to children and because play therapy recognizes the limited language ability of children, the importance of short therapeutic responses is key. Supervisors help play
therapists to communicate their intent in as few words as possible. A maximum of ten words is a good rule of thumb. Lengthy responses lose the interest of the child quickly, confuse the child, and often convey a lack of understanding on the part of the therapist.

Rate of responses is a second skill in the delivery of verbal responses. The therapist should match the interaction of the child. If the child is quiet and reserved, then the play therapist will slow his responses. If the child is highly interactive and talkative, the play therapist will want to match this level of energy with increased number of responses. In initial sessions with children, play therapists will have a quicker rate of responses, because silence can be uncomfortable for the child in a new situation. In subsequent sessions, the therapist will learn to create a pace that matches the child. Both delivery skills of length of responses and rate of responses are typically problematic skills at the very beginning of a play therapist’s experience. These skills are quickly acquired and most supervisors will not address them with experienced play therapists.

In the initial supervision of the play therapists, it helps to present categories of verbal responses. These categories provide the play therapist with structure from which to work when the situation is new and foreign to them. For experienced play therapists, the construct of categorical responses helps them to review the basics when they are feeling unfocused or confused about specific cases. The following are several relevant categories of verbal responses.

*Tracking behavior.* Tracking behavior is the most basic of play therapist responses. The therapist tracks behavior when she verbally responds to the behavior of the child simply by stating what is seen or observed. Tracking behavior allows the child to know that the therapist is interested and accepting of the child. It also helps the therapist immerse herself into the child’s world. Examples of tracking behavior include, (as a child picks up the clay) “You’re picking that up” or (as child runs in a circle) “You’re running around and around.”

*Reflecting content.* Reflecting content in play therapy is identical to reflecting content in adult talk therapy. To reflect content, the play therapist paraphrases the verbal interaction of the child. Reflecting content validates the children’s perceptions of their experience and helps to clarify children’s understanding of themselves (Landreth, 2002). An example of reflecting content includes, (child excitedly shares detailed story of building a rocket with his dad) “You got to build something cool with your dad this weekend.”

Although tracking behavior and reflecting content are essential to the play therapy process, they are the most basic skills in play therapy. These two skills help to build a relationship with a child so that the child can benefit from higher-level skills. The following skills are used to move directly toward the goals of building self-concept, developing self-responsibility, creating awareness, and building the therapeutic relationship.

*Reflecting feeling.* Reflecting feeling is the verbal response to emotions expressed by children in play therapy. Reflecting feeling is considered a higher-level skill, because children rarely communicate in terms of verbally expressing emotion. However, they are
quite emotive. In addition, the reflection of feeling can sometimes be threatening to a child and should be presented carefully. Reflecting feeling helps a child become aware of emotions, thereby, leading to the appropriate acceptance and expression of such emotions. Examples of reflecting feeling include, (child throws the spider across the room while saying, “He’s bad, I hate him.”) “You are really angry with that bad spider” or (child tries several times to take the top off marker unsuccessfully and then throws it on the floor) “You’re really frustrated with that.”

Facilitating decision-making/Returning responsibility. One of the play therapist’s goals is to help the child experience a sense of their own capability and to take responsibility for their expression of capability. The therapist does not do for a child what a child can do for himself (Landreth, 2002). Responses that facilitate decision-making or return responsibility help a child experience self as able and empowered. Examples of responses that facilitate decision-making or return responsibility include, (child wants to draw a picture and asks, “What color should the car be?”) “In here, you can decide the color you want it to be”, or (without making an attempt, the child asks, “Can you get the ball from behind the shelf for me?”) “That looks like something you can do.”

Facilitating creativity/Spontaneity. Helping a child experience his own sense of creativity and freedom to experience creativity is another goal of play therapy. Acceptance and encouragement of creativity sends a message to the child that she is unique and special in her own way. Maladjusted children are often trapped in rigid ways of acting and thinking. Experiencing the freedom of expression allows them to develop flexibility in thought and action. Examples of responses that facilitate creativity or spontaneity include (child asks, “What do I make with these straws?”) “You can create whatever you want with those”, or (child moves from one project to another in play session) “You changed to do just what you want.”

Esteem-building/Encouraging. Encouraging children to feel better about themselves is a constant objective for the play therapist. The use of esteem-building statements works to help children experience themselves as capable. Examples of esteem-building/encouraging responses include, (child tries a few ways to reach the top shelf) “You’re not giving up, you just keep trying” or (child tries and tries to fit doll into car, after a few attempts, she succeeds) “You did it. You figured it out.”

Initially, play therapists often struggle with the difference between praising and esteem-building responses. The play therapist supervisor must often help a play therapist determine how an esteem-building response is more effective than a praising response. A praise response, such as, “That’s a pretty picture” or “I like the way you did that” encourages the child to perform for the therapist, and continue to seek external reinforcement, thereby eroding a sense of self. An esteem-building response, such as, “You’re really proud of your picture,” or “You made that just the way you wanted,” encourages children to develop an internal sense of evaluation leading to an internal sense of responsibility.

Facilitating relationship. Responses that focus on the relationship between the therapist and child help the child to experience a positive relationship. Because the therapy relationship serves as a model for all intimate relationships, the therapist should
respond to any attempt by the child to address the relationship. Relational responses help the child learn effective communication patterns and express the therapist’s care for the child. Example of responses that facilitate the relationship include, (child is building something in sand and stops to look up at therapist but says nothing) “You’re wondering what I think about that,” or (therapist sneezes, child gives therapist a bowl and says, “Eat the soup so you’ll feel better.”) “You really want to take care of me” or (after therapist sets limit, child responds, “I hate you. I hate you.”) “You’re really angry with me for this.” Relationship responses should always include a reference to the child and reference to self as therapist.

Limit Setting

Landreth (2002) proposed a specific method for setting limits in play therapy. This method has been widely adopted by play therapists as the initial response to setting a limit in the playroom. The A-C-T model of limit-setting includes: Acknowledge the feeling, Communicate the limit, and Target an alternative. In this model, the play therapist recognizes and addresses the child’s feelings in the moment, “You’re really angry with me.” Secondly, the therapist sets a short, concrete, definitive limit, “but I’m not for hitting.” Finally, the therapist provides an alternative to the action, “You can hit the Bop bag.” When children have directed energy in the moment, it is important to provide them an alternative for that energy so that they do not feel the need to act on impulse. Although there are other methods for setting limits, the A-C-T model is short, direct, and works effectively.
APPENDIX D

PLAY THERAPY SESSION SUMMARY FORM
University of North Texas - Department of Counseling, Development and Higher Education
Counseling Program Clinical Services

Date__/___/__ Session #__

Clinic/Rm #: ___________  Page 1 of 2  --- continued on back ---

Signature required

Child/Age___________________________/________ Counselor______________________________ Theory ____________________

Specific Interventions Used (if any) ________________________________________________________________________________

I. SUBJECTIVE: Underline all feelings, including capitalized words, expressed directly or through a toy (write toy above feeling). Circle predominate feeling(s).

HAPPY: relieved, satisfied, pleased, delighted; excited, surprised, silly
CONFIDENT: proud, strong, powerful, determined, free
SAD: disappointed, hopeless, pessimistic, discouraged, lonely
hesitant: timid, confused, nervous, embarrassed, ashamed
ANGRY: impatient, annoyed, frustrated, mad, mean, jealous
CURIOUS: interested, focused
AFRAID: vulnerable, helpless, distrustful, anxious, fearful, scared, terrified
FLAT: contained, ambiguous, restricted

II. OBJECTIVE:

A. TOYS/PLAY BEHAVIOR Circle specific toys used (not category), give brief description of play. In blank, indicate meaningful/sustained play with "!", indicate play disruption as "PD", and indicate therapist initiated activity as "TH" (Use your own code system for info important to you - ex:1st time or discontinued use of toy).

__hammer/log/woodworking
__sandbox/water/sink
__theater/puppets
__kitchen/cooking/food
__easel/paint/chalkboard
__bean bag/pillows/sheet/blanket
__bag/bag foam bats/etc
__dress up: clothes/fabrics/shoes/jewelry/hats/masks/wand
__crafts/clay/markers/etc.
__doll house/doll family/bottle/pacifier/baby
__cash register/money/phone
__camera/flashlight
__medical kit/bandages
__musical instruments
__games/bowling/ring toss/balls/etc.
__cars/trucks/bus/emergency vehicles/planes/boats/riding car
__animals: domestic/zoo/alligator/dinosaurs/shark/snake
__soldiers/guns/knife/sword/handcuffs/rope
__constructive toys/blocks/barricade
__sandtray/miniatures

B. SIGNIFICANT VERBALIZATION: CH=Child initiated  TH=Therapist initiated

C. LIMITS SET: Write limit set beside the RATIONALE (ex: threw sand on floor) & in the blank, indicate # of times limit set. If consequence and/or ultimate limit was set in response to broken limit, describe process.

__Protect Child (Physical & Emotional Safety):
__Protect Therapist and/or Maintain Therapist Acceptance/Relationship:
__Protect Room/Toys:
__Structuring:
__Reality Testing:

Developed by Bratton & Homeyer (updated 7/2002)
### III. ASSESSMENT: General Impressions/Clinical Understanding

#### A. DYNAMICS OF SESSION: Rate Child’s Overall Play Behavior

<table>
<thead>
<tr>
<th></th>
<th>Child’s Activity Level (low)</th>
<th>Child’s Activity Level (high)</th>
<th>Intensity of Play (low)</th>
<th>Intensity of Play (high)</th>
<th>Inclusion of Therapist (low)</th>
<th>Inclusion of Therapist (high)</th>
<th>Destructive</th>
<th>Messy/Chaotic/Disorganized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

#### B. PLAY THEMES: Underline all that apply, including capitalized words, & describe how theme was played out (toys used, etc). Circle predominating theme(s).

- EXPLORATORY: (not a true play theme - rather the way child gets comfortable & familiar with playroom)
- RELATIONSHIP: connecting/trust/approval seeking/manipulative/collaborative/testing limits
- POWER/CONTROL:
- HELPLESS/INADEQUATE:
- AGGRESSION/REVENGE:
- SAFETY/SECURITY:
- MASTERY: deconstructing/constructive/competency/integration/resolution
- NURTURING: self-care/reparative/healing
- DEATH/LOSS/GRIEVING:
- SEXUALIZED:
- OTHER:

#### C. OVERALL, CHILD’S BEHAVIOR / AFFECT WAS:

<table>
<thead>
<tr>
<th>MALADAPTIVE / NON-COPING</th>
<th>ADAPTIVE / COPING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad/depressed/angry/fearful</td>
<td>Content/satisfied (Appropriate Affect)</td>
</tr>
<tr>
<td>Anxious/Insecure</td>
<td>Confident/secure</td>
</tr>
<tr>
<td>Dependent/clingy/needy</td>
<td>Autonomous/Independent</td>
</tr>
<tr>
<td>Immature/regressed/hypermature</td>
<td>Age appropriate</td>
</tr>
<tr>
<td>Low frustration tolerance</td>
<td>High frustration tolerance</td>
</tr>
<tr>
<td>External locus of control</td>
<td>Internal locus of control (self-controlled)</td>
</tr>
<tr>
<td>Impulsive/easily distracted</td>
<td>Purposeful/focused</td>
</tr>
<tr>
<td>Inhibited/Constricted</td>
<td>Creative/Expressive/Spontaneous/Free</td>
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<tr>
<td>Isolated/Detached</td>
<td>Connected/Sense of Belonging</td>
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#### D. CONCEPTUALIZATION OF CLIENT AND CLIENT’S PROGRESS BASED ON THEORETICAL ORIENTATION:

### IV. PLANS / RECOMMENDATIONS: check all that apply

- Parent Consult
- Family Session
- Sibling(s) 1X
- Friend 1X
- Filial therapy
- Therapy for parent(s)
- Recommend Parent Resources:
- Other Plans / Recommendations:

**Medication Evaluation**
**Psychological Testing**
**School Consult**
**Classroom Observation**
**Professional Consult: Psychiatrist, Pediatrician, Attorney**
**Request Records:**

Developed by Bratton & Homeyer (updated 7/2002)  
Play Therapist Signature (with credentials)  
Date
APPENDIX E

GROUP GUIDANCE SESSION SUMMARY FORM
### Group Guidance Session Summary Report

Date ___________________________                Counselor ___________________________________________

Grade Level ___________________________ Unit Taught ___________________________ Lesson Taught ________________

<table>
<thead>
<tr>
<th>1. CLIENT’S NAME:</th>
<th>Present □ Absent □ (reason for):</th>
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<tbody>
<tr>
<td>Positive Behaviors:</td>
<td>None</td>
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<tr>
<td>Participation</td>
<td>X</td>
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<tr>
<td>Respectful</td>
<td>X</td>
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<td>Expression of Feelings</td>
<td>X</td>
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<tr>
<td>Self-Esteem</td>
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<td><strong>Negative Behaviors:</strong></td>
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<tr>
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<td>Self-Esteem</td>
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<td>Self-Esteem</td>
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### 5. CLIENT’S NAME:

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<th>Medium</th>
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<th>Very High</th>
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**Negative Behaviors:**

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**Present:** ☐ Absent ☐ (reason for): ____________________

**Overall, Group’s participation was:**

**Significant Verbalizations:**

**Significant Happenings:**

**Limits Setting:**

**Referral:**

---

Therapist’s signature with credentials

Date
APPENDIX F

INDEPENDENT SAMPLE T-TESTS OF PRETEST SCORES

FOR TEACHER’S RATINGS
For all 6 of the following Individual Sample t-tests, Levene’s Tests for Homogeneity of Variances, $F=6.71$, $p>.05$, were computed. No significant differences were found. Therefore, homogeneity of variance was assumed, and the statistic was considered valid.

**Behavioral Assessment System for Children-Teacher Rating Scale**

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<th>Group</th>
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<th>Pretest mean</th>
<th>SD</th>
<th>df</th>
<th>T</th>
<th>Sig of t</th>
<th>Cohen’s d</th>
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APPENDIX G

INDEPENDENT SAMPLE T-TESTS OF PRETEST SCORES

FOR PARENT’S RATINGS
For all 6 of the following Individual Sample t-tests, Levene’s Tests for Homogeneity of Variances, $F=6.71$, $p>.05$, were computed. No significant differences were found. Therefore, homogeneity of variance was assumed, and the statistic was considered valid.

<table>
<thead>
<tr>
<th>Scale</th>
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