IMPACT OF CHILD-CENTERED GROUP PLAY THERAPY ON SOCIAL-EMOTIONAL
ASSETS OF KINDERGARTEN CHILDREN

Yi-Ju Cheng, MEd.

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APPROVED:

Dee Ray, Major Professor
Natalya Lindo, Committee Member
Leslie Jones, Committee Member
Jan Holden, Chair of the Department of
   Counseling and Higher Education
Jerry Thomas, Dean of the College of
   Education
Costas Tsatsoulis, Interim Dean of the
   Toulouse Graduate School
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Early childhood is a critical period during which children develop social-emotional competence that will affect future success. Developing social-emotional assets is of importance for kindergarten children because of their concurrent cognitive and social changes as well as the experience of transitioning from home to school environment. A growing number of schools have adopted social-emotional learning (SEL) programming to focus on fostering children’s prosocial behaviors through direct instruction and engaging activities in classroom settings. However, some researchers have proposed that learning should capitalize on children’s natural interests rather than adult-determined agendas. Based on theoretical assumptions regarding potential effectiveness of child-centered group play therapy (CCGPT) as a treatment modality, I sought to explore the effects of CCGPT on social-emotional assets of kindergarten children utilizing parent and teacher reports across pretest, posttest, and one-month follow-up. Additionally, given that group sizes have been inconsistent and rarely explored across previous studies, I investigated the therapeutic aspect of group sizes in CCGPT outcome by comparing 2-member and 3-member CCGPT groups.

Forty-three participants with mean age of 5.14 were recruited from three elementary schools, including 19 Hispanic, 14 Caucasian, and 10 African American. Twenty-one participants were randomly assigned to the intervention group receiving a mean of 15.32 CCGPT sessions over 8 weeks, and 22 participants were assigned to the waitlist control group. Six mixed between-within ANOVAs were conducted applying an alpha level of .05 to interpret statistical significance and η² calculation to assess practical significance. Results indicated a statistically
significant interaction effect on SEARS-P Total score, $F (2, 72) = 4.533, p = .014$, with medium effect size of $\eta^2 = .101$. Post Hoc analyses indicated a non-statistically significant interaction effect on SEARS-P Self-Regulation/Responsibility subscale with a small effect, $F (1.868, 67.248) = 1.776, p = .179, \eta^2 = .043$; a statistically significant interaction effect on SEARS-P Social Competence subscale with a medium effect, $F (1.696, 61.049) = 3.413, p < .05, \eta^2 = .079$; and a statistically significant interaction effect on SEARS-P Empathy subscale with a medium effect, $F (1.439, 51.79) = 4.592, p < .05, \eta^2 = .106$. Thus, participants in the CCGPT group showed a non-significant increase in the ability to self-regulate emotions and to take responsibility for actions and a significant increase in competence to interact socially with others and in empathy for others. Teacher reports did not show statistically significant results with a small effect, $F (2, 70) = .917, p = .404, \eta^2 = .013$. Results on group sizes indicated that no statistical differences were detected between two-member and three-member groups with no effect, $F (1.493, 25.377) = .039, p = .942, \eta^2 = .001$. Moreover, the results on follow-up supported that a certain level of the effects of CCGPT lasted one month after the intervention. Overall, children seemed to benefit from CCGPT, and CCGPT may be considered a viable treatment for enhancing kindergarten children’s social-emotional development.
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IMPACT OF CHILD-CENTERED GROUP PLAY THERAPY ON SOCIAL-EMOTIONAL ASSETS OF KINDERGARTEN CHILDREN

Introduction

Early childhood is an important period during which children develop social-emotional competence that will affect future success (Denham et al., 2012; Kramer, Caldarella, Christensen, & Shatzer, 2010; Yates et al., 2008). Between 9.5% and 14.2% of children from birth to 5 years of age are likely to experience social, emotional, and behavioral problems (Brauner & Stephens, 2006). In the 2011 National Survey for Health Statistics, Bloom, Cohen, and Freeman (2012) estimated that more than 5% of children ranging from 4 to 17 years old displayed serious difficulties with emotions, relationships, concentration, or behaviors. The National Academy of Sciences also reported that only 40% of children enter school with the needed social-emotional skills to succeed in kindergarten even though 60% of children enter school possessing appropriate cognitive skills (Ashdown & Bernard, 2012). These statistics seem to suggest the prevalence of social-emotional problems in young children.

Social-Emotional Assets of Young Children

Social-emotional assets and resiliencies are adaptive characteristics important for children’s success at school, at home, and in the outside world (Merrell, 2011). Such characteristics include, but are not limited to, friendship skills, empathy, interpersonal skills, emotional competency, self-concept, and self-management (Merrell, 2011). Well-developed social-emotional assets enable children to build close and secure relationships with peers and adults; to experience, regulate, and express emotions in a socially supportive and accepting ways; to understand others’ emotions, thoughts, and needs; and to explore the world (Gormley, Newmark, Welti, & Adelstein, 2011; Yates et al., 2008). However, social-emotional difficulties
in young children contribute to various negative consequences including obstacles that prevent excelling in academics; inability to identify and understand own and other’s feelings; struggles with regulating behavior, emotions, and thoughts; and difficulties establishing relationships with others (National Scientific Council on the Developing Child, 2004). Developing social-emotional assets is critical for kindergarten children because of their concurrent cognitive and social changes as well as the experience of transitioning from home to school environment (Vecchiotti, 2003). Kindergarten children learn to engage in relationships with people outside of family, to manage performance and expectations in schools, and to cope with physical and psychological space while transitioning from preschool to kindergarten (McWayne, Cheung, Wright, & Hahs-Vaughn, 2012). To adapt to these challenges and tasks, children must develop appropriate social-emotional and cognitive competencies (McWayne et al., 2012).

In response to these observed concerns and needs, a growing number of schools adopted social-emotional learning (SEL) programming to focus on fostering children’s prosocial behaviors. SEL programming consists of different programs targeting at enhancing children’s social and emotional capacities through systematic and direct instruction and engaging activities in classroom settings (Collaborative for Academic, Social, and Emotional Learning [CASEL], 2013; Kramer et al., 2010). Several researchers have investigated the effects of utilizing SEL programs as a prevention or intervention to facilitate children’s social-emotional competence in school settings and have reported positive outcomes (e.g., Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Kramer et al., 2010).

When reporting on a large-scale meta-analysis, Durlak et al. (2011) suggested that SEL programs have positive effects on ethnically diverse children’s social-emotional skills, academic performance, conduct problems, and attitudes toward self, others, and school across in-school
and after-school environments. However, Kramer et al. (2010) discussed some limitations applying SEL programs to school curriculum, including scarcity of resources, failure to attend to each student’s needs, and inappropriateness for children’s developmental stages. Moreover, researchers have indicated that childhood education should capitalize on interactive and relational ways of learning, that is, capitalize on children’s natural interests rather than adult-determined agendas (National Scientific Council on the Developing Child, 2004). These discrepancies seem to signify the importance of exploring the use of relational and experiential approaches that are developmentally appropriate to promote children’s social-emotional assets.

Kindergarten children use concrete reasoning without developing strategies for remembering information (Gelman, 1999; Seefeldt & Wasik, 2002). They have egocentric thinking but also the ability to be aware of and understand others’ feelings and opinions (Seefeldt & Wasik, 2002; Siegler, 1997). The nature of kindergarten children’s developing cognition highlights the importance of providing them with experiential, contextual, and relatable learning experiences (Seefeldt & Wasik, 2002). Play is a process in which children learn and grow; learning occurs during play (Frost, Wortham, & Reifel, 2008; Golinkoff, Hirsh-Pasek, & Singer, 2006; Landreth, 2012; Ray, 2011). Play not only allows children to play out their feelings, beliefs, experiences, and problems but also facilitates their development of social, emotional, and cognitive competencies (Landreth, 2012; O’Shea, 2004; Seefeldt & Wasik, 2002). Particularly, play is critical for children as they develop self-regulation, social competence, and confidence in peer relationships (Golinkoff et al., 2006; Raver, 2002). Given that psychoeducational groups may exceed young children’s cognitive developmental abilities (Jones, 2002) and play is a natural language of children (Landreth, 2012), play therapy appears to be a developmentally appropriate modality for working with kindergarten age children.
Child-Centered Play Therapy (CCPT)

CCPT is “the most identified play therapy approach” among diverse theoretical modalities of working with children (Ray, 2011, p. 61). Meta analytical reviews have shown CCPT as an effective treatment modality for children in reducing children’s externalizing and internalizing behaviors, increasing children’s self-esteem and self-concept, and improving children’s academic performance (Bratton, Ray, Rhine, & Jones, 2005; Leblanc & Ritchie, 2001; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015). Child-centered group play therapy (CCGPT) is especially appropriate for children struggling with social-related difficulties (Axline, 1969; Ginott, 1961; Ray, 2011; Sweeney, Baggerly, & Ray, 2014). Schectman, Gilat, Fos, and Fisher (1996) proposed that group play therapy is an ideal intervention that addresses children’s emotional, social, and learning impairments. CCGPT combines the advantages of CCPT and group process (Landreth & Sweeney, 1999). Through interactions with other group members who serve as therapeutic agents for each other, each group member has opportunities to explore individual intrapersonal issues and interpersonal issues (Landreth & Sweeney, 1999; Ray, 2011; Sweeney et al., 2014). These interactions in the CCGPT process allow children to learn coping behaviors, problem-solving skills, and alternatives of self-expression; children also connect group play therapy experiences to reality (Ray, 2011; Sweeney et al., 2014). A play therapist’s facilitations and reflections as well as the presence of other group members enable all participating children to become more aware of their own and others’ feelings, thoughts, and needs as well as to learn how to interact in accepting and supportive ways (Ginott, 1961; Ray, 2011; Sweeney et al., 2014).

To date, only one study involved exploring the effects of CCGPT on children’s social-emotional development. Trostle (1988) examined the effects of CCGPT and sex differences on
self-control, free play, and sociometric ratings with 48 young bilingual Puerto Rican children aged 3 to 6 years old. The results showed that after 10 sessions of CCGPT, children in the experimental group outperformed those in the control group on self-control and higher developmental level play behaviors of make-believe and reality. Specifically, boys receiving CCGPT displayed a statistically significantly higher acceptance of others after treatment compared to girls from the experimental group and all children in the control group. Nevertheless, Trostle did not address practical significance, implementation fidelity, biases generated by using self-reports, and the lack of parental perspectives in the data. Therefore, the need to conduct more research investigating CCGPT on children’s social-emotional assets with sound methodology and procedures is apparent.

CCGPT aims to create a therapeutic environment in which each group member manifests both verbal and nonverbal play expressions, develops relationships with other group members and the therapist, and actualizes potential (Landreth & Sweeney, 1999; Ray, 2011; Sweeney et al., 2014). In group settings, group size can be critical for maximizing the multiple relationships, activities, behaviors, interactions, and dynamics likely to occur simultaneously during sessions (Ray, 2011). CCPT therapists convey genuineness, empathetic understanding, and unconditional positive regard regardless of group size (Ray, 2011); however, the intensity of interactions, sound level, and activity level may influence therapists’ internal access for conveying conditions and attitudes (Ray, 2011). With more children in a group, therapists face challenges with developing adequate therapeutic relationships with all group members (Ray, 2011). Whereas Axline (1969) recommended group sizes of up to eight children in each group led by a play therapist, Landreth and Sweeney (1999) and Ray (2011) posited that two or three children per CCGPT group can be beneficial. Chiefly, previous literature (e.g., Baggerly & Parker, 2005;
Danger & Landreth, 2005; Trostle, 1988; Shen, 2002; Tyndall-Lind et al., 2001) appears devoid of discussions about the therapeutic aspects of group size. Hence, given that group sizes have been inconsistent and rarely explored across previous research, a gap between the factor of group size and the outcome of group play therapy is present.

Purpose

The purpose of the current study was to explore the effects of CCGPT with kindergarten children demonstrating apparent problems or emerging deficits in social-emotional assets. Numerous researchers have studied the effects of integrating socially-focused programming into school curriculum to facilitate children’s growth in social-emotional competencies; however, the use of the child-centered approach for targeting the social-emotional assets of kindergarten children in school settings appears to be missing from the literature. Moreover, due to a gap between the factor of group size and therapeutic outcome in CCGPT, the current study also investigated the differences in CCGPT effects between two-member and three-member groups. Specifically, the research questions were the following: (a) Do children who participate in CCGPT improve overall social-emotional assets over children who do not participate in CCGPT as measured by the Total score of Social Emotional Assets and Resilience Scale–Teacher (SEARS-T) over time (pre, post, and one-month follow-up)? (b) Do children who participate in CCGPT improve overall social-emotional assets over children who do not participate in CCGPT as measured by the Total score of Social Emotional Assets and Resilience Scale–Parent (SEARS-P) over time (pre, post, and one-month follow-up)? (c) Is there a difference in overall social-emotional assets for children who participate in two-member versus three-member CCGPT groups?
Methodology

Participants

Participants were children enrolled in kindergarten at three Title I local elementary schools in the southwest United States. Criteria for inclusion in this study included the following: (a) Children were enrolled in kindergarten and 5 years of age or older; (b) Children were referred by the teacher or school counselor due to apparent problems or emerging deficits in social-emotional assets as exhibited by specific behavioral, emotional, or interpersonal concerns; (c) Children were rated in At-Risk or High-Risk range by parent or teacher on any subscale or total score of the pretest instrument; (d) Children understood and spoke English; (e) Parents of children were willing to give consent and complete assessments; (f) Teachers of children were willing to give consent and complete assessments; and (g) Children did not receive other types of mental health services during the study.

Of the 43 participants, 19 identified as Hispanic, 14 as Caucasian, and 10 as African American. Thirty participants were male, and 13 were female. Thirty-seven of the participants were 5 years old, while six participants were 6 years old at pretest ($M = 5.14$). Twenty-one participants were in the CCGPT group, and 22 were in the waitlist control group. Among the participants in the CCGPT group, 12 were in two-member groups, and 9 were in three-member groups.

Instruments

Social Emotional Assets and Resilience Scales (SEARS) is a strength-based, cross-informant instrument developed to assess the social-emotional competencies of children and adolescents from 5 to 18 years old (Merrell, 2011). It includes a parent report form to assess children aged 5 to 18 years or in Grades K to 12 and a teacher report form to assess children aged
5 to 18 years or in Grades K to 12 (Merrell, 2011). In the current study, I used Social Emotional Assets and Resilience Scale-Parent (SEARS-P) and Social Emotional Assets and Resilience Scale-Teacher (SEARS-T) to gain parents’ and teachers’ perspectives, respectively.

SEARS is based on the three-tiered prevention model (Merrell, 2011) that served as the criteria for participant qualifications and outcome interpretations in the current study. The first tier, average to high functioning, includes individuals whose SEARS’s scores fall from the 21st to the 99th percentile, occupying around 80% of the normative sample (Merrell, 2011). The second tier is At-Risk and includes SEARS scores from the 6th to 20th percentile with approximately 15% of the normative sample scoring in this range (Merrell, 2011). The third tier is High-Risk and includes SEARS scores falling at or below the 5th percentile (Merrell, 2011).

*SEARS-P.* The SEARS-P is a self-administered assessment for parents, guardians, or other home-based caregivers of children and adolescents who are 5 to 18 years old (Merrell, 2011). The SEARS-P consists of 32 items, uses a 4-point response format (i.e., never, sometimes, often, always), and focuses specifically on home and community contexts (Merrell, 2011). The SEARS-P reflects parents’ perceptions of their children’s social-emotional competencies across three domains titled Self-Regulation/Responsibility (22 items), Social Competence (10 items), and Empathy (7 items; Merrell, 2011).

Reliability estimates for the SEARS-P were considered strong by Merrell (2011), who reported an alpha coefficient of .96 for the Total score of the SEARS-P, .95 for the subscale of Self-Regulation/Responsibility, .89 for Social Competence, and .87 for Empathy. Regarding test-retest reliability, the SEARS-P Total score yielded .93 for test-retest and the subscale scores ranged from .88 to .92. When examining the validity of SEARS-P, Merrell thoroughly conducted analysis of internal structure, intercorrelations among scales of SEARS, and
relationships to other measures. In the current study, parents whose primary language was Spanish completed the Spanish version of the SEARS-P, and Cronbach's alpha demonstrated a .909 for all participants on the SEARS-P pretest.

**SEARS-T.** The SEARS-T is self-administered by classroom teachers or other educators who have in-depth knowledge about children aged 5 to 18 years (Merrell, 2011). The SEARS-T includes 41 items using 4-point response format (i.e., never, sometimes, often, always) and is designed to measure teachers’ perspectives about children’s social-emotional competencies across the four domains titled Self-Regulation (13 items), Social Competence (12 items), Empathy (6 items), and Responsibility (10 items; Merrell, 2011). Although some similarities regarding item content between the SEARS-P and SEARS-T are present, the SEARS-T focuses on school context (Merrell, 2011).

The internal consistency reliability for the SEARS-T Total score was a Cronbach’s alpha of .98 that was considered strong by Merrell (2011). Additionally, the alpha for Self-Regulation was .95, for Social Competence was .94, for Empathy was .91, and for Responsibility was .95. The test-retest reliability for the SEARS-T Total score was .94 with coefficients ranging from .84 to .92 for subscale scores (Merrell, 2011). Regarding validity, the SEARS-T was thoroughly examined through analysis of internal structure, intercorrelations among SEARS scores, and convergent construct validity (Merrell, 2011). For the current study, Cronbach's alpha for all participants on the SEARS-T pretest was .96.

**Procedures**

I obtained human subjects approval prior to the recruitment of participants and data collection. I met with school counselors and asked for kindergarten teachers’ help in identifying children who seemed to display some emerging limits or apparent problems in social-emotional
assets. Teachers made referrals to school counselors for children who they believed would qualify for and benefit from the study. Data collection began approximately 1.5 months after the beginning of the fall semester so that teachers had time to engage in sufficient interactions and observations of the students before making referrals.

In accordance with randomized and controlled trial procedures, participants were stratified first by school and then were randomly assigned into the intervention group or the waitlist control group. Participants in the intervention group were also assigned into either two-member or three-member groups. I did not control for gender in random assignment process due to the suggestion that prior to 9 years of age, mixed gender CCGPT groups are appropriate (Landreth & Sweeney, 1999). Participants in the intervention group ideally should have received two 30-minute CCGPT sessions per week for the period of 8 weeks. Due to student absences, participants in the intervention group received between 15 and 16 sessions of play therapy with a mean of 15.32 sessions. Counselors did not hold CCGPT sessions if either one of the two-member group members was absent; in this case, they rescheduled make-up sessions. Given the difficulty in rescheduling three-member groups, counselors proceeded to hold the CCGPT session if only one of the three-member group members was absent. All play therapy sessions were held in each student’s school in a fully equipped playroom in accordance with the CCPT manual (Ray, 2011). At the completion of the 8-week intervention period, I distributed the SEARS-P for parents and SEARS-T for teachers to complete as a posttest measure. To obtain follow-up data, I utilized the same procedures 1 month after the intervention, without providing participants CCGPT services during that month.

*Intervention group procedures.* Participants assigned to the intervention group participated in 30-minute sessions of CCGPT occurring two times per week over 8 weeks.
CCGPT uses children’s natural language of play to provide a developmentally appropriate therapeutic environment for young children. Counselors followed the child-centered play therapy treatment manual (Ray, 2011) with modifications enacted as necessary and appropriate for CCGPT throughout the intervention. Counselors developed the therapeutic relationship by responding with both verbal communication and nonverbal language including being warm, genuine, empathetic, and consistent. Counselors used reflections of feeling, meaning, and content; returned responsibility; and employed limit setting, encouragement, and other skills to facilitate a safe environment for the participants to express and explore themselves, develop self-esteem, and learn self-responsibility.

Playrooms were assembled and materials were selected according to Landreth’s (2012) and Ray’s (2011) recommendations. The toys in the playrooms were appropriate for the participants’ developmental age and allowed for exploration via various play behaviors and related feelings. In the current study, materials in the playroom were similar to materials available for individual play therapy. However, I intentionally matched the quantity of dart guns, swords, construction paper, and butcher paper with the number of group members. Rationale for this modification was based on the premise that materials in play therapy serve as the therapeutic and communicative process for children (Landreth, 2012; Ray, 2011). Instead of assuming that children have the opportunity to work through conflicts with limited group play therapy materials, CCGPT aims to provide an environment where group members free themselves for full expression and choose direction for self and the group, leading to the development of the self-actualizing tendency (Ray, 2011; Sweeney et al., 2014). Ultimately, fairness was not the purpose of the modification, but the freedom for full movement led to the modification.
Counselors were doctoral-level counseling students trained and experienced in both individual and group child-centered play therapy procedures. The participating counselors held a master’s degree in counseling, conducted CCGPT for at least one year prior to participating in the study, completed at least two play therapy courses, and supervised clinical practice in play therapy. Prior to delivering play therapy protocol, counselors participated in training on the protocol for conducting CCGPT in schools. Counselors included 4 females who identified as African American (n = 1), Asian (n = 1), and Caucasian (n = 2). In consideration of implementation fidelity, all play sessions were video recorded, and all counselors received weekly supervision by a faculty member with advanced experience in play therapy. I assessed protocol adherence by randomly reviewing one session per child using the revised Group Play Therapy Skills Checklist (GPTSC; Ray, 2011) seen in Table 1. Sessions adhered to CCPT protocol with appropriate modifications for CCGPT over 90% of the time with an average of 98% adherence to protocol per session.

Participants in the waitlist control group did not receive any treatment during the study. Upon the completion of data collection at pretest, posttest, and 1-month follow-up, participants in the waitlist control group received the same CCGPT intervention that was implemented by the counselors with the intervention groups. The counselors followed the same protocol used with the two-member and three-member intervention groups.

Results

In order to address the research question exploring the impact of CCGPT on kindergarten children’s social-emotional assets, I conducted two mixed between-within analysis of variance (ANOVA) tests with the Total scores on the SEARS-P and SEARS-T as the dependent variables and two groups (i.e., intervention and waitlist control groups) as independent variable. Given
that the interaction effect on the SEARS-T Total was not statistically significant, I conducted the third mixed between-within ANOVA on only the SEARS-P Total to examine the effects of CCGPT regarding group size. Following the initial analyses, I conducted three post hoc analyses of mixed between-within ANOVAs on the remaining subscales of SEARS-P to gain more information on understanding the statistically significant change in the Total score. Table 2 presents the mean scores for pre, post, and follow-up SEARS-P Total and subscale scores for the intervention and waitlist control groups. Table 3 displays the mean scores for pre, post, and follow-up SEARS-T Total scores for intervention and waitlist control groups. Table 4 exhibits the mean scores for pre, post, and follow-up SEARS-P Total scores for two-member and three-member groups.

The assumptions for all analyses were analyzed. The assumption of sphericity was violated when examining group size and the SEARS-P subscales of Social Competence and Empathy. Given the consideration of sample size and power, I applied Greenhouse-Geisser corrections to make the $F$ ratio more conservative by adjusting the degree of freedom that controls for the Type I error rate (Brace, Kemp, & Snelgar, 2013; Field, 2013; Stevens, 2009; Tanguma, 1999). In the current study, I addressed the violation on sphericity and controlled for the Type I error rate in the post hoc analyses by using Greenhouse-Geisser corrections. Therefore, I used an alpha level of .05 for all analyses without lowering alpha level to avoid lower power. All other assumptions were met. To assess the practical significance of findings, I calculated $\eta^2$ and utilized Cohen’s (1977) guidelines for interpreting $\eta^2$ as a measure of effect size for the univariate tests where $\eta^2$ of .01 is small, .06 is medium, and .14 is large.
Parent Report on SEARS

I conducted a mixed between-within ANOVA to assess whether from parents’ perspectives children who participated in the CCGPT group demonstrated improvements in their overall social-emotional assets when compared to those in the waitlist control group across pre, post, and 1-month follow-up. Three parents did not return the posttests (1 in intervention and 2 in waitlist control groups). One parent in the intervention group did not complete the follow-up test, and one participant in the waitlist control group dropped out of the study at the 1-month follow-up. SPSS excluded these cases while analyzing SEARS-P Total score.

Results of the mixed between-within ANOVA on the Total score of SEARS-P indicated a statistically significant interaction effect between treatment group and time, $F(2, 72) = 4.533, p = .014$, with a medium effect size, $\eta^2 = .101$. The main effect of time was statistically significant, $F(2, 72) = 3.784, p < .05$, with a medium effect size, $\eta^2 = .084$. The main effect of treatment group was not statistically significant, $F(1, 36) = .146, p = .704$, and the effect size was near zero, $\eta^2 = .004$. Polynomial contrasts detected a statistically significant linear trend over three points of time with a medium effect size, $F(1, 36) = 4.812, p < .05, \eta^2 = .118$, and a statistically significant quadratic trend on the interaction effect with a large effect size, $F(1, 36) = 1.571, p < .01, \eta^2 = .218$.

Post Hoc Analyses for Parent Reports

Self-regulation/responsibility. To control for Type I error, I reported Greenhouse-Geisser corrected tests, $\varepsilon = .943$. Results of the mixed between-within ANOVA indicated a non-statistically significant interaction effect between treatment group and time with a small effect size, $F(1.868, 67.248) = 1.776, p = .179, \eta^2 = .043$. The main effects for time and treatment group were not statistically significant with small effect sizes, $F(1.868, 67.248) = 2.273,$
\[ p = .114, \eta^2 = .055 \text{ and } F(1, 36) = .320, p = .575, \eta^2 = .009, \text{ respectively. Additionally, polynomial contrasts did not reveal any statistically significant trends.} \]

**Social competence.** To correct the violation on sphericity, \( x^2 (2) = 6.919, p = .031 \), and to control for Type I error, I reported Greenhouse-Geisser corrected tests, \( \epsilon = .848 \). Results indicated a statistically significant interaction effect for Social Competence between treatment group and time, \( F(1.696, 61.049) = 3.413, p < .05 \), with a medium effect size, \( \eta^2 = .079 \), as well as a statistically significant main effect for time, \( F(1.696, 61.049) = 3.699, p < .05 \), with a medium effect size, \( \eta^2 = .085 \). The main effect for treatment group was not statistically significant, \( F(1, 36) = .059, p = .810 \), with a near zero effect size, \( \eta^2 = .002 \). Polynomial contrasts revealed a statistically linear trend on the main effect of time, \( F(1, 36) = 7.275, p < .05 \), with a large effect size, \( \eta^2 = .168 \).

**Empathy.** To correct the violation on sphericity, \( x^2 (2) = 17.314, p < .001 \), and to control for Type I error, I reported Greenhouse-Geisser corrected tests, \( \epsilon = .719 \). Results indicated a statistically significant interaction effect for empathy between treatment group and time, \( F(1.439, 51.79) = 4.592, p < .05 \), with a medium effect size of \( \eta^2 = .106 \). The main effect for time was not statistically significant, \( F(1.439, 51.79) = 2.756, p = .089 \), with a medium effect size of \( \eta^2 = .063 \). The main effect for treatment group was not statistically significant, \( F(1, 36) = .035, p = .852, \eta^2 = .001 \). Correspondent with these findings, polynomial contrasts revealed a statistically quadratic trend on the interaction effect, \( F(1, 36) = 22.089, p < .001, \eta^2 = .380 \).

**Teacher Report on SEARS**

I conducted a mixed between-within ANOVA to examine teachers’ reports of children who participated in the CCGPT group regarding overall social-emotional assets when compared to those on the waitlist control group across pre, post, and 1-month follow-up tests. One of the
teachers was unable to complete posttest for five participants (three children in the intervention group and two children in the waitlist control group) due to severe illness and one participant in the waitlist control group dropped out of the study at the 1-month follow-up. SPSS excluded these cases while analyzing SEARS-T Total score.

Results showed no statistically significant interaction between treatment group and time with a small sample size, $F (2, 70) = .917, p = .404, \eta^2 = .013$. The main effect comparing the two groups was not statistically significant, $F (1, 35) = .1277, p = .266$, with a small effect size, $\eta^2 = .035$. The main effect of time was statistically significant, $F (2, 70) = 21.645, p < .001$, with a substantially large effect size of $\eta^2 = .317$, indicating that teachers’ scores on both groups increased across time. Polynomial contrasts detected statistically significant linear and quadratic trends on the main effect of time, $F (1, 35) = 31.862, p < .001, \eta^2 = .476,$ and $F (1, 35) = 4.302, p < .05, \eta^2 = .109$, respectively.

**Two-Member and Three-Member Groups**

The parent of one participant in the two-member group did not return the posttest and the parent of one two-member group did not complete the follow-up test, resulting in a two-member group of 10 and a three-member group of nine. I reported the following analytical results with caution due to the small sample size.

Mauchly’s test indicated that the assumption of sphericity was violated, $\chi^2 (2) = 6.643, p = .036$; therefore, I reported Greenhouse-Geisser corrected tests, $\epsilon = .746$. Results of the mixed between-within ANOVA on the Total score of SEARS-P indicated a non-statistically significant interaction effect between group size and time, $F (1.493, 25.377) = .039, p = .942, \eta^2 = .001$. The main effect of time was statistically significant, $F (1.493, 25.377) = 6.912, p < .01$, with a large effect size of $\eta^2 = .244$; and the main effect of group size was not statistically significant, $F$
(1, 17) = 2.137, $p = .162$, with a medium effect size of $\eta^2 = .112$. Polynomial contrasts detected statistically significant linear and quadratic trends between three points of time with large effect sizes, $F (1, 17) = 4.672, p < .05, \eta^2 = .216$ and $F (1, 17) = 13.993, p < .01, \eta^2 = .415$, respectively.

Discussion

I sought to investigate the impact of CCGPT on social-emotional assets of kindergarten children, the difference of CCGPT effect between two-member and three-member groups, and the long-range effect of CCGPT. Results indicated that parents observed substantial positive changes over time on overall social-emotional assets, social competence, and empathy among the children who participated in CCGPT as compared to children in the waitlist control group. While comparing the two-member and three-member CCGPT groups, no differences for participants’ overall social-emotional assets regarding group size were detected. Teacher reports did not attain any statistically significant results.

Parent Perceptions

Regarding overall social-emotional assets, parents indicated a level of positive impact of CCGPT for kindergarten children who were identified as displaying apparent or emerging deficits in social-emotional development. The medium effect size found in the current study is consistent with the findings in Lin and Bratton (2015) and Ray et al.’s (2015) meta-analytic reviews of CCPT outcomes. The results further correspond to Trostle’s (1988) conclusion about CCGPT improving the social and emotional skills of bilingual Puerto Rican children. In addition, mean differences on all subscales of the SEARS-P indicated that when compared to no treatment, CCGPT served to accelerate children’s overall social-emotional development, and this growth displayed a certain level of sustainability a month after termination.
The findings indicate that CCGPT may be a viable intervention that facilitates and supports children to explore and expand their social and emotional assets in a safe environment through play. Child development experts have historically proposed that children develop social, emotional, and cognitive competencies through play (Frost et al., 2008; Seefeldt & Wasik, 2002). In CCGPT, therapist’s facilitations and the presence of other children enable children to become more attuned to their own and others’ feelings and needs as well as to learn to express themselves in socially acceptable ways (Ray, 2011). Ultimately, CCGPT seems to create an atmosphere in which children develop and reflect on social and emotional growth through therapeutic relationships with the therapist and group members. In the process of CCGPT, children further connect CCGPT experiences and vicarious learning into their daily lives.

In terms of self-regulation and responsibility, the current results did not detect statistical significance. It is worth noting that participants in the intervention group illustrated a mean $T$-score increase of approximately four points from pretest to posttest on the Self-Regulation/Responsibility domain whereas the waitlist group maintained similar $T$-scores from pretest to posttest. These observations suggested that the participants in CCGPT groups made some progress in self-regulation and self-responsibility, but the changes were not substantial enough as perceived by parents to reach statistical significance. Alternatively, the small number of participants might limit the probability of reaching statistical significance. To date, most of the reviewed CCPT studies examined the impact of CCPT on children’s overall externalizing problem behaviors rather than on the specific areas of self-regulation and self-responsibility. Results of several CCPT studies support the positive impact of CCPT in reducing externalizing disorders (e.g., Lin & Bratton, 2015; Ray et al., 2015). The inconsistency of this study as
compared to others on externalizing behaviors seems to reflect the need to further explore the impact of CCGPT on the construct of self-regulation and self-responsibility.

With regard to social competence, children in the current study who received CCGPT demonstrated statistically significant improvement in social behaviors, a finding consistent with previous CCGPT studies (e.g., Fleming & Synder, 1947; Trostle, 1988; Tyndall-Lind et al., 2001). Social relations are influential in kindergarten children’s cognitive and emotional development (Frost et al., 2008; Seefeldt & Wasik, 2002). Researchers have asserted the importance of play in enhancing social development in children (e.g., Berk et al., 2006; Frost et al., 2008; Landreth, 2012; Piaget, 1999; Ray, 2011; Seefeldt & Wasik, 2002; Vygotsky, 1966). Especially, group play therapy is an approach that reflects children’s everyday world and meets their need for social acceptance (Axline, 1979; Ginott, 1961; Landreth & Sweeney, 1999; Ray, 2011, Sweeney et al., 2014). CCGPT offers a less threatening environment for children to engage in new experiences because of the company of other group members (Ginott, 1961; Landreth & Sweeney, 1999; Ray, 2011). By observing each other in the process of CCGPT, group members increase vicarious learning and learn that certain social skills are needed to maintain peer relationships (Ray, 2011). As Ginott (1961) stressed, “in return for peer acceptance, a child is motivated to change behavior” (p. 17). Groups are accordingly a crucial socializing influence in children’s development (Erikson, 1963; Frank & Zilbach, 1968).

Regarding empathy, the statistical and practical significance found in the post hoc analysis provided preliminary evidence for supporting the use of CCGPT for enhancing kindergarten children’s empathy. To date, no study in review was designed to explore the effectiveness of play therapy on empathy. Empathy is a crucial interpersonal ability that affords social-emotional development and prevents impairment throughout childhood and adolescence.
(Eisenberg & Miller, 1987; Ezpeleta, Granero, de la Osa, & Guillamon, 2000; Findlay, Girardi, & Coplan, 2006). Dadds et al. (2009) argued that most children are capable of conceptually understanding empathy but may not emotionally experience empathy. Responding to this phenomenon, Ray, Stulmaker, Lee, and Silverman (2013) proposed that providing an environment in which children actually experience empathy and express emotions may be beneficial for advancing individual levels of empathy, a premise supported by the current findings.

CCPT is embedded in the tenet that children experience self-direction, grow in self-acceptance, and eventually release the self-actualizing tendency when the therapist displays empathy, unconditional positive regard, and congruence (Axline, 1969; Landreth, 2012; Ray, 2011). Conveying empathetic understanding to children could potentially be one of the most vital attitudes within the therapeutic relationship because children continuously engage in the therapeutic relationship as a result of feeling understood (Landreth, 2012). In the process of CCGPT, children not only experience a consistent acceptance and understanding from the therapist but also have opportunities to expand their capacity to recognize, consider, and understand group members’ feelings and opinions through therapists’ facilitations (Axline, 1969; Ray, 2011; Sweeney et al., 2014). Additionally, supporting the empathic role that group members serve in group play process, Ray (2011) asserted that group members’ approach to each other is “one of genuineness and naturally felt empathy, especially when children have experienced similar contexts, personality characteristics, or presenting issues” (p. 192). Consequently, CCGPT offers group members experiences with feeling empathy as well as opportunities to provide empathy to each other.
Teacher Perceptions

Results on the SEARS-T Total scores indicated that from pretest, posttest, to follow-up test, both the intervention and waitlist control groups demonstrated gradual improvements in social-emotional assets. The lack of statistically significant results on Total score on SEARS-T is consistent with previous research. Garza and Bratton (2005) investigated the effect of CCPT with 29 Hispanic children, and only parents reported a statistically significant improvement in children’s externalizing behavior after the treatment. Garza and Bratton (2005) attributed lack of significant results among teachers to challenges in teacher data collection procedures. In addition, Helker and Ray (2009) discussed the difficulty some teachers face in noticing and accepting behavioral changes for children.

Aligned with Garza and Bratton’s (2005) conclusions and Helker and Ray’s (2009) discussion, the current study was impacted by several end-of-the-year and beginning-of-the-year factors that might have limited teachers’ sensitivity to individual children’s changes in challenging classroom environments. I distributed and collected posttests during the final week prior to a long semester break and the follow-up tests after the first week of the new semester. I made multiple requests to obtain assessments from teachers and observed that some teachers hurriedly completed the assessments during lunch time and planning time. This process might have impeded the teachers from attending carefully to each item, recalling each student’s performance throughout the 8 weeks of CCGPT, and completing the assessments with a consistent and stress-free perspective. Given that the quality of teacher-child relationship influences children’s social and emotional development (Helker, Schottelkorb, & Ray, 2007; Pianta & Stuhlman, 2004), it is also possible that the teachers in the current study developed a
stronger sense of closeness with all of their students over time which accordingly may have contributed to the lack of statistically significant findings.

Group Size

Results of the current study indicated that both the two-member and three-member groups exhibited improvement in overall social-emotional assets over time, which supports Landreth and Sweeney’s (1999) and Ray’s (2011) suggestions that assigning two or three members per CCGPT group is effective and beneficial. Therapeutic impact of group size is rarely discussed in play therapy literature. Ray (2011) stressed that group size is important in CCGPT given that CCGPT promotes the full movement of each child; however, the intensity of verbal and nonverbal expressions may be elevated with more group members. The therapist’s ability to engage with and attune to all group members as well as to communicate the core conditions may be limited when groups have more members (Ray, 2011).

In the current study, all group members appeared to experience a secure level of acceptance from the therapist and each other, regardless of group size. Therapists in the current study seemed to be able to access their internal resources and communicate conditions and attitudes while accepting and managing multiple group interactions within the presence of three group members. It is important to note that although the analytical results did not detect differences between the two-member and three-member groups, the therapists observed a two versus one in the group dynamic across all of the three-member groups. Play therapists may desire to engage in two-member groups in order to avoid this dynamic. If engaging in three-member groups, therapists may need to mindfully facilitate each group member’s awareness of each other and of the overall group interactions during the therapy process. Further investigation on the appropriateness and impact of three-member CCGPT groups is needed.
Long-Range Effects of CCGPT

To date, none of the reviewed studies examined the long-range effects of play therapy. In a meta-analysis and systematic review of 23 studies exploring the effectiveness of CCPT in elementary schools, Ray et al. (2015) identified the absence of knowledge in long-range effects of CCPT and emphasized the crucial need for investigation. The results of the current study served as exploratory evidence of the sustainability of the effects of CCGPT on kindergarten children’s overall social-emotional assets and the areas of social competence and empathy 1 month after termination.

Although the examination of mean differences of the CCGPT group across time revealed that the mean scores at follow-up were lower than posttest, they were still moderately higher than the mean scores at pretest indicating overall improvement across the study. Data collection procedures may have impacted follow-up results. I distributed and collected follow-up assessments 1 month after the termination of CCGPT, falling about a week after the winter break from school ended. It is possible that participants were still transitioning from winter break to the beginning of the new school year during the follow-up period. Given that regular routines are important in establishing children’s stability and predictability in relation to overall growth (Brody & Flor, 1997; Keltner, 1990; Sytsma, Kelley, & Wymer, 2001), the decrease in mean scores at follow-up might be a reflection of participants’ adjustments to resuming routines. Additionally, despite research showed that statistically significant effects of CCPT are reached at approximately 12 sessions (Ray et al., 2015), optimal changes are reached up to 30 to 40 sessions (Bratton et al., 2005; LeBlanc & Ritchie, 2001). This implication regarding the duration of CCPT might suggest that more CCGPT sessions are needed to carry out and stabilize the effects of CCGPT.
Limitations

Participants in the current study represented a specific age range and represented three local elementary schools in which Hispanic students made up the majority of the participants, contributing to the lack of generalizability. This study may also be threatened by mono-operation bias and mono-method bias to construct validity due to the use of only two assessments by parents and teachers (Heppner, Wampold, & Kivlighan, 2008). However, other methods of data collection, such as in-class observation forms, are theoretically inconsistent with the strength-based underpinning embedded in CCGPT and SEARS. Additionally, most kindergarten children have not developed the cognitive ability to comprehend and answer self-report assessments that require interpersonal and intrapersonal insights (Merrell, 2011). As a result, collecting data from only the parents and teachers of the CCGPT participants was appropriate and applicable for the current study.

Moreover, given that parent-child relationships (Frost et al., 2008) and teacher-child relationships (Baker, 2006; Pianta, Steinberg, & Rollins, 1995; Pianta & Stuhlman, 2004) are influential in children’s social-emotional development, reports from parents and teachers might reflect changed perceptions toward the children in relation to their relationships with the children rather than the truly objective changes in the children’s behaviors. Moreover, the length of the intervention may limit the effects on the intervention group. Because the optimal effect of CCPT is around 30 to 40 sessions (Bratton et al., 2005; LeBlanc & Ritchie, 2001), longer durations of CCGPT might be required for obtaining statistically significant results on self-regulation and self-responsibility and stabilizing the long-range effect of CCGPT.
Implications for Practice

The current findings offer hope and assurance for the application of CCGPT, a relational approach centered on children’s natural way of communication, for promoting social-emotional growth among kindergarten children. In CCGPT, the therapist develops relationships with each child, facilitates relationships among children, and has opportunities to observe children holistically through their interactions with each other. CCGPT seems to provide an environment that enables children to express and explore themselves within safe and accepting relationships, to develop congruence between self-regard and environment, and to acquire appropriate overall social-emotional assets. Particularly, CCGPT appears beneficial in promoting kindergarten’s social skills and empathy. In addition, the current study supports the appropriate implementation of 30-minute CCGPT with kindergarten children in school settings. This short-term success counseling experience in schools appears to provide school counselors or other school mental health professionals with an applicable intervention for aiding children who display concerning or problematic social-emotional development.

Another implication for practice is group size. The current study supports the effectiveness of both two-member and three-member CCGPT groups. Nevertheless, given that the intensity of noise, mess, and activity may possibly increase with more group members, therapists may face more challenges in the group format than with the individual format (Ginott, 1961; Ray, 2011). Setting limits may be a concern for therapists in group settings. Therapists might face dilemmas between trusting their group members to solve problems on their own versus worrying that group members’ interactions will become non-therapeutic or out of control. Therapists might also need to prepare themselves to address difficulties with scheduling and appropriate group composition when applying CCGPT with more group members.
Lastly, it appears necessary to develop a formal treatment manual for CCGPT. CCGPT represents a combination of CCPT and group therapy. Therapists have different therapist roles between the two formats. The formats target different client populations. The extended play therapist training, structure of the playroom, and therapist verbal skills differ between individual and group play therapy. To advocate the use of CCGPT and maintain the integrity and fidelity of CCGPT implementation, the development of manual with a protocol and a skills checklist may be helpful.

**Implications for Research**

As this was the first study designed to specifically investigate CCGPT with kindergarten children struggling with social-emotional assets in school settings, replication studies with more demographically diverse populations and larger sample sizes are needed. It may be helpful to aim studies at younger populations to explore the possible preventative effects of CCGPT on social-emotional assets. Due to the inconsistent findings between parent and teacher reports in the current study, future researchers are encouraged include both parent and teacher reports to validate the effects of CCGPT. To determine the true, direct, and independent effects of CCGPT, future researchers could investigate whether other variables, such as the parent-child relationship and teacher-child relationship, mediate or influence parents’ and teachers’ ratings regarding the effects of CCGPT on children’s social-emotional assets.

To ensure integrity regarding data collection procedures, future researchers are advised to provide increased environmental structure and support for teachers to complete instruments. Researchers are urged to be mindful regarding the timing for instrument distribution and collection. In addition, it may be imperative to examine therapists’ experiences working with two-member and three-member groups to explore the therapeutic aspect of group size from the
therapist’s perspective. Finally, specifically investigating the effects of CCGPT on self-regulation with a larger sample size and with longer length of intervention may advance the understanding and application of this therapeutic approach with children.

Conclusion

The current study examined the effects of CCGPT on 43 kindergarten children identified as lacking of social-emotional assets. Statistical findings for data reported by the children’s parents indicated that children who participated in CCGPT increased their social-emotional assets over children who did not receive treatments. Results also demonstrated that CCGPT accelerated participants’ social-emotional development when compared with the waitlist control group from pretest to posttest. Particularly, the children in the CCGPT group demonstrated statistically significant improvements in the areas of social competence and empathy. However, teachers did not report statistically significant differences between the CCGPT and waitlist control groups. This finding could be associated with some teachers having limited ability to observe and perceive change in students or with the teachers experiencing increased satisfaction in their relationships with all of their students as a whole. Moreover, the current study supported that a certain level of the effects of CCGPT lasted 1 month after the intervention. Additionally, CCGPT produced equally effective results for both the two-member and three-member groups. Overall, the participating children seemed to benefit from CCGPT, and CCGPT may be considered a viable treatment option for enhancing kindergarten children’s social-emotional development.
References


Table 1

*Group Play Therapy Skills Checklist (GPTSC)*

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<tr>
<th>Therapist Nonverbal Communication</th>
<th>Too Much</th>
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<th>Therapist Responses/Examples</th>
<th>Comments</th>
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<td>Lean Forward/Open</td>
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<td>Appeared Interested/Engaged</td>
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<td>Tolerance for Noise/Messiness/Intense activity</td>
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<td>Use Second-Person</td>
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<td>Overall Rate of Responses</td>
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Table 1 (continued)

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<tr>
<td>Identified Individual Themes</td>
<td>Child A:</td>
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<td></td>
<td>Child B:</td>
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<td>Child C:</td>
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<td>Therapist’s Strengths</td>
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<tr>
<td>Areas for Growth</td>
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</tbody>
</table>

Note. Group play therapy skills checklist (GPTSC) was adapted from D.C. Ray’s (2011) *Advanced Play Therapy: Essential Conditions, Knowledge, and Skills for Child Practice* (pp. 310-311).
Table 2

**Mean Scores and Standard Deviations on SEARS-P Total and Three Subscales for Each Group**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Intervention Group (n = 19)</th>
<th>Waitlist Control Group (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>37.47</td>
<td>42.89</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>5.93</td>
<td>5.96</td>
</tr>
<tr>
<td>Self-Regulation/Responsibility</td>
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<td></td>
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<tr>
<td><strong>M</strong></td>
<td>37.74</td>
<td>41.79</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>6.71</td>
<td>6.50</td>
</tr>
<tr>
<td>Social Competence</td>
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<td></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>39.05</td>
<td>45.21</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>5.80</td>
<td>7.81</td>
</tr>
<tr>
<td>Empathy</td>
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<td></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>41.63</td>
<td>48.37</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>8.49</td>
<td>7.33</td>
</tr>
</tbody>
</table>

Table 3

**Mean Scores and Standard Deviations on SEARS-T Total Score for Each Group**

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 18)</th>
<th>Waitlist Control Group (n = 19)</th>
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<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>33.83</td>
<td>37.94</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>6.14</td>
<td>6.80</td>
</tr>
</tbody>
</table>

*Note. An increase in mean scores indicates an improvement in social-emotional assets.*
Table 4

*Mean Scores and Standard Deviations on SEARS-P Total Score for Two Sizes of Groups*

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Two-Member Group (n = 10)</th>
<th>Three-Member Group (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>$M$</td>
<td>39.30</td>
<td>44.40</td>
</tr>
<tr>
<td>$SD$</td>
<td>5.36</td>
<td>7.55</td>
</tr>
</tbody>
</table>
APPENDIX A

EXTENDED LITERATURE REVIEW
The following review is a synthesis of literature and research in relation to five areas: (a) the importance of children’s social-emotional assets, (b) the normal development for kindergarten children regarding social-emotional assets, (c) current school-based prevention or intervention approaches aiming to promote children’s social-emotional assets, (d) importance of play and child-centered group play therapy, and (e) a rationale for investigating the element of group size in relation to the effectiveness of CCGPT.

Social-Emotional Assets

Between 9.5% and 14.2% of children from birth to 5 years of age are likely to experience social, emotional, and behavioral problems that negatively influence social-emotional development, cognitive functioning, as well as school readiness (Brauner & Stephens, 2006). In the 2011 National Survey for Health Statistics, Bloom, Cohen, and Freeman (2012) estimated that more than 5% of children ranging from 4 to 17 years old displayed serious difficulties with emotions, relationships, concentration, or behaviors. Over the past few decades, researchers increasingly demonstrated the interconnectedness among children’s cognitive, language, social, emotional, and behavioral competences, and academic standing (Denham, 2006; Schore, 1994; Tolan & Gorman-Smith, 2002; Wentzel & Asher, 1995).

Early childhood is an important period during which children develop social-emotional competence that will affect future success (Denham et al., 2012; Kramer, Caldarella, Christensen, & Shatzer, 2009; Yates, Ostrosky, Cheatham, Shaffer, & Santos, 2008). Well-developed social-emotional assets enable children to build close and secure relationships with peers and adults; to experience, regulate, and express emotions in a socially supportive and accepting ways; to understand others’ emotions, thoughts, and needs; and to explore the world (Gormley, Newmark, Welti, & Adelstein, 2011; Yates et al., 2008). For example, Poulou (2005)
proposed that children who develop appropriate social-emotional assets are less likely to display problematic behaviors such as aggression, depression, or violence. Hintsamen, Alatupa, Pullmann, Hirstio-Snellman, and Keltikangas-Jarvinen (2010) also indicated that children with the characteristics of flexibility and empathy and without the tendency to argue or display aggressiveness appear more able to develop and maintain positive relationships with others.

Social-emotional well-being serves as the foundation for cognitive abilities and school success (Blair & Diamond, 2008; Downer & Pianta, 2006; National Education Goals Panel, 1997; National Scientific Council on the Developing Child, 2007; Raver & Knitzer, 2002; Valiente, Lemery-Chalfant, Swanson, & Reiser, 2008). In longitudinal studies, Jacobsen and Hofmann (1997), O’Neil et al. (1997), and Pettit, Bates, and Dodge (1997) confirmed the relationship between academic success and early social-emotional development related to self-regulation, friendship, adjustment, and class involvement. For example, Eisenberg, Sadovsky, and Spinrad (2005) claimed that emotional regulation in early childhood is associated with emotional understanding and language skills which consequently affect academic motivation and abilities. Children who have positive interactions with teachers, display positive self-representations, and possess emotional knowledge and regulation abilities are likely to develop non-rejected relationships with peers, utilize healthy social skills, and often excel academically (Eisenberg et al., 2005; Jacobsen & Hofmann, 1997; O’Neil, Welsh, Parke, Wang, & Strand, 1997; Pianta, Steinberg, & Rollins, 1995; Shields et al., 2001). Additionally, children’s early academic skills and social-emotional competence may be reciprocal indicating that children with reading and learning difficulties may exhibit more externalizing and disruptive behaviors (Arnold et al., 1999; Hinshaw, 1992).
Social-emotional difficulties in young children contribute to various negative impacts including obstacles that prevent excelling in academics; inability to identify and understand own and other’s feelings; struggles with regulating own behavior, emotions, and thoughts; and difficulties establishing relationships with others (National Scientific Council on the Developing Child, 2004). With poor social-emotional assets, children are likely to display behavioral problems or antisocial disorders leading to lower acceptance from peers and impaired teacher-child relationships throughout middle childhood and adolescence (Gormley et al., 2011).

Difficulty with paying attention, following instructions, making friends, and controlling negative emotions contributes to less satisfying performance at school (Arnold et al., 1999; McLelland, Morrison, & Holmes, 2000). Children displaying antisocial behaviors attain little acceptance from teachers and classmates and are more likely to experience rejection, become friendless, and engage in conflictual relationships (Ladd, Birch, & Buhs, 1999; Shores & Wehby, 1999). This antisocial style of relating teachers and peers is based on the inability to regulate emotions. Consequently, those relationships further become a “source of provisions that facilitate or impede children’s early school adjustment” (Ladd et al., 1999, p. 1375).

Gagnon, Craig, Tremblay, Zhou, and Vitaro (1995) studied the correlation between stable social maladjustments of boys 10 to 12 years old and teachers’ behavioral ratings in kindergarten. In the study, kindergarten teachers rated 1,034 boys on hyperactivity, aggression, inattention, anxiety-withdrawal, and prosocial behavior, while parents provided socio-demographic information. The results of logistic regression analyses showed that kindergarten teachers’ ratings were predictive of later social maladjustments of children (Ganon et al., 1995). Specifically, low prosocial behavior related to peer rejection in kindergarten predicted steady problems with anxiety and withdrawal in later years.
In addition, Kochenderfer and Ladd (1996) investigated the peer victimization and school maladjustment of 200 kindergarten children who were 5 and 6 years old. They concluded that victimization is a precursor of loneliness and school avoidance of children and that the duration of victimization experiences was correlated with school adjustment problems. After reviewing and analyzing the literature, Parker and Asher (1987) indicated that children with poor peer relations (e.g., acceptance, aggressiveness, and shyness/withdrawal) are likely to have difficulty with adjustments, especially with dropping out and criminality, later in life. This summary corresponds to the results of the longitudinal examination by O’Neil et al. (1997) who found that peer and social rejection assessed in kindergarten correlated with deficits in first-grade work habits and with second-grade work habits and academic achievement.

In summary, social-emotional assets provide the essential foundation of human development and life course. When children fail to develop social-emotional assets, the risk of maladjustment, academic failure, failed relationships, and delinquency increases (Bryan, 1994; Gresham, 1992; Denham, Zahn-Waxler, Cummings, & Iannotti, 1991; Gagnon et al., 1995; Greenberg, Domitrovich, & Bumbarger, 2001; Haapasalo & Tremblay, 1994; Rubin & Clark, 1983; Payton et al., 2008).

Kindergarten and Social-Emotional Development

The National Academy of Sciences reported that only 40% of children enter school with the needed social-emotional skills to succeed in kindergarten even though 60% of children enter school possessing appropriate cognitive skills (Ashdown & Bernard, 2012). These statistics seem to suggest the prevalence of social-emotional problems in young children. In a national survey that included reports from more than 3,000 teachers, 20% of kindergarten teachers indicated that more than half of their students lacked social skills, and 30% of kindergarten
teachers reported that at least half of the children struggled with following directions and gaining academic skills (Rimm-Kaufman, Pianta, & Cox, 2000). These findings not only reflect the importance of children’s social-emotional development in academics but also suggest a need for the implementation of prevention or intervention strategies during kindergarten to facilitate or promote children’s social-emotional assets.

**Development of Kindergarten Children’s Social-Emotional Assets**

Kindergarten represents a key developmental period. During kindergarten, children experience changes in their roles, responsibilities, and relationships. They learn to engage in relationships with people outside of family, to manage performance and expectations in schools, and to cope with physical and psychological space while transitioning from preschool to kindergarten (McWayne, Cheung, Wright, & Hahs-Vaughn, 2012). To adapt to these challenges and tasks, children must develop appropriate social-emotional and cognitive competencies (McWayne et al., 2012).

Developing social-emotional assets is critical for kindergarten children because of their concurrent cognitive, social changes, and the experience of transitioning from home to school environment (Vecchiotti, 2003). Kindergarten children increase their capacity to recall, manipulate, and store information. The growth in capacity may facilitate their abilities to understand the world and reflect on their own emotions (Ornstein & Haden, 2001). Denham (1998) posited that the emergence of self-conscious emotions may assist kindergarten children in regulating their feelings, behaving in socially appropriate ways, and separating their feelings from their actions. Supporting with this claim, Seefeldt and Wasik (2002) also proposed that kindergarten children tend to internalize socially accepted and expected behaviors.
According to Erikson’s (1963) model of psychosocial development, as children enter elementary school, they become less dependent on their parents and gain independence and opportunities for increasing social experiences and social skills with peers and teachers. Success in school and peer relationships, in addition to family experiences, play critical roles in development (Frost, Wortham, & Reifel, 2008). Frost et al. (2008) indicated that kindergarten children are in the stage where they prefer socializing with children more than with adults, start developing some appropriate cooperative skills, and know how to make friends. Children able to develop positive relationships with peers and teachers have greater ability to engage with the learning environment, and therefore, they are more able to excel academically in kindergarten and beyond (Coolahan, Fantuzzo, & Mendez, 2000). In contrast, children who feel rejected by peers or teachers may develop low self-esteem that affects social-emotional development and school performance (Frost et al., 2008).

Kindergarten children start developing confidence and competence through tasks and becoming aware of their own and others’ abilities (Denham, 1998). Through interactions with others, they compare themselves with others, use perspective thinking to understand others in social relationships, and interpret others’ thoughts toward them as part of forming a self-concept (Rosenberg, 1979, as cited in Frost et al., 2008). Kindergarten children who are more able to imagine the thoughts and feelings of others are more likely to display empathy and improved social problem solving skills (Frost et al., 2008).

In summary, well-adjusted kindergarten children learn not only to internally control and regulate their emotions but also to express them in a socially acceptable way. As kindergarten children interact with others, they learn how to play and get along with others. They also
develop sense of self and increased self-esteem. They become aware of the influence of social acceptance and rejection.

Research Related to Kindergarten Children’s Social-Emotional Assets

Empirical research has supported that kindergarten children with healthy social-emotional competence exhibit positive attitudes toward school, successful early adjustment to school, and improved academic achievement. For example, Ladd, Birch, and Buhs (1999) investigated the relations between entry factors, such as cognitive maturity, family backgrounds and behavior, and participation and achievement at schools, for 200 kindergarten children. The results of correlational analyses showed that children who make more friends, gain more peer acceptance, and develop closer teacher-child relationships tend to have better achievement and classroom participation. The results of path analyses also demonstrated that peer rejection and child-teacher conflict influences children’s adaptive participation in schools, which in turn impacts academic performance. Perren, Wyl, Stadelmann, Bürgin, and Klitzing (2006) explored the associations between behavioral and emotional difficulties and peer victimization and rejection with 153 kindergarten children. Perren et al. showed a statistically significant correlation between children’s difficulties and teacher- and self-reported peer rejection and victimization. They concluded that children with conduct problems and hyperactivity/impulsivity are more likely to experience rejection and victimization by peers.

Malti, Perren, and Buchmann (2010) examined the concurrent and longitudinal relations among peer victimization, empathy, and emotional symptoms of children. After collecting data from 175 children’s parents, teachers, and self-reports, Malti et al. found that negative peer relations predicted increases in boys’ emotional symptoms and the increase in victimization correlated with the decrease in children’s empathy. Moreover, using a sample of 325
kindergarten children, Graziano, Reavis, Keane, and Calkins (2007) explored the role of emotion regulation as a predictor of children’s academic success. The analyses demonstrated a positive correlation between emotion regulation and children’s academic success and productivity, academic achievement, and mathematics and literacy achievement. In addition, Graziano et al. determined the quality of the child-teacher relationship predicts academic success and productivity. Malti et al.’s and Graziano et al.’s statistics suggested that kindergarten children with better emotion regulation skills are more likely to succeed academically as well as to develop positive relationships with teachers. Kindergarten children with positive teacher-student relationships are more motivated to learn and to perform well.

Researchers have confirmed that kindergarten children’s social-emotional assets predict academic and relationship success; however, kindergarten teachers reported a significant amount of children do not possess some or all of the needed social-emotional competencies to be successful (Whitted, 2011). Over the last few decades, various prevention and intervention programs have become available to teachers as classroom curriculum supplements to help children gain social-emotional assets (Whitted, 2011; Zins, Bloodworth, Weissberg, & Walberg, 2004). Therefore, it is imperative to implement appropriate strategies to help and improve children’s social-emotional development and assets prior to entering formal schooling.

School Related Interventions

Given increased attention to the need for interventions related to the social-emotional competence of children and to the empirical evidence supporting the effectiveness of Social-Emotional Learning (SEL) programs, several states including Illinois and New York have passed legislation enabling schools to strengthen educational guidelines through the integration of social and emotional standards (Rivers & Brackett, 2011). Collaborative for Academic, Social, and
Emotional Learning (CASEL) established SEL programs within the framework that social-emotional competencies are a critical part of education from preschool through high school (Payton et al., 2000). Currently, many schools have incorporated SEL programs into curricula to support students’ social and emotional development in step with promoting their academic success (Greenberg et al., 2003; Kramer et al., 2010; Rivers & Brackett, 2011; Zins et al., 2004). SEL is based on the belief that students learn best in supportive relationships that facilitate challenging and meaningful learning experiences (CASEL, 2013). According to Payton et al. (2000), SEL programming is “systematic classroom instruction that enhances children’s capacities to recognize and manage their emotions, appreciate the perspectives of others, establish prosocial goals and solve problems, and use a variety of interpersonal skills to effectively and ethically handle developmentally relevant tasks” (p. 13). Especially, SEL programs aim to foster children’s development of knowledge, attitudes, and skills for self-awareness; social awareness; self-management; relationship management; and responsible-decision-making skills through direct instruction and experiential activities in classroom settings (CASEL, 2013; Greenberg et al., 2004).

Research Related to the Effectiveness of SEL Programs

Numerous SEL programs are available and differ in terms of targeted grade levels, class approaches, contexts, average number of sessions, and assessment tools for monitoring progress. SEL programs need to correspond to school learning standards and be incorporated into existing curricula in order to meet the high demands on administrators, teachers, and students in the schools (Rivers & Brackett, 2011). Researchers have investigated and reported positive findings regarding SEL programming effectiveness (Durlack et al., 2011; Kramer et al., 2010).
Kramer et al. (2010) investigated the effects of the Strong Start program that was implemented by kindergarten teachers in classroom on children’s social-emotional competence. Strong Start is a universal prevention program focusing on facilitating prosocial behaviors and competencies and preventing internalizing disorders of kindergarten children through direct instruction, example scenarios, and role-play for 10 lessons (Kramer et al., 2010). The researchers’ sample was 67 kindergarten children. They conducted a single group time-series design. Results of the repeated measure analysis of variance (ANOVA) yielded a statistically significant difference between pretest and posttest mean scores on parents’ ratings of children for the Home and Community Social Behavior Scales (HCSBS; Merrell & Caldarella, 2002) and teachers’ ratings of children for the School Social Behavior Scale–Second Edition (SSBS; Merrell, 2002, as cited in Kramer, 2010) and for the Social Skills Rating System (SSRS; Gresham & Elliott, 1990).

The changes in scores from pretest to posttest provided evidence of Strong Start as an effective program for increasing prosocial behaviors among kindergarten children. However, teachers indicated a substantial decrease in internalizing problem behaviors after the intervention, but parents reported only a slight decline (Kramer et al., 2010). Additionally, although teachers reported that the Strong Start is an acceptable and feasible curriculum to implement, they indicated that the lessons were too long to retain kindergarten children’s attention, some tasks were beyond kindergarteners’ developmental level, the lessons seemed to lack visual aids and activities, and explicit instruction for demonstration seemed absent (Kramer et al., 2010).

Beirman et al. (2010) examined the effects of the Fast Track Promoting Alternative Thinking Strategies (PATH) curriculum and teacher consultation and the effect of the
characteristics of children and school environment on outcomes. The longitudinal analysis involved 2,937 ethnically diverse children living in three areas of the United States. Students were tracked from first grade to third grade and measures included teacher ratings and peer nominations.

Fast Track PATH aimed to integrate the provision of universal services for all children and selective services for children at risk into a model that comprehensively included the child, school, family, and community (Beirman et al., 2010). The Fast Track PATH program was based on the belief that promoting children’s competencies, improving parenting effectiveness, and facilitating school context and school-home communications could prevent certain problem behaviors beginning in early childhood through adolescence (Beirman et al., 2010). The PATH curriculum focused on promoting the social-emotional competence of children and emphasized teachers’ abilities to generalize the program’s curriculum-based skills throughout the day and to facilitate students’ use and internalization of these skills (Beirman et al., 2010).

Beirman et al. (2010) demonstrated PATH as effective for promoting children’s social competence, authority acceptance, cognitive concentration, and reducing aggressive behaviors. Boys in the control group were more likely to be nominated by peers as aggressive and hyperactive compared to those in the intervention group, whereas no significant effects were detected for girls. Beirman et al. concluded that most intervention effects were moderated by school environment, suggesting that the program demonstrated stronger effects within less disadvantaged schools. Nevertheless, Beirman et al. excluded the children who displayed high-risk behavioral problems; this exclusion might limit the finding’s external validity. The use of sociometric measurement in which students are asked to identify classroom peers as fitting the provided descriptions of aggressive, hyperactive-disruptive, or prosocial might not represent an
appropriate measure. Also, nominations from peers seemed more likely to reflect children’s processes of social comparison rather than a validated measure (Beirman et al., 2010).

Raimundo, Margues-Pinto, and Lima (2013) conducted a longitudinal study using a cohort-sequential design. They investigated the effects of the Slowly but Steadily program on 213 fourth-grade Portuguese children’s social-emotional competencies during a 1-year period. Slowly but Steadily is a classroom-based program for targeting the development of social-emotional competencies, promoting psychological adjustment, and enhancing academic performance through explicit instructions and application of the skills in real situations (Raimundo et al., 2013). This program was rooted in the belief that social-emotional skills could be learned and taught in schools (Zins et al., 2004).

The results of the mixed two-way analyses of intercorrelations (ANCOVA) showed that the Slowly and Steadily program partially improved the fourth-graders’ social-emotional competencies and psychological adjustment (Raimundo et al., 2013). Specifically, the children participating in the program outperformed the children in the control group on peer relations and social competence. Moreover, boys participating in the program displayed improved self-management and lower levels of aggressive social behaviors than those who did not participate in the program. However, girls in both groups did not display any statistically significance differences.

Raimundo et al. (2013) demonstrated that children who scored in the middle quartiles of self-management and peer relations at pretest benefited from the program more than the children most in need of intervention. The authors expressed that the limitations of the study included lack of true randomization, absence of parental reports, and lack of attention to other individual and organizational moderators such as family, teachers, class, or school influencing the outcome.
Particularly, the authors recommended that future researcher explore programs that benefit girls in the same way that boys benefited from their study.

Jones, Brown, and Aber (2011) explored the impact of the 2-year 4Rs (Reading, Writing, Respect and Resolution) Program on third graders’ social-emotional, behavioral, and academic functioning. This longitudinal cohort study was a school-randomized experimental design with 1,184 children in 18 elementary schools in New York City. The 4Rs Program is a grade-specific SEL program designed to facilitate prekindergarten through eighth grade students’ SEL via book talks, read-alouds, and interactive skill lessons (CASEL, 2013). The classroom approach involves explicit instruction and integration with literacy for approximately 35 lessons.

Jones et al. (2011) concluded that children self-reported improvements in hostile attributional bias, aggressive interpersonal negotiation strategies, and depression in the intervention schools. Teachers indicated that children participating in the intervention displayed improved attention skills, reduced aggressive behavior, and increased social competence. Additionally, children identified as having the highest behavioral risk at baseline demonstrated progress in math and reading achievement after the intervention. The authors reported the following limitations of the study: (a) intervention impacts only sustained through the end of the second of the 3-year intervention, (b) variability in implementation of the 4Rs curriculum might exist, (c) control schools implemented programs and activities in relation to social and emotional domain, and (d) intervention outcomes were accounted for by SEL activities or literacy activities was unknown.

Durlak et al. (2011) conducted a meta-analysis of 213 school-based, universal SEL programs involving 270,034 students from kindergarten through high school. The means across the areas of SEL skills, attitudes, positive social behavior, conduct problems, emotional distress,
and academic performance were significantly greater than zero (Durlak et al., 2011). Students who participated in SEL programs outperformed those who did not participate the programs in social-emotional skills; academic performance; conduct problems; and attitudes toward self, others, and school across ethnicity in in-school and after-school settings, urban and rural areas, and educational levels (Durlak et al., 2011). Although the results supported the positive effects of SEL programming, limitations of the study included the following: (a) only 16% of the studies included information regarding academic achievement at posttest, (b) although all studies aimed at the development of social-emotional skills, only 32% of the studies included skills evaluations as outcome measures, (c) lack of attention to factors such as ethnicity, gender, socioeconomic status, developmental level, etc. was noticeable among the studies, and (d) 43% of retrieved studies were excluded from the results due to lack of monitoring implementation (Durlak et al., 2011).

**Limitations of SEL Programs**

Kramer et al. (2010) discussed some limitations of SEL programming associated with the application to school curriculum, including scarcity of resources, failure to attend to each student’s needs, and developmentally inappropriate activities for children. Schools have limited time available to implement SEL programming and are under pressure to promote academic achievement leading to increases in demand for implementing evidence-based approaches (Durlak et al., 2011). Durlak et al. (2011) pointed out that several SEL programs lack a strong research base, and it is possible that schools do not incorporate the SEL programs with strong fidelity into curricula. Moreover, Hughes, Cavell, Meehan, Zhang, and Collie (2005) posited that teachers at highly disadvantaged schools experience the increased possibility for having difficulties with implementing SEL programs appropriately due to resources. It is also worth
noting that a common limitation across the studies of SEL interventions lay in rater bias. Teachers both served as SEL programming facilitators and completed the assessments used for data collection (Durlack et al., 2011; Kramer et al., 2010). Their dual roles might have weakened the degree of reliability in these findings.

Childhood education should capitalize on interactive and relational ways of learning suggesting the importance of emphasizing children’s natural interests rather than adult-determined agendas (National Scientific Council on the Developing Child, 2004). Katz (1985) argued for the imperative to provide play-oriented and socially-based contexts for children to develop the skills and dispositions for learning (as cited in Graue, 1999). Baker (2004) also asserted that classroom guidance lessons and achievement programs are not sufficient as developmentally appropriate interventions for elementary-age children. Moyer (2001) emphasized the role of play in kindergarten and posited that play promotes not only critical thinking, problem-solving, and creativity skills, but also social and emotional development. In addition, small group environments can successfully be utilized for reducing children’s negative social interactions and disruptive behaviors (Lane, Menzies, Barton-Arwood, Doukas, & Munton, 2005). Therefore, the discrepancies between currently used programs and the literature suggest a need for exploring the use of an experiential, relational, and developmentally appropriate approach to promoting children’s social-emotional assets.

Importance of Play

As early as the 1700s, Rousseau recognized the role of play in children’s healthy development (Bratton et al., 2005). Play and activity serve as the agency in which children develop and reflect on cognitive, social, and emotional competencies (Frost et al., 2008; O’Shea, 2004; Seefeldt & Wasik, 2002). When children play, they experiment with various objects as
well as classify, relate, and compare information with existing knowledge (Seefeldt & Wasik, 2002). Children practice self-regulation and socially responsible behavior in play by learning to calm themselves down and to express emotions appropriately while feeling upset (Berk, Mann, & Ogan, 2006). During the process of play, children explore and construct individual identities and generate an understanding of the physical properties of the world (O’Shea, 2004; Seefeldt & Wasik, 2002). Play primarily offers children a manageable and safe environment in which they use play materials to directly or symbolically act out feelings, thoughts, and experiences that they are not able express through words (Axline, 1969; Landreth, 2012). Play provides opportunities to learn how to cope with unmanageable experiences in reality (Axline, 1969; Landreth, 2012).

Piaget (1999) supported play as a context in which children develop cognitive skills, interact with objects in the environment, and form the ability to understand the world. Assimilation and accommodation are two primary concepts to understand in Piaget’s theory (Ray, 2011). Assimilation refers to making new information fit into children’s existing ways of thinking, whereas accommodation leads to children changing established patterns of thinking according to the new perceived information (Piaget, 1999). Ray (2011) validated the importance of assimilation and accommodation in play therapy by stating that children utilize assimilation to gain control over the world by fitting information gained from the outside environment into playroom. Ray (2011) also proposed that children in play therapy change their patterns of thinking to meet the expectations they encounter in the real world while experiencing “mastery, safety, and empathy from the therapist” (p. 7) during the process of accommodation.

Vygotsky (1986) believed that children test out new skills, practice new social roles, and attend to things of interest and complex problems through play. Vygotsky recognized the zone of proximal development, separation of thought from action, and facilitation of self-regulation as
three functions of play (Hirsh-Pasek & Golinkoff, 2003). Ray (2011) further discussed several implications of Vygotsky’s theories in the context of play therapy. First, play therapy is particularly important for troubled children because according to Vygotsky, rather than purely pursuing fun, children tend to use play as a way to react to distress resulting from the inability to meet internal needs with available external resources (Ray, 2011). Second, Vygotsky’s zone of proximal development illustrates how play therapy facilitates children’s confidence and self-direction while experiencing their own ability as beyond their current capabilities. Third, Vygotsky believed verbalization to be important to understanding children’s narrations of their play, even though verbalization is perceived as unnecessary in nondirective play therapy (Ray, 2011). Nevertheless, it is imperative for play therapists to pay attention to both nonverbal and verbal expressions of children in order to convey empathy, genuineness, and understanding of the world (Ray, 2011).

Child-Centered Play Therapy (CCPT)

Basic Tenets of CCPT

CCPT is “the most identified play therapy approach” among diverse theoretical modalities of working with children (Ray, 2011, p. 61). CCPT supports the conviction that children have the capacity and innate tendency to be self-directive and move toward self-actualization (Landreth, 2012). Carl Rogers (1951) founded person-centered therapy (PCT) with adults. Axline (1969) later applied Rogers’ principles to play therapy and stated that nondirective play therapy is much more than a technique.

It is imperative for CCPT therapists to understand and embrace personality development and change as a process or basis for relating to children and providing effective practice (Landreth & Sweeney, 1997; Ray, 2011). Rogers (1951) proposed 19 propositions as a
framework for understanding human development and personality within PCT. Rogers’ propositions included the following:

1. Every individual exists in a continually changing world of experience of which he or she is the center.

2. The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, “reality.”

3. The organism reacts as an organized whole to this phenomenal field.

4. The organism has one basic tendency and striving-to actualize, maintain, and enhance the experiencing organism.

5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.

6. Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.

7. The best vantage point for understanding behavior is from the internal frame of reference of the individual.

8. A portion of the total perceptual field gradually becomes differentiated as the self.

9. As a result of the interaction with the environment, and particularly as a result of the evaluational interaction with others, the structure of the self is formed—an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with the values attached to these concepts.
10. The values are attached to experiences, and the values are part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.

11. As experiences occur in the life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization because the experience is inconsistent with the structure of the self.

12. Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of the self.

13. Behavior may, in some instances, be brought about by organismic experiences and needs that have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not “owned” by the individual.

14. Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basis for potential psychological tension.

15. Psychological adjustment exists when the concept of the self is such that all sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of the self.
16. Any experience that is inconsistent with the organization or structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.

17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences that are inconsistent with it may be perceived and examined, the structure of the self-revised to assimilate and include such experiences.

18. When the individual perceives all his sensory and visceral experiences and accepts them into one consistent and integrated system, then he is necessarily more understanding and accepting of others as separate individuals.

19. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system-based so largely on introjections that have been distortedly symbolized with a continuing organismic valuing process. (pp. 483-524)

With regard to CCPT, the 19 tenets illustrate that children exist in a world where they are the center of perceived experiences (Landreth & Sweeney, 1997; Ray, 2011). As children interact with the environment, they gradually form concepts of self and environment as well as self in relation to the environment. Their interactions are accompanied by the tendency to self-actualize and to enhance the experience of self (Landreth & Sweeney, 1997; Ray, 2011). Behaviors consistent with the experience of self represent children’s attempts to satisfy their perceived needs, highlighting that understanding children’s internal frame of reference is critical to understand their behaviors (Landreth & Sweeney, 1997; Ray, 2011). Maladjustment occurs when self-concept is inconsistent with experience (Landreth & Sweeney, 1997). In contrast,
children experience freedom and adjustment when the self-concept and experience are congruent in a nonthreatening environment, and this integrated, positive self-concept contributes to their ability to be more understanding of others and to develop healthy interpersonal relationships (Landreth & Sweeney, 1997; Ray, 2011).

Axline (1969) clarified the child-centered approach described by Rogers as guiding play therapists’ work with children and presented the following eight basic principles as needing to be consistently and genuinely followed by play therapists in both individual and group play therapy:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child’s ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child.

6. The therapist does not attempt to direct the child’s actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the
   therapy to the world of reality and to make the child aware of his responsibility in the
   relationship. (pp. 73-74)

   Within the framework of CCPT, these eight principles ground therapists’ way of being
   with children to ensure that children can safely express and explore their “current versions of the
   self-structure” (Ray, 2011, p. 55) and thereby foster therapeutic change (Landreth & Sweeney,
   1997). Landreth (2012) described CCPT as:

   A complete therapeutic system, not just the application of a few rapport-building
   techniques, and is based on a belief in the capacity and resiliency of children to be
   constructively self-directing. . . . They are quite capable of appropriately directing their
   own growth, and they are granted the freedom in the play therapy relationship to be
   themselves in the process of playing out feelings and experiences. (p. 59)

   The eight characteristics of CCPT highlight the person-centered philosophy that the
   relationship itself is therapy as well as therapists’ belief in and respect for children’s inner ability
   and pace toward growth and healing. With the unique therapeutic relationship supporting
   children’s creative and forward-moving power, children know and take themselves to the
   direction they need to go in the process of therapy (Landreth, 2012).

   CCPT encompasses the general objectives of (a) developing a positive self-concept, (b)
   assuming greater self-responsibility, (c) becoming more self-direction, (d) becoming more self-
   accepting, (e) becoming more self-reliant, (f) engaging in self-determined decision making, (g)
   experiencing a feeling of control, (h) becoming sensitive to the process of coping, (i) developing
   an internal source of evaluation, and (j) becoming more trusting of himself (Landreth, 2012, p.
   84-85). The child, the person, is the focus of CCPT (Landreth, 2012). Rather than attempting to
imply, suggest, or decide what children should do, child-centered play therapists believe and
value the power in facilitating children’s abilities and efforts to cope with their struggles or
obstacles (Axline, 1969; Landreth, 2012). CCPT generates a safe relationship between therapist
and child and opportunity for children to control and lead their own ways of exploration (Axline,

Research Related to the Effectiveness of Play Therapy

Scholars and researchers have augmented theories and literature on play therapy in the
past few decades (O’Connor, 1991; White & Allers, 1994). Play therapy has been widely used
to work with children’s emotional and behavioral problems (Bratton et al., 2005). In particular,
CCPT is an effective treatment modality for children and has been shown to be beneficial for
reducing children’s externalizing and internalizing behaviors, increasing children’s self-esteem
and self-concept, and improving children’s academic performance (Lambert et al., 2005;
Landreth et al., 1996; Ray 2011).

LeBlanc and Ritchie (2001) used meta-analysis to investigate the overall effectiveness of
play therapy and related variables with 42 studies. The results showed a medium average
treatment effect of 0.66 with a standard error of 0.09 and demonstrated that children receiving
play therapy performed 25 percentile units higher on outcome measures compared to children
who did not participate in play therapy (LeBlanc & Ritchie, 2001). Moreover, they reported a
strong relationship between parental involvement and treatment effect and observed the
maximum effect to occur at a treatment duration of approximately 30 sessions.

Later, Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis on the
effectiveness of play therapy that included 93 studies in the analysis. The results showed a large
overall effect of 0.80. They indicated play therapy was effective across theoretical orientations,
settings, and presenting problems. In addition, nondirective or humanistic play therapy produced a large overall mean effect size of 0.92, whereas directive intervention displayed a moderate effect size of 0.71 (Bratton et al., 2005). Particularly, in terms of treatment format, Bratton et al. reported similar effect sizes of 0.79 and 0.82 for individual and group play therapies, respectively, when provided by mental health professionals.

These research results along with the fact that 62 research studies on play therapy were conducted between 1947 and 2010 (Ray, 2011) support the use and effectiveness of play therapy, CCPT, or nondirective play therapy with young children concerning a variety of issues. In addition, across the analytic results of Casey and Berman (1985), LeBlanc and Ritchie (2001), and Bratton et al. (2005), children benefit similarly from individual as well as group psychotherapy. Bratton et al. (2005) suggested that this finding might be a result of the appropriate assignment of therapy based on children’s needs rather than on the identical effectiveness of both formats. Hence, future researchers may need to address questions related to determining a rationale for assignment, individual or group play therapy, according to children’s age and presenting issues, to name a few potential variables (Bratton et al., 2005).

Child-Centered Group Play Therapy (CCGPT)

Basic Tenets of CCGPT

Child-centered group play therapy (CCGPT) combines the advantages of CCPT and group process (Landreth & Sweeney, 1999). In CCGPT, children encounter opportunities to understand themselves; learn about themselves as perceiving regard from both the therapist and other group members; and explore the importance of individuality and uniqueness, cooperation and compliance, creativity, and originality (Sweeney et al., 2014). CCGPT not only helps children develop interpersonal and intrapersonal skills, but also assists children in processing
emotional issues (Landreth, Homeyer, Glover, & Sweeney, 1996). The integration of play therapy and the framework of the group process are beneficial for facilitating children’s senses of control, feelings of empowerment, and abilities to master overwhelming emotions (Landreth et al., 1996).

Axline (1969) stated that “group experience injects into therapy a very realistic element because the child lives in the world other children and must consider the reaction of others and must develop a consideration of other individuals’ feelings” (p. 25). Axline also suggested that children struggling with social adjustments may benefit more from group play therapy than from individual therapy. Correspondingly, Landreth (2012) described group play therapy as “a psychological and social process in which children, in the natural course of interacting with one another in the playroom, learn not only about other children but also about themselves” (p. 42). Ray (2011) cited Slavson and Schiffer (1975) as positing the term social hunger as embedded in human beings and pertaining to the potential to relate to others. Ginott (1961) supported this conviction by expressing the belief that people desire to conform, to gain acceptance by others, and to maintain status in their groups. Ray (2011), however, noted that the group approach may be less effective when a child does not possess awareness of social interactions or a longing for another’s acceptance.

With these foundational concepts in mind, CCGPT’s primary objective is providing an environment in which children can increase their self-acceptance and self-reliance, learn coping skills, increase self-responsibility, improve self-control, and connect CCGPT experiences to reality (Ray, 2011; Sweeney & Homeyer, 1999). With a play therapist’s facilitation and reflections, children participating in a group can become more aware of their own and others’ feelings, thoughts, and needs; they can also learn to interact in accepting and supportive ways
Children serve as therapeutic agents for each other is a unique feature of CCPGT (Ray, 2011). Through relating and interacting with each other in the group setting, children may help each other consider personal responsibility in interpersonal relationships that they can accordingly extend to other relationships in the real world (Landreth, 2012). In addition, given that CCGPT is grounded in person-centered theory and children are egocentric regarding their developmental nature (Ray, 2011), group cohesion is not the focus of CCGPT (Landreth, 2012; Ray, 2011).

Groups are a primary socializing influence in the development of children (Erikson, 1963). Frank and Zilbach (1968) proposed that “since the beginning of mankind, children at the age of 5 or 6 have started to move away from the succor of their parents and to draw together to play and work in groups” (p. 447). Landreth and Sweeney (1999) identified different dimensions of CCGPT that makes it a desirable, appropriate method of intervention for children:

1. It is less threatening for the child to enter the new experience in the company of two or three other children.
2. It facilitates the establishment of desired relationships.
3. It diminishes tension and stimulates activity.
4. It increases spontaneity.
5. It provides peer reactions from which children can re-evaluate their behavior.
6. It ties the therapy to the child’s real world.
7. It provides models and opportunities for vicarious and direct learning. (p. 53)

Ray (2011) discussed additional benefits of CCGPT. First, the CCGPT setting provides a level of permissiveness that may facilitate children’s engagement and participation in the process (Ray, 2011; Sweeney & Homeyer, 1999). Second, in the group play process, individual catharsis
may be induced by observations from other group members (Ray, 2011). Third, in the group play setting, therapists have the opportunity to observe children holistically and gain an understanding of the children that is less likely to be obtained in individual therapy (Ray, 2011). Finally, with facilitation and reflections from therapists, children experience an environment with “interactions coupled with awareness” that may increase “positive experiences with peers” (Ray, 2011, p. 185).

Group provides a “microcosm of the child’s everyday world” (Sweeny & Homeyer, 1999, p. 3), and the characteristics of social play in school-age children provide more emphasis on peer relationships than on parenting roles (Frost et al., 2008). As children move through elementary school, they experience personality changes and other factors that impact their social-emotional development (Frost et al., 2008). Peer relationships and academic performance become important to them. Children learn to be aware of their own as well as others’ abilities while working with peers in the school (Frost et al., 2008). Given that kindergarten facilitates the transition to learning about themselves through interactions and contacts with peers and adults other than parents, optimally children need opportunities to develop social-emotional assets in a setting that consistently reflects their needs and experiences. Thus, CCGPT could be a developmentally appropriate treatment modality for improving kindergarten children’s social-emotional assets.

Child-Centered Group Play Therapy Research

According to Landreth et al. (1996), individual and group play therapies have been correlated with promoting growth in children. Such growth includes decreases in externalizing behaviors such as aggression, impulsivity, and self-control; decreases in internalizing behaviors such as depression and anxiety; improvement in academic performance; and increases in self-
esteem and self-concept. Specifically, researchers have indicated the beneficial effects of group play therapy on children’s anxiety (e.g., Shen, 2002), self-control (e.g., Trostle, 1988), speech or language delay (e.g., Danger & Landreth, 2005), self-concept (e.g., Baggerly, 2004), and social adjustment (e.g., Elliott & Pumfrey, 1972).

Fleming and Synder (1947) investigated the effects of nondirective group play therapy on young children’s social and personal adjustment. Among 46 participants, seven children were assigned to one of two groups for nondirective group play therapy while the other 33 children served as the control group. In the experimental groups, three girls were in one group and four boys were in the other group. Fleming and Synder reported that after 12 weeks of treatment, four out of the seven experimental group children showed improvement, and girls exhibited a greater level of change in personal than in social adjustment. With regard to the limitations of the study, Fleming and Synder did not address their small sample size, practical significance, treatment and evaluation protocol, and implementation fidelity.

DeMaria and Cowden (1992) examined the effects of 10 CCGPT sessions on the self-concept of six children aged 6 to 9 years. The group size was six and included mixed genders. Two individual case studies indicated the positive effect of CCGPT on promoting self-concept of children. The fact that therapists’ observations and participants’ verbal data were the only sources of study outcome data represented a critical limitation of the study.

Shen (2002) investigated the effectiveness of short-term CCGPT on the anxiety, depression, and adjustment of Taiwanese elementary children who experienced an earthquake. Thirty participants from 8 to 12 years old were randomly assigned to the experimental and control groups. In the experimental group, children were classified into groups of three according to gender and age. After ten 40-minute CCGPT sessions during a 4-week period of
time, children in the experimental group scored significantly lower than did those in the control group on the Revised Children’s Manifest Anxiety Scale (RCMAS) and the Multiscore Depression Inventory for Children (MDI-C). The results supported the implementation and effectiveness of CCGPT in a non-western country; however, lack of treatment protocol, implementation fidelity, and data from the control group; and cultural and language differences in relation to the understanding of and meaningfulness of the instruments limited the generalizability of the findings.

Tyndall-Lind, Landreth, and Giordano (2001) investigated the effectiveness of enhancing self-concept and reducing internalizing, externalizing, and overall behavior problems via intensive sibling group therapy with children who had witnessed domestic violence. Tyndall-Lind et al. compared the effectiveness of the intensive sibling group play therapy with intensive individual play therapy and a waitlist control group. The participants were aged between 4 and 10 years old. The number of participants in the experimental group was 10, and 11 children participated in individual play, while the control group included 11 children. Each group play therapy group consisted of two siblings, and the individual and group play sessions occurred daily as 45-minute sessions spanning a period of 12 days (Tyndall-Lind et al., 2001).

Results showed that intensive group play therapy children scored statistically significantly higher than the control group children on the Joseph Pre-School or Primary School Self-Concepts Screening Test (JPPST), the Child Behavior Checklist (CBCL) Total Behavior Problems subscale, the CBCL Externalizing Behavior Problems subscale, the CBCL Aggressive Behavior subscale, and the CBCL Anxious/Depressed subscale (Tyndall-Lind et al., 2001). No statistically significant differences were detected between the intensive sibling group play therapy and the intensive individual play therapy. However, in group play therapy, participants
had opportunities to express and work on interpersonal conflicts and aggressive feelings and behaviors through their interactions and they developed new interactional skills within these relationships (Tyndall-Lind et al., 2001). These findings suggested group play therapy compensates for the limitations of individual play therapy. Regarding limitations, Tyndall-Lind et al. (2001) did not discuss the theoretical perspective followed in the treatments, the treatment protocol, implementation fidelity, methodology, the assignment of participants, the study’s small sample size, and the effect of attrition.

Baggerly (2004) explored the effects of CCGPT on self-concept, depression, and anxiety of 42 children from 5 to 11 years old who were homeless. Only two children were in each CCGPT group. Baggerly noted that due to the 48% dropout rate and the need for services for the control group, all children in both experimental and control groups received services instead of maintaining the control group. Therefore, paired sample t-tests were employed to determine mean differences from pretest to posttest. After receiving between nine to twelve 30-minute CCGPT sessions, the children’s scores on the Total Anxiety and Physiological Anxiety on the RCMA decreased significantly with moderate to large effect sizes. The results of the paired samples t-tests showed small effect sizes on Global Self-Concept and the category of Self-Concept measured by the Joseph Pre-School and Primary Self Concept Screening Test (JPSPSCS), a medium effect size on Competence of the JPSPSCS, a large effect size on Negative Mood of the Children’s Depression Inventory (CDI), and a medium effect size on Negative Esteem of the CDI. Baggerly found the degrees of the effectiveness of CCGPT differed in reducing the anxiety and depression and increasing the self-concept of the participating homeless children. The limitations of the study involved the lack of a comparison
or control group, the absence of random assignment, biases related to self-report, and fidelity among therapists.

Baggerly and Parker (2005) discussed the effectiveness of CCGPT with African American boys. Participants were placed in groups of two, and each group received from nine to 11 CCGPT sessions in school. Baggerly and Parker concluded that CCGPT is a culturally sensitive and appropriate counseling approach with African American boys that values the African worldview and facilitates self-confidence building.

Danger and Landreth (2005) examined the effectiveness of CCGPT on pre-kindergarten and kindergarten children with speech difficulties. The 11 children in the experimental group of three children per therapy group received twenty-five 30-minute CCGPT sessions concurrently with regular speech therapy. Children in the comparison group only received regularly scheduled speech therapy sessions. Results showed that although no significant difference between the experimental and comparison groups was detected, children in the experimental group exhibited improvement in receptive and expressive language skills as evidenced by a large effect size, increased in expressive language skills with a large effect size, as well as decreased in anxiety level as reported by teachers with a small effect size. It is worth noting that according to clinical significance, CCGPT appeared to positively impact children with speech difficulties. In terms of limitations, Danger and Landreth indicated that the small sample size seemed to negatively impact the power of the statistical procedure and the overall results of the study. Moreover, the fact that children in the CCGPT group demonstrated more severe difficulties in articulation than children in the comparison group might have contributed to the difficulty with facilitating change.
To date, only one study involved exploring the effects of CCGPT on children’s social-emotional development. Using three separate two-by-two repeated measures ANOVAs and post hoc Tukey tests, Trostle (1988) examined the effects of CCGPT and sex differences on self-control, free play, and sociometric ratings with 48 young bilingual Puerto Rican children aged 3 to 6 years old. The participants were randomly assigned to experimental or unstructured free play control groups with the group size being four in the CCGPT groups. The results showed that after 10 sessions of CCGPT, children in the experimental group outperformed those in the control group on self-control, as measured by the Self-Control Rating Scale (SCRS) scores reported by teachers, and on the higher developmental level play behaviors of make-believe and reality, as measured by Play Observation Scale (POS). Regarding the sociometric results, the Peer Rating Scale (PRS) yielded a significant group by gender interaction effect. Specifically, boys receiving CCGPT displayed a statistically significantly higher acceptance of others after treatment compared to girls from the experimental group and all children in the control group. The results supported CCGPT’s preventative, remedial, or enrichment purposes for improving Puerto Rican children’s social, emotional, and adaptive skills in school settings. Additionally, gender differences were observed for aggression, self-control, and sociability level (Trostle, 1988). Nevertheless, Trostle did not address practical significance, implementation fidelity, biases generated by using self-reports, and the lack of parental perspectives in the data.

This review of CCGPT research highlighted the effectiveness of group play therapy on facilitating growth among children of different ethnicities struggling with internalizing and externalizing behaviors, self-concept, life adjustment, trauma, and speech difficulties. It is also evident that a considerable portion of the reviewed studies appears to be limited by the lack of attention to treatment and evaluation protocols, implementation fidelity, instrumentations,
procedures, development of methodology and research design, small sample sizes, and lack of effect size reporting. However, the researchers did not address decisions regarding group size across the reviewed group play therapy research in which group size varied from 2 to 10 members.

The limitations may significantly influence both the internal and external validity of the studies. Moreover, the number of children included in a group is an aspect of research therapists have not considered when composing a group for play therapy (Landreth & Sweeney, 1999; Ray, 2011). Hence, the need to conduct more research utilizing a group play therapy approach with sound methodology and procedures while exploring the function of group size is apparent.

*Group Size*

When implementing group play therapy, therapists need to consider different aspects of the composition of the therapy group (Ray, 2011). Given that CCGPT “allows for full movement and decision making by each member of the group” (p. 189), group size can be critical for maximizing the multiple relationships, activities, behaviors, interactions, and dynamics likely to occur simultaneously during sessions (Ray, 2011). Whereas Ginott (1961) and Axline (1969) recommended group sizes of up to eight children in each group led by a play therapist, Landreth and Sweeney (1999) posited that according to the needs and ages of the children, two or three children per group can be beneficial. However, conducting CCGPT with more than five members may be inappropriate (Landreth & Sweeney, 1999).

Ray (2011) suggested that CCGPT is most effective with two or three group members due to practical considerations, including the size of the playroom, scheduling issues, and the provision of therapists. Child-centered play therapists convey genuineness, empathy, and unconditional positive regard regardless of group size (Ray, 2011); however, the intensity of
interactions, sound level, and activity level may influence therapists’ internal access for conveying conditions and attitudes (Ray, 2011). Moreover, with more children in a group, therapists face challenges with developing adequate therapeutic relationships with all group members. Chiefly, the literature appears devoid of discussions about the therapeutic aspects of group size. Thus, given that group sizes in studies have been inconsistent and rarely explored across research, a gap between the element of group size and the effectiveness of group play therapy is present.

Play Therapy in School Settings

To date, a considerable amount of play therapy research has been conducted in the schools. The meta-analysis by Bratton et al. (2005) on the effectiveness of play therapy indicated that 36 out of 93 studies, or 38%, were implemented in school settings. Landreth (2012), Bratton (2010), and Ray (2011) concluded that play therapy is developmentally appropriate for elementary school-age children with diverse backgrounds and at-risk concerns. Landreth (1987) suggested that play therapy in elementary school is a part of the vital integration of the total educational process. Play therapy and school are consistent in terms of the goals regarding providing opportunities to facilitate children’s emotional, physical, intellectual, and social development (Landreth, 2012). In other words, conducting play therapy in schools helps children learn and accept themselves and the world and facilitates readiness for learning in school.

Although some limitations, modifications, and accommodations are considered while doing play therapy in schools such as scheduling and playroom setup (Landreth, Ray, & Bratton, 2009; Ray, Muro, & Schumann, 2004), school is a convenient setting where all children can be evaluated and have access to services (Ray, 2011; Ray et al., 2004). Play therapists are able to
provide treatment to children without depending on parents’ ability to attend consistently to therapy. In addition, school offers opportunities to address children’s academics, emotional, and behavioral health as well as family life from a preventative or remedial perspective (Ray et al., 2004). In the schools, play therapists also have more opportunities to gain direct information from teachers, who spend 6 to 8 hours with children a day, regarding their observations and perceptions of children’s issues and progress. Hence, school is an appropriate setting for the implementation of this study given the practical advantages, the interrelationships between social-emotional development and academic success in children, and the effectiveness of play therapy in schools illustrated in previous studies (e.g., Blanco & Ray, 2011; Fall, Balvanza, Johnson, & Nelson, 1999; Fall, Navelski, & Welch, 2002; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Post, 1999).

Summary

Children who experience deficits in social-emotional assets have a higher risk for failing school, not establishing relationships, displaying disruptive behaviors, and struggling with regulating emotions, thoughts, and behaviors. Social-emotional assets appear particularly critical for kindergarten children who are transitioning from the home to the school environment. Empirical research has linked social-emotional growth in early childhood, academic success, and delinquency throughout adolescent and early adulthood. To respond to the increasing awareness of the importance of children’s social-emotional development, schools integrate SEL programs into curricula to enhance and support students’ social, emotional, behavioral, and academic competencies. However, implementing SEL programs in schools is limited given constrained time and resources, lack of strong empirical base, and the priority of academic achievement. With the SEL programming, teachers are less likely to attend to each student’s needs due to size
of classroom and programmatic activities that may be developmentally inappropriate for those children.

CCPT has been shown to be effective with young children concerning various issues. CCGPT is especially appropriate for children struggling with social difficulties. Although group size is a condition that therapists consider while composing groups for play therapy, group size was inconsistently reported throughout group play therapy research and left unexplored as a variable, contributing to a lack of understanding as to the therapeutic aspect of group size in the therapy process. To date, only one study (i.e., Trostle, 1988) was designed to examine the effectiveness of CCGPT on social-emotional aspects of development and presented positive findings. However, sound methodology, research design, and descriptions of the treatment and evaluation protocols seemed lacking in the study.

Gettinger (2004) posited that the focus of interventions for children should be on facilitating social-emotional competence to advance social relationships and academic performance rather than to stop or reduce problematic behaviors. Barbarin, Iruka, Harradine, Winn, McKinney, and Taylor (2013) also recommended the use of strength-based research to develop appropriate interventions for children transiting from early childhood programs to elementary schools. These ideas not only highlight the need to value the potential, strength, and positive characteristics of children but also support the theoretical perspective of this study of the impacts of CCGPT on kindergarten children’s social-emotional assets with strength-based measures.
APPENDIX B

DETAILED METHODOLOGY
The purpose of the current study was to explore the effects of CCGPT with kindergarten children demonstrating apparent problems or emerging deficits in social-emotional assets. Examining the factor of group size in relation to CCGPT outcomes as well as long-range effects of CCGPT on kindergarten children’s social-emotional assets were important foci of the study. An experimental design was used to comparing outcomes for the CCGPT intervention group to a wait-list control group selected through random assignment. The following research methodology contains the research questions, definition of terms, participants, instruments, procedures, analysis of data, and limitations of the study.

Research Questions

The overall research question was: What is the impact of CCGPT on social-emotional assets of kindergarten children? Three specific questions that the study attempted to address were:

1. Do children who participate in CCGPT improve overall social-emotional assets over children who do not participate in CCGPT as measured by total score of Social Emotional Assets and Resilience Scale–Teacher (SEARS-T) over time (pre, post, and follow-up)?

2. Do children who participate in CCGPT improve overall social-emotional assets over children who do not participate in CCGPT as measured by total score of Social Emotional Assets and Resilience Scale–Parent (SEARS-P) over time (pre, post, and follow-up)?

3. Is there a difference in overall social-emotional assets for children who participate in two-member versus three-member CCGPT groups?
Definition of Terms

Social-Emotional Assets

Social-emotional assets and resiliencies refer to adaptive characteristics that are important for children’s success at school, at home, and in the outside world, such as friendship skills, empathy, interpersonal skills, social support, problem solving, emotional competence, social maturity, self-concept, self-management, social independence, cognitive strategies, and resilience (Merrell, 2011). In this study, social-emotional assets were operationalized as the total scores on the parent and teacher forms of the Social Emotional Assets and Resilience Scale (SEARS; Merrell, 2011).

Self-Regulation (SR)

Self-regulation refers to children’s self-awareness, metacognition, intrapersonal insight, self-management, and direction (Merrell, 2011, p. 4). In the current study, self-regulation was operationalized as the self-regulation score on the teacher form of SEARS and the self-regulation/responsibility score on the parent form of SEARS.

Social Competence (SC)

Social competence is defined as children’s ability to maintain relationship with peers, engage in effective verbal communication, as well as feel comfortable around peers (Merrell, 2011, p. 4). In the current study, social competence was operationalized as the social competence score on the teacher and parent forms of SEARS.

Empathy (E)

Empathy is children’s ability to empathize with, relate to, and understand others’ feelings and situations (Merrell, 2011, p. 4). In the current study, empathy was operationalized as the empathy score on the teacher and parent forms of SEARS.
Responsibility (R)

Responsibility refers to children’s ability to accept responsibility, think before acting, and behave conscientiously (Merrell, 2011, p. 4). In the current study, responsibility was operationalized as the responsibility score on the teacher form of SEARS and the Self-Regulation/Responsibility score on the parent form of SEARS.

Child-Centered Group Play Therapy (CCGPT)

CCGPT is an integration of child-centered play therapy (CCPT) and group process (Landreth & Sweeney, 1999). Landreth (2012) defined CCGPT as “a psychological and social process in which children, in the natural course of interacting with each other in the playroom, learn not only about other children but also about themselves” (p. 40). Rather than techniques and prescription, the relationship serves as the healing power in a child’s journey of self-exploration. The trained therapist provides intentionally selected play materials and facilitates safe relationships among group members so that the children can fully explore themselves through feelings, thoughts, experiences, and behaviors as well as their relationships with others through play (Landreth & Sweeney, 1999). In this study, CCGPT was operationalized as following the CCPT treatment protocol proposed by Ray (2011) with modifications appropriate for the dynamics and interactions found in group settings.

Participants

Participants were children enrolled in kindergarten at three Title I local elementary schools in the southwest United States. Upon obtaining approval from Institutional Review Board (IRB) from the University of North Texas, I asked school counselors and kindergarten teachers to identify and refer children who displayed emerging limits or apparent problems with social and emotional assets. Criteria for inclusion in this study included the following: (a)
Children were enrolled in kindergarten and were at least 5 years of age; (b) Children were referred by the teacher or school counselor due to apparent problems or emerging deficits in social-emotional assets as exhibited by specific behavioral, emotional, or interpersonal concerns; (c) Children were rated in At-Risk or High-Risk range by parent or teacher on any subscale or total score of the pretest SEARS; (d) Children understood and spoke English; (e) Parents of children were willing to give consent and complete assessments; (f) Teachers of children were willing to give consent and complete assessments; (g) Children did not receive other types of mental health services during the study.

A priori power analysis using the G*Power 3.1 indicated that a sample size of 36 participants was required to detect a medium effect size ($f = .25$) with a power of .9 and an alpha equal to .05. Initially 44 parents and teachers of potential participants gave their consent for participating in the study; however, one potential participant’s scores on both SEARS-P and SEARS-T fell in the normal range leading to disqualification for the study. I contacted the parent of this potential participant, explained the situation, and offered play therapy services that were not included as a part of the study. The remaining 43 participants met the criteria and were randomly assigned by school site to the intervention group ($n = 21$) or the waitlist control group ($n = 22$). One participant in the waitlist control group dropped out of the study during the period of follow-up data collection. The number of qualified participants in each school was 15, 11, and 17 participants, respectively. Of the 43 participants, 19 identified as Hispanic, 14 as Caucasian, and 10 as African American. Thirty participants were male, and 13 were female. Thirty seven of the participants were 5 years old while six participants were 6 years old at pretest. Table B.1 displays the distribution of gender, ethnicity, age at three points of time, and recruitment in schools.
Table B.1

**Demographics of Child Participants**

<table>
<thead>
<tr>
<th>Variable</th>
<th>CCGPT Group (n = 21)</th>
<th>Waitlist Control Group (n = 22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
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<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
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<td>4</td>
</tr>
<tr>
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<td>7</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Age at Pretest</td>
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<td></td>
</tr>
<tr>
<td>5 years old</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>6 years old</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Age at Posttest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years old</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>6 years old</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Age at Follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years old</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>6 years old</td>
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<td>School 2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>School 3</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
Instruments

Both the Parent and Teacher forms of the SEARS (Merrell, 2011) were the measurements utilized to evaluate the effectiveness of CCGPT on kindergarten children’s social-emotional assets.

Social Emotional Assets and Resilience Scales (SEARS)

SEARS is a strength-based, cross-informant instrument developed to assess the social-emotional competencies of children and adolescents from 5 to 18 years old (Merrell, 2011). It includes a parent report form to assess children aged 5 to 18 years or in Grades K to 12, and a teacher report form to assess children aged 5 to 18 years or in Grades K to 12 (Merrell, 2011).

The strength-based assessment is different from the traditional pathology-based assessment approach due to its focus on strengths, assets, and other positive characteristics rather than problems, deficits, and mental illness (Merrell, 2011). Epstein and Sharma (1998) defined the strength-based assessment as a measurement of emotional and behavioral competencies, skills, and characteristics that facilitate a sense of personal accomplishment, contribute to satisfying relationships with others, and promote personal and academic development (as cited in Merrell, 2011). Strength-based assessments not only allow for empowerment, optimism, and hope for collaborating children, families, and professionals but also provide connections between identified strengths and intervention planning (Merrell, 2011). In addition, the application of a strength-based assessment does not eliminate the validity of using the traditional pathological approach; rather, using a strength-based assessment enables a switch in perspective that allows for emphasizing positive attributes and qualities (Merrell, 2011).
The Social Emotional Assets and Resilience Scale–Parent (SEARS-P) is a self-administered assessment for parents, guardian, or other home-based caregivers of children and adolescents 5 to 18 years old (Merrell, 2011). The SEARS-P consists of 39 items, uses a 4-point response format (i.e., never, sometimes, often, always), and focuses specifically on home and community contexts (Merrell, 2011). The SEARS-P reflects parents’ perceptions of their children’s social-emotional competencies across three domains titled Self-Regulation/Responsibility (22 items), Social Competence (10 items), and Empathy (7 items; Merrell, 2011). The Self-Regulation/Responsibility subscale measures parents’ perceptions of their children’s self-awareness, metacognition, intrapersonal insight, self-management, and ability to accept responsibility. The Social Competence subscale provides parents’ assessments of their children’s ability to maintain friendships, engage in effective communication, and feel comfortable with peers. The Empathy subscale assesses parents’ observations of their children’s ability to understand and relate to others’ feelings and situations (Merrell, 2011).

Reliability estimates for the SEARS-P were considered strong by Merrell (2011), who reported an alpha coefficient of .96 for the total score of the SEARS-P, .95 for Self-Regulation/Responsibility, .89 for Social Competence, and .87 for Empathy. Regarding test-retest reliability of SEARS-P, total score yielded a .93 along with a range from .88 to .92 for the subscale scores. When examining the validity of SEARS-P, Merrell thoroughly conducted analysis of internal structure, intercorrelations among scales of SEARS, and relationships to other measures. The results reflected important underlying psychological constructs and strong convergent construct validity with other strength-based assessments (Merrell, 2011). Specifically, the results of exploratory and confirmatory factor analyses showed that the factor
structure of Self-Regulation/Responsibility ranged from .50 to .77 across 22 items, the factor structure of Social Competence ranged from .45 to .82 across 10 items, and the factor structure of Empathy ranged from .49 to .71 across seven items. In the current study, parents whose primary language was Spanish completed the Spanish version of the SEARS-P, and Cronbach's alpha demonstrated a .909 for all participants on the SEARS-P pretest.

*Social Emotional Assets and Resilience Scale–Teacher (SEARS-T)*

The SEARS-T is self-administered by classroom teachers or other educators who have in-depth knowledge about the assessed children who may be 5 to 18 years of age (Merrell, 2011). The SEARS includes 41 items using 4-point response format (i.e., never, sometimes, often, always) and is designed to measure teachers’ perspectives about children’s social-emotional competencies across the four domains titled Self-Regulation (13 items), Social Competence (12 items), Empathy (6 items), and Responsibility (10 items; Merrell, 2011). The Self-Regulation subscale measures teachers’ observations of students’ self-awareness, metacognition, intrapersonal insight, self-management, and direction (Merrell, 2011). The Social Competence subscale assesses teachers’ insights of their students’ abilities in maintaining friendship, engaging in effective communication, and feeling comfortable with peers (Merrell, 2011). The Empathy subscale measures teachers’ perceptions about their students’ abilities in empathizing with others’ feelings and situations (Merrell, 2011). The Responsibility scale collects teachers’ evaluations of their students’ acceptance of responsibility, conscientious behaviors, and abilities to think before taking action (Merrell, 2011). Although some similarities regarding item content between the SEARS-P and SEARS-T are present, the SEARS-T focuses on school context (Merrell, 2011).
Reliability estimates for the SEARS-T were considered strong by Merrell (2011) who reported internal consistency reliability for the total score as a Cronbach’s alpha of .98, for Self-Regulation as .95, for Social Competence as .94, for Empathy as .91, and for Responsibility as .95. When examining test-retest reliability for the SEARS-T, Merrell reported .94 for total score with .84 to .92 for subscale scores. Regarding validity, Merrell reported that the SEARS-T as thoroughly examined through analysis of internal structure, intercorrelations among SEARS scores, and convergent construct validity (Merrell, 2011). The evidence demonstrated important underlying psychological constructs and strong convergent construct validity with other strength-based assessments, suggesting that the contents of the scales measure the constructs Merrell claimed they measured. Specifically, the results of exploratory and confirmatory factor analyses showed that the factor structure of Self-Regulation ranged from -.34 to -.87 across 13 items, the factor structure of responsibility ranged from .58 to .83 across 10 items, the factor structure of social competence ranged from .39 to .87 across 12 items, and the factor structure of empathy ranged from .30 to .60 across six items. In the current study, Cronbach's alpha demonstrated a .96 for all participants on the SEARS-T pretest.

*Interpretation of SEARS Scores*

In terms of interpretations of the SEARS scores, Merrell (2011) suggested a three-step approach. The first step involves examining $T$ scores and percentiles. When scoring the SEARS, scale scores and raw scores are converted to $T$ scores. Merrell noted that the SEARS normative samples, like most child and adolescent behavior rating scales, do not exactly follow the perfect normal distribution (Merrell, 2011). Thus, standard deviation units based on a value of 10 might only be close to 10 and become more apparent as scores fall further away from the normative mean for the scale score (Merrell, 2011). In addition, given that the SEARS is a
strength-based assessment, the questions are worded positively, indicating that higher scores and higher percentiles present greater levels of social-emotional assets and resilience (Merrell, 2011).

The second step involves understanding the SEARS scores on the three-tiered prevention model (Merrell, 2011). The first tier, average to high functioning, includes individuals whose SEARS’s scores from about the 21st to the 99th percentile, occupying around 80% of the normative sample (Merrell, 2011). Children whose scores fall within this tier demonstrate average to excellent social-emotional competency and may be either adequate or outstanding due to their social-emotional adjustment; therefore, they may be skilled and popular with others (Merrell, 2011). The second tier is At-Risk and includes SEARS scores from about the 6th to 20th percentiles, and approximately 15% of the normative sample scored in this range (Merrell, 2011). Children scoring within Tier 2 may display some emerging social-emotional deficits that could require more comprehensive evaluations in order to determine if they could benefit from social-emotional learning interventions or group-based efforts in classrooms or other settings (Merrell, 2011). The third tier is high risk and includes SEARS scores falling at or below the 5th percentile (Merrell, 2011). Children scoring within this range may be at high risk for serious deficits regarding social-emotional competencies and may display problems concurrent with such deficits (Merrell, 2011). Such high risk children are likely to struggle with adjustment problems associated with deficits in social competence, self-regulation, empathy, or responsibility skills. Therefore, providing carefully designed individual services or preventative intervention services may be desirable and beneficial for a small group or classroom setting (Merrell, 2011).

The third step involves evaluating items closely when children score in the At-Risk or High-Risk ranges (Merrell, 2011). Merrell (2011) recommended test users identify specific
social-emotional concerns or strengths as well as investigate common patterns among items of concern. Merrell further suggested examining a rating of 0 or 1 as being useful information for developing intervention plan.

Procedures

I applied and received approval to conduct the study from the University of North Texas IRB and Denton Independent School District prior to the recruitment of participants and data collection. I first met with school counselors and then with kindergarten teachers of the schools to explain the purposes and procedures of the study as well as the parent and teacher informed consent forms as seen in Appendix E. I asked for teachers’ help in identifying children who seem to display some emerging limits or apparent problems in developing relationships with others, having appropriate self-regulation skills, demonstrating age-appropriate levels of self-responsibility, and empathizing with others as seen in Appendix E. Teachers made referrals to school counselors for children who they believed would qualify for and benefit from the study. It is worth noting that the study began approximately 1.5 months after schools started in the fall semester in order to provide adequate time for teachers to engage in sufficient interactions and observations of the students before identifying any children for the study.

To explain the study and to obtain consents from the parents or legal guardians of the referrals, I was present in the schools during the week of parent-teacher conferences. Teachers and school counselors introduced me to the parents of identified children and I reviewed the informed consent with them, which includes a full explanation of the purpose, procedures, and foreseen risks of the study. For those parents with whom I did not obtain the opportunity to speak due to scheduling conflicts, the kindergarten teachers were responsible for explaining the
study and obtaining consent forms from them. Teachers gave their consent following parents’ consent. I later collected the informed consent forms that were returned to the school counselors.

Following informed consent receptions from parents and teachers, I collected pretest measures of identified children from parents via the SEARS-P and from teachers via the SEARS-T to determine their eligibility for the study. I sent SEARS-P home with identified children and delivered SEARS-P for teachers to complete. Upon receipt of the assessments, children whose scores fell in the At-Risk or High-Risk range on any subscale or total score for either SEARS-P or SEARS-T became eligible for the study, and the scores officially represented the pretest. Additionally, I collected the identified children’s demographic information on age through SEARS-P and ethnicity through school counselors or teachers. One identified child disqualified for the study due to normal-range SEARS-P and SEARS-T scores.

In accordance with randomized and controlled trial procedures, participants were stratified first by school and then were randomly assigned into the intervention group or the waitlist control group. Regarding gender, Ginott (1961) suggested that before latency, gender is not a concern while composing groups for CCGPT. Landreth and Sweeney (1999) proposed that prior to 9 years of age, mixed gender CCGPT groups are appropriate. Ray (2011) also recommended that gender is not an issue in children’s play and verbalization before 6 years of age. Therefore, I did not control for gender in randomization process.

All parents and teachers in School 1 returned the informed consent forms and pretest assessments within a week after the parent-teacher conference. I listed the names of the children in order of received consent and then randomized the participants into either the intervention or waitlist control based on the random number generator. Participants who were assigned even numbers were in the intervention CCGPT group while odd numbers were in the waitlist control.
group. Additionally, I followed the same procedures and randomized the participants in the intervention group into either the two-member CCGPT group or three-member CCGPT group. I assigned participants with even numbers in the two-member CCGPT group and those with odd numbers to the three-member CCGPT group.

To account for time differences when consent forms and pretest were received in School 2 and School 3, I utilized block randomization. In School 2, I first received the consent forms and pretests for eight participants. Next, I randomized these participants into either the intervention group or waitlist control group utilizing the same randomization procedures for each school. Participants began treatment the following week for 8 weeks in their respective groups. After receiving additional three participants, I applied the randomization procedures and participants started the 8-week treatment phase. The participants in the intervention group in School 2 were all in the two-member CCGPT group due to randomization results. In School 3, I followed the same randomization concepts and procedures.

Participants in the intervention group ideally should have received two 30-minute CCGPT sessions per week for the period of 8 weeks. Due to student absences, participants in the intervention group received between 15 and 16 sessions of play therapy with a mean of 15.32 sessions. Counselors did not hold CCGPT sessions if either one of the two-member group members was absent and therefore were responsible for rescheduling make-up sessions. Given the difficulty in rescheduling three-member groups, counselors proceeded to hold the CCGPT session if only one of the three-member group members was absent. Participants in the waitlist group did not receive any treatments until the process of data collection was completed. All play therapy sessions were held in the respective students’ schools in fully equipped playrooms in accordance with the CCPT manual (Ray, 2011).
At the completion of the 8-week intervention period, I distributed the SEARS-P for parents and SEARS-T for teachers to complete as a posttest measure. To obtain follow-up measure, I utilized the same procedures 1 month after the intervention. It is important to note that upon completion of the intervention, no CCGPT was provided to the participants for the purpose of assessing follow-up effect. Given counselors’ schedules, none of the participants in the intervention group displaying the need for continuing therapy started receiving individual CCPT services before returning the follow-up assessments.

All information collected was kept confidential. Names of the children, teachers, parents, and counselors were excluded from any documentation or reports of the study. The information collected at pretest, posttest, and follow-up was recorded by the use of a code number for each participant. These numbers were only available to me to serve as a master list. Clinical files were retained in compliance with IRB approval.

**Intervention Group Procedures**

The participants randomly assigned to the two-member \((n = 12)\) and three-member \(n = 9\) intervention groups participated in 30-minute sessions of CCGPT occurring two times per week over 8 weeks. CCGPT uses children’s natural language of play to provide a developmentally appropriate therapeutic environment for young children. Counselors followed the Child-Centered Play Therapy Treatment Manual (Ray, 2011) with modifications enacted as necessary and appropriate for CCGPT throughout the intervention. Counselors developed the therapeutic relationship by responding with both verbal communication and nonverbal language including being warm, genuine, empathetic, and consistent. Counselors used reflections of feeling, meaning, and content; returned responsibility; and employed limit setting, encouragement, and other skills to facilitate a safe environment for the participants to express
and explore themselves, develop self-esteem, and learn self-responsibility. Counselors helped children gain an understanding of themselves and others through bridging. These skills and responses aim to convey the message of, “I am here, I hear you, I understand you, and I care” (Landreth, 2012, p. 209-210).

Playrooms were assembled and materials were selected according to Landreth’s (2012) and Ray’s (2011) recommendations. The toys in the playrooms were appropriate for the participants’ developmental age and allowed for exploration via various play behaviors and related feelings. Toys represented different categories facilitating different emotional expressions, such as mastery, nurturing, aggression, power and control, security, imaginary, creative expression, relationship, and others. Furthermore, Sweeney et al. (2014) proposed that increasing the quantity of different types of play materials may deprive the opportunity for group members to learn to share.

In the current study, materials in the playroom were similar to materials available for individual play therapy. However, I intentionally matched the quantity of dart guns, swords, construction paper, and butcher paper with the number of group members. Rationale for this modification was based on the premise that materials in play therapy serve as the therapeutic and communicative process for children (Landreth, 2012; Ray, 2011). Instead of assuming that children have the opportunity to work through conflicts with limited group play therapy materials, CCGPT aims to provide an environment where group members free themselves for full expression and choose direction for themselves and the group, leading to the development of self-actualizing tendency (Ray, 2011). In the process of group play, each child is provided with means of entry to aggressive toys, such as dart guns and swords, to have opportunity to express individual aggressive drives (Ray, 2011) while exploring self-control and appropriate ways of
self-expression with the presence of other group members. Given that arts and crafts materials allow for the expressions of both positive and negative feeling as well as creativity (Ray, 2011), providing appropriate amounts of construction paper and butcher paper according to group size allowed free self-expression for each group member. Ultimately, fairness is not the purpose of the modification, and the freedom for full movement is the purpose.

Counselors were doctoral-level counseling students trained and experienced in both individual and group child-centered play therapy procedures. The participating counselors held a master’s degree in counseling, conducted CCGPT for at least one year prior to participating in the study and completed at least two play therapy courses and supervised clinical practice in play therapy. Prior to delivering play therapy protocol, counselors participated in training on the protocol for conducting CCGPT in schools. Counselors included four females who identified as African American (n = 1), Asian (n = 1), and Caucasian (n = 2). In consideration of implementation fidelity, all play sessions were video recorded, and all counselors received weekly supervision by a faculty member with advanced experience in play therapy. I assessed protocol adherence by randomly reviewing one session per child using the revised Group Play Therapy Skills Checklist (GPTSC; Ray, 2011) as seen in Appendix E. Sessions adhered to CCPT protocol with appropriate modifications for CCGPT over 90% of the time with an average of 98% adherence to protocol per session.

Toward the end of the 8-week intervention period, one child in a two-member group exhibited slightly concerning sexual play behaviors. In addition to CCGPT, the counselor conducted individual CCPT with the child for two weeks to monitor the continuity and appropriateness of his sexual play behaviors. The counselor stopped the individual CCPT with the child after confirming the play behaviors were developmentally appropriate.
Participants in the waitlist control group did not receive any treatment during the study. Upon the completion of data collection at pretest, posttest, and 1-month follow-up test, participants in the waitlist control group received the same CCGPT intervention that had been implemented by the counselors with the intervention groups. The counselors followed the same protocol that was used in the two-member and three-member intervention groups.

Statistical Analysis

Following the completion of the study, I scored all assessments using computer software and entered the scores into IMB SSPSS Statistics 22. Prior to testing the research questions, I examined descriptive statistics as well as assumptions about outliers, normal distributions, independence of observations, homogeneity of variances, homogeneity of covariance, and sphericity.

To examine whether the sample data were representative of a normal distribution, I screened kurtosis and skewness values, Q-Q Plots, boxplots, and the Kolmogorov-Smirnov statistics. The data were reflective of a normal distribution within the acceptable range. In terms of outliers, the boxplot tests detected a few extreme scores throughout the data; however, I was not able to identify and conclude any theoretical rationale for eliminating the outliers after a careful examination. While performing each mixed between-within ANOVA, I checked the assumption of homogeneity of variance using Levene’s Test of Equality of Error Variances, the assumption of homogeneity of intercorrelations through the Box’s Test of Equality of Covariance Matrices, and the assumption of sphericity with Mauchly’s Test of Sphericity.

In order to examine statistically significant change over time between the CCGPT intervention group and control group, I conducted two mixed between-within subjects ANOVAs on two dependent variables (Total score on the SEARS-T and Total score on the SEARS-P) with
the intervention group (i.e., the two-member CCGPT group and the three-member CCGPT group) and the waitlist control group \((k = 2)\) serving as the between-subjects variable and time across pretest, posttest, and 1-month follow-up \((k = 3)\) serving as the within-subjects variable. Following the statistically significant findings with Total score on the SEARS-P, I conducted three mixed between-within ANOVAs as post hoc analyses with the remaining three SEARS-P subscales of Self-Regulation/Responsibility, Social Competence, and Empathy as the dependent variables. Given that the construct of the Total score on the SEARS-P is a result of the total of these three subscales (Merrell, 2011), these separate analyses served to provide information on understanding the statistically significant change in the Total score.

It is worth noting that the assumption of sphericity was not met in the mixed between-within ANOVA on the two-member versus three-member groups and in the post hoc analyses on the SEARS-P subscales of Social Competence and Empathy. When sphericity is violated, the \(F\) ratio is no longer the preset alpha but a larger value (Huck, 2008; Tabachnick & Fidell, 2013; Tanguma, 1999). In other words, the probability of committing a Type I error increases to 10% or 15% instead of 5%. Researchers such as Field (2013), Stevens (2009), and Tanguma (1999) suggested applying the options of univariate and multivariate test statistics to address this issue. Given the consideration of sample size and power, I decided to apply the univariate approach through epsilon (\(\epsilon\)) corrections to make \(F\) ratio more conservative by adjusting the degree of freedom to control for the Type I error rate (Brace, Kemp, & Snelgar, 2013; Field, 2013; Stevens, 2009; Tanguma, 1999). Therefore, I used Greenhouse-Geisser corrections, which was proposed as the most conservative among the three estimates (Brace et al., 2013; Field, 2013; Stevens, 2009), to address the violation on sphericity and all involved effects. In order to examine the third research question investigating whether a statistically significant change over
time occurred between two sizes of the intervention groups, I conducted a mixed between-within subjects ANOVA on the dependent variable of Total score on the SEARS-P with two-member across pretest, posttest, and 1-month follow-up (k = 3) serving as the within-subjects variable. I did not conduct any analyses to investigate group size differences on the SEARS-T Total due to non-statistically significant results.

Henson (2006) proposed that null hypothesis statistical testing only has the capability of detecting the presence of an effect, whereas effect sizes are helpful in determining whether the differences matter in a more practical way. Instead of presenting a dichotomous statement regarding the existence of an effect, the Publication Manual of the American Psychological Association (APA, 2010) also highlighted the importance of examining and reporting effect sizes in quantitative research to provide information on the magnitude of the observed effects. To assess the practical significance of findings, I calculated $\eta^2$ and utilized Cohen’s (1977) guidelines for interpreting the eta squares for the univariate tests; $\eta^2$ of .01 is small, .06 is medium, and .14 is large effect size. Because I applied Greenhouse-Geisser estimate to adjust the degree of freedom associated with the critical values in the study, Type I error was controlled accordingly (Huck, 2008; Tanguma, 1999). Therefore, I used an alpha level of .05 for all analyses without lowering the alpha level while conducting post hoc analyses to avoid lower power. Additionally, in order to explore clinical significance, I examined percentage of participants whose scores improved and no longer fell in the elevated range on the SEARS-P and SEARS-T.
APPENDIX C

UNABRIDGED RESULTS
The following results are intended to answer the following three research questions: (a) Do children who participate in CCGPT improve overall social-emotional assets over children who do not participate in CCGPT as measured by total score of Social Emotional Assets and Resilience Scale–Teacher (SEARS-T) over time (pre, post, and follow-up)? (b) Do children who participate in CCGPT improve overall social-emotional assets over children who do not participate in CCGPT as measured by total score of Social Emotional Assets and Resilience Scale–Parent (SEARS-P) over time (pre, post, and follow-up)? (c) Is there a difference in overall social-emotional assets for children who participate in two-member versus three-member CCGPT groups? I first present results of the data analyses and include the tests for assumptions for each analysis. Finally, I discuss clinical significance.

Research Question 1: Teacher Reports for SEARS

The first mixed between-within analysis of variance (ANOVA) examined teachers’ reports of children who participated in the CCGPT group regarding overall social-emotional assets when compared to those on the waitlist control group across pretest, posttest, and the 1-month follow-up. The assumptions of random sampling, independence of observations, homogeneity of variance, normal distribution, homogeneity of intercorrelations, and sphericity were all analyzed and reasonably met. One of the teachers was unable to complete posttest for five participants, including three in the intervention group and two in the waitlist control group, due to severe illness. One participant in the waitlist control group dropped out of the study at the 1-month follow-up. SPSS excluded these cases while analyzing SEARS-T Total score resulting in intervention group of 18 and waitlist control group of 19. Table C.1 presents the pre, post, and follow-up tests’ mean scores and standard deviations for both groups’ SEARS-T Total scores.
Table C.1

**Mean Scores and Standard Deviations on SEARS-T Total for Each Group**

<table>
<thead>
<tr>
<th></th>
<th><strong>Intervention Group (n = 18)</strong></th>
<th></th>
<th><strong>Waitlist Control Group (n = 19)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Score</strong></td>
<td><strong>Pretest</strong></td>
<td><strong>Posttest</strong></td>
<td><strong>Follow-up</strong></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>33.83</td>
<td>37.94</td>
<td>39.33</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>6.14</td>
<td>6.80</td>
<td>6.56</td>
</tr>
</tbody>
</table>

*Note.* An increase in mean scores indicates an improvement in social-emotional assets.

Results showed no statistically significant interaction between treatment group and time, $F(2, 70) = .917, p = .404$, along with a small effect size, $\eta^2 = .013$. The main effect comparing the two groups was not statistically significant, $F(1, 35) = 1.277, p = .266$, and the effect size was small, $\eta^2 = .035$. The main effect of time was statistically significant, $F(2, 70) = 21.645$, $p < .001$, with a substantially large effect size of $\eta^2 = .317$, indicating that teachers’ scores of children in both groups increased across time. Table C.2 displays a summary of mixed between-within ANOVA results for SEARS-T Total score as dependent variable. Polynomial contrasts detected statistically significant linear and quadratic trends on the main effect time, $F(1, 35) = 31.862, p < .001, \eta^2 = .476$, and $F(1, 35) = 4.302, p < .05, \eta^2 = .109$, respectively.

Corresponding with these results, Figure 1 displays the means of the teachers’ scores for the two groups increased more from pretest to posttest than from posttest to the 1-month follow-up test.
Table C.2

Summary for Mixed Between-Within ANOVA for SEARS-T Total

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>234.872</td>
<td>234.872</td>
<td>1.277</td>
<td>.266</td>
<td>.035</td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>416.008</td>
<td>208.004</td>
<td>21.645</td>
<td>.000*</td>
<td>.317</td>
</tr>
<tr>
<td>Group*Time</td>
<td>2</td>
<td>17.630</td>
<td>8.815</td>
<td>.917</td>
<td>.404</td>
<td>.013</td>
</tr>
<tr>
<td>Within Cells</td>
<td>70</td>
<td>672.676</td>
<td>9.610</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>1341.186</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. * indicates statistical significance at p < .05.

Figure 1. Means Between Intervention and Waitlist Control Groups Over Time on SEARS-T Total.
Research Question 2: Parent Reports for SEARS

The second mixed between-within ANOVA assessed whether from parents’ perspectives children who participated in the CCGPT group improved overall social-emotional assets when compared to those in the waitlist control group across pretest, posttest, and the 1-month follow-up test. The assumptions of random sampling, independence of observations, homogeneity of variance, normal distribution, homogeneity of intercorrelations, and sphericity were all analyzed and reasonably met.

Three parents did not return the posttests for one child in the intervention group and two children in the waitlist control group. One parent in the intervention group did not complete the follow-up test, and one participant in the waitlist control group dropped out the study at the 1-month follow-up. SPSS excluded these cases while analyzing SEARS-P Total score resulting in intervention group of 19 and waitlist control group of 19. Table C.3 displays the pre, post, and follow-up tests’ mean scores and standard deviations on the SEARS-P Total score and three subscales for the intervention group and waitlist control group.

Results of the mixed between-within ANOVA on the Total score of SEARS-P indicated a statistically significant interaction effect between treatment group and time, $F(2, 72) = 4.533, p = .014$, with a medium effect size of $\eta^2 = .101$. The main effect of time was statistically significant, $F(2, 72) = 3.784, p < .05$, and attained a medium effect size, $\eta^2 = .084$. The main effect of treatment group was not statistically significant, $F(1, 36) = .146, p = .704$, and displayed a near zero effect size, $\eta^2 = .004$. Polynomial contrasts detected a statistically significant linear trend over the three points in time, $F(1, 36) = 4.812, p < .05$, with a large effect size, $\eta^2 = .118$, and a statistically significant quadratic trend on the interaction effect, $F(1, 36) = 1.571, p < .01$, with a large effect, $\eta^2 = .218$. 
Table C.3

Mean Scores and Standard Deviations on SEARS-P Total and Three Subscales for Each Group

<table>
<thead>
<tr>
<th>Scale</th>
<th>Intervention Group (n = 19)</th>
<th>Waitlist Control Group (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>37.47</td>
<td>42.89</td>
</tr>
<tr>
<td>SD</td>
<td>5.93</td>
<td>5.96</td>
</tr>
<tr>
<td>Self-Regulation/Responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>37.74</td>
<td>41.79</td>
</tr>
<tr>
<td>SD</td>
<td>6.71</td>
<td>6.50</td>
</tr>
<tr>
<td>Social Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>39.05</td>
<td>45.21</td>
</tr>
<tr>
<td>SD</td>
<td>5.80</td>
<td>7.81</td>
</tr>
<tr>
<td>Empathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>41.63</td>
<td>48.37</td>
</tr>
<tr>
<td>SD</td>
<td>8.49</td>
<td>7.33</td>
</tr>
</tbody>
</table>

These results along with Figure 2 displaying the means of parents’ scores for both groups across time suggested the following: (a) children in the intervention group obtained statistically significantly higher scores on the SEARS-P over time when compared with the children’s scores for the waitlist control group; (b) the mean on the SEARS-P Total for the intervention group increased from pretest to posttest and then declined from posttest to follow-up test; (c) the mean on the SEARS-P Total for the waitlist control group decreased from pretest to posttest but increased at the follow-up. Table C.4 presents a summary of mixed between-within ANOVA results for SEARS-P Total score.
Table C.4

*Summary for Mixed Between-Within ANOVA for SEARS-P Total*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>31.579</td>
<td>31.579</td>
<td>.146</td>
<td>.704</td>
<td>.004</td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>153.053</td>
<td>84.271</td>
<td>3.784</td>
<td>.027*</td>
<td>.084</td>
</tr>
<tr>
<td>Group*Time</td>
<td>2</td>
<td>183.368</td>
<td>91.684</td>
<td>4.533</td>
<td>.014*</td>
<td>.101</td>
</tr>
<tr>
<td>Within Cells</td>
<td>72</td>
<td>1456.246</td>
<td>20.226</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>1824.246</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. * indicates statistical significance at p < .05.*

*Figure 2. Means Between Intervention and Waitlist Control Groups Over Time on SEARS-P Total.*
Research Question 3: Two-Member and Three-Member Groups

Given that the interaction effect on the SEARS-T Total was not statistically significant, I conducted the third mixed between-within ANOVA on only the SEARS-P Total to assess from the parents’ perspectives whether a difference on overall social-emotional assets between children who participated in the two-member CCGPT and three-member CCGPT across pre, post, and 1-month follow-up could be detected. The parent of one participant in the two-member group did not return the posttest, and the parent of one two-member group did not complete the follow-up test, resulting in two-member group of 10 and three-member group of 9. The following analytical results were considered with caution due to small sample size.

The tests for the assumptions of random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations indicated all assumption criteria were reasonably met. However, Mauchly’s test indicated that the assumption of sphericity was violated, $x^2(2) = 6.643, p = .036$; therefore, I reported Greenhouse-Geisser corrected tests using the epsilon correction ($\varepsilon = .746$). Table C.5 displays the pre, post, and follow-up tests’ mean scores and standard deviations on the SEARS-P Total score for the intervention and three-member groups.

Table C.5

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Two-Member Group ($n = 10$)</th>
<th>Three-Member Group ($n = 9$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>$M$</td>
<td>39.30</td>
<td>44.40</td>
</tr>
<tr>
<td>$SD$</td>
<td>5.36</td>
<td>7.55</td>
</tr>
</tbody>
</table>
Results of the mixed between-within ANOVA on the Total score of SEARS-P indicated a non-statistically significant interaction effect between group size and time, $F(1.493, 25.377) = .039, p = .942$, with a near zero effect size, $\eta^2 = .001$. The main effect of time was statistically significant, $F(1.493, 25.377) = 6.912, p < .01$, with a large effect size, $\eta^2 = .244$. The main effect of group size was not statistically significant, $F(1, 17) = 2.137, p = .162$, but displayed a medium effect size $\eta^2 = .112$. Polynomial contrasts detected statistically significant linear and quadratic trends between the three points of time, $F(1, 17) = 4.672, p < .05, \eta^2 = .216$ and $F(1, 17) = 13.993, p < .01, \eta^2 = .415$, respectively, and both attained large effect sizes. The polynomial contrasts along with Figure 3 demonstrated an increase in the means of parents’ scores for both groups of children from pretest to posttest and a reduction from posttest to the 1-month follow-up test. Table C.6 presents a summary of mixed between-within ANOVA results for SEARS-P Total score by two-member versus three-member group size.

Table C.6

*Summary for Mixed Between-Within ANOVA for SEARS-P Total According to Group Size*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>$F$</th>
<th>$p$</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1.000</td>
<td>190.776</td>
<td>190.667</td>
<td>2.137</td>
<td>.162</td>
<td>.112</td>
</tr>
<tr>
<td>Time</td>
<td>1.493</td>
<td>302.609</td>
<td>202.716</td>
<td>6.912</td>
<td>.007*</td>
<td>.244</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1.493</td>
<td>1.696</td>
<td>1.136</td>
<td>0.039</td>
<td>.924</td>
<td>.001</td>
</tr>
<tr>
<td>Within Cells</td>
<td>25.377</td>
<td>744.304</td>
<td>29.330</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29.363</td>
<td>1239.385</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* * indicates statistical significance at $p < .05$.  

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Figure 3. Means Between Two-member and Three-member Groups Over Time on SEARS-P Total.

Post Hoc Analyses

In order to further explore the statistically significant findings with Total score on the SEARS-P, I conducted three separate mixed between-within ANOVAs as post hoc analyses with the remaining three SEARS-P subscales of Self-Regulation/Responsibility, Social Competence, and Empathy as the dependent variables. The waitlist and control groups ($k = 2$) served as the between-subjects variable, and time across pretest and posttest and 1-month follow-up ($k = 3$) served as the within-subjects variable. Given that the construct of the Total score on the SEARS-P is a result of the total of these three subscales (Merrell, 2011), these post hoc analyses served to provide information on understanding the statistically significant change in the Total
score. I reported Greenhouse-Geisser tests to adjust the violation on sphericity and to avoid an increase to the Type I error rate contributed by performing multiple univariate analyses.

*Mixed Between-Within ANOVA on SEARS-P Self-Regulation/Responsibility*

For the Self-Regulation/Responsibility scores, the assumptions for random sampling, independence of observations, homogeneity of variance, normal distribution, homogeneity of intercorrelations, and sphericity were reasonably met. However, to control for Type I error, I used Greenhouse-Geisser corrected tests, $\varepsilon = .943$. The results of the mixed between-within ANOVA indicated a non-statistically significant interaction effect between treatment group and time, $F(1.868, 67.248) = 1.776, p = .179$, with a small effect size, $\eta^2 = .043$. The main effects on time and treatment group were not statistically significant and produced small effect sizes, $F(1.868, 67.248) = 2.273, p = .114, \eta^2 = .055$ and $F(1, 36) = .320, p = .575, \eta^2 = .009$, respectively. Additionally, polynomial contrasts did not reveal any statistically significant trends. Figure 4 indicates that the participants in the intervention group obtained higher SEARS-P Self-Regulation/Responsibility scores from pretest to posttest and slightly declined scores from posttest to the 1-month follow-up test, when compared with the waitlist control group’s display of a subtle increase in scores over time. However, this analysis did not detect any statistically significant results. Table C.7 summarizes the SEARS-P Self-Regulation/Responsibility mixed between-within ANOVA results. Of note, Table C.3 presented the mean scores and standard deviations for the SEARS-P Self-Regulation/Responsibility.
Table C.7

Summary for Mixed Between-Within ANOVA for SEARS-P Self-Regulation/Responsibility

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>63.377</td>
<td>63.377</td>
<td>.320</td>
<td>.575</td>
<td>.009</td>
</tr>
<tr>
<td>Time</td>
<td>1.868</td>
<td>105.386</td>
<td>56.416</td>
<td>2.273</td>
<td>.114</td>
<td>.055</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1.868</td>
<td>82.333</td>
<td>44.076</td>
<td>1.776</td>
<td>.179</td>
<td>.043</td>
</tr>
<tr>
<td>Within Cells</td>
<td>67.248</td>
<td>1668.947</td>
<td>24.818</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>71.984</td>
<td>1920.043</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* indicates statistical significance at $p < .05$.

Figure 4. Means Between Intervention and Waitlist Control Groups Over Time on SEARS-P Self-Regulation/Responsibility.
Mixed Between-Within ANOVA on SEARS-P Social Competence

For the Social Competence scores, the assumptions for random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were reasonably met. To correct the violation on sphericity, \( x^2 (2) = 6.919, \ p = .031 \), and to control for Type I error, Greenhouse-Geisser corrected tests, \( \varepsilon = .848 \), were used.

Results indicated a statistically significant interaction effect for the Social Competence subscale between treatment group and time with a medium effect size, \( F (1.696, 61.049) = 3.413, \ p < .05, \eta^2 = .079 \), as well as a statistically significant main effect for time with a medium effect size, \( F (1.696, 61.049) = 3.699, \ p < .05, \eta^2 = .085 \). The main effect on treatment group was not statistically significant, \( F (1, 36) = .059, \ p = .810, \eta^2 = .002 \). Polynomial contrasts revealed a statistically linear trend on the main effect of time, \( F (1, 36) = 7.275, \ p < .05, \) with a large effect size, \( \eta^2 = .168 \). Figure 5 demonstrates that the scores for the intervention group declined from posttest to follow-up after a substantial increase from pretest to posttest while the waitlist control group obtained a gradual increase in the SEARS-P Social Competence scores over time. Table C.8 summarizes the SEARS-P Social Competence mixed between-within ANOVA results. Of note, Table C.3 presented the mean scores and standard deviations for the SEARS-P Social Competence.

Table C.8

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>( \eta^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1.000</td>
<td>14.035</td>
<td>14.035</td>
<td>0.059</td>
<td>(.810)</td>
<td>(.002)</td>
</tr>
<tr>
<td>Time</td>
<td>1.696</td>
<td>202.789</td>
<td>119.583</td>
<td>3.699</td>
<td>(.037^*)</td>
<td>(.085)</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1.696</td>
<td>187.070</td>
<td>110.313</td>
<td>3.413</td>
<td>(.047^*)</td>
<td>(.079)</td>
</tr>
<tr>
<td>Within Cells</td>
<td>61.049</td>
<td>1973.474</td>
<td>32.326</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mixed Between-Within ANOVA on SEARS-P Empathy

For the Empathy subscale, the assumptions for random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were reasonably met. To correct the violation on sphericity, $\chi^2 (2) = 17.314, p < .001$, and to control for Type I error, I used the Greenhouse-Geisser corrected tests, $\varepsilon = .719$. Results indicated a statistically significant interaction effect for empathy between treatment group and time, $F (1.439, 51.79) = 4.592, p < .05$, with a medium effect size, $\eta^2 = .106$. The main effect on time was not statistically significant, $F (1.439, 51.79) = 2.756, p = .089$, with a medium effect.
size, $\eta^2 = .063$. The main effect for the treatment group was not statistically significant, $F (1, 36) = .035, p = .852, \eta^2 = .001$. Correspondent with these findings, polynomial contrasts revealed a statistically significant quadratic trend on the interaction effect, $F (1, 36) = 22.089, p < .001, \eta^2 = .380$. Figure 6 displays the intervention group’s increased SEARS-P Empathy scores from pretest to posttest followed by a decline from posttest to follow-up as well as the waitlist control group’s increased SEARS-P Empathy scores from posttest to follow-up after a reduction from pretest to posttest. Table C.9 summarizes the SEARS-P Empathy mixed between-within ANOVA results. Of note, Table C.3 presented the mean scores and standard deviations for the SEARS-P Empathy.

Table C.9

Summary for Mixed Between-Within ANOVA for SEARS-P Empathy

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1.000</td>
<td>7.895</td>
<td>7.895</td>
<td>0.035</td>
<td>.852</td>
<td>.001</td>
</tr>
<tr>
<td>Time</td>
<td>1.439</td>
<td>198.439</td>
<td>137.938</td>
<td>2.756</td>
<td>.089</td>
<td>.063</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1.439</td>
<td>330.684</td>
<td>229.863</td>
<td>4.592</td>
<td>.024*</td>
<td>.106</td>
</tr>
<tr>
<td>Within Cells</td>
<td>51.790</td>
<td>2592.211</td>
<td>50.052</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>55.668</td>
<td>3129.229</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Note. * indicates statistical significance at $p < .05$. 
Clinical Significance

According to Kazdin (2003), clinical significance refers to the practical benefit or the important effect that the intervention offers to the client in daily functioning. To explore the clinical significance of CCGPT for facilitating social-emotional assets of kindergarten children, I examined the number of participants in the intervention group ($n = 21$) whose scores improved based upon three tiers (i.e., Average to High Functioning, At-Risk, and High-Risk; Merrell, 2011) on the SEARS-P Total scores across pretest, posttest, and 1-month follow-up test. I included all available data during the examination without excluding any cases with missing...
data. The missing data were from one participant in the intervention group and two participants in the waitlist control group at posttest as well as one participant in the intervention group and one participant in the waitlist control group at follow-up. I did not explore the data from SEARS-T for clinical significance due to the lack of statistical and practical significance found during data analysis.

**SEARS-P Total Score**

A total of 15 of the 21 intervention group participants were identified as in the At-Risk or High-Risk range for social-emotional assets at pretest. At posttest, 71.4% ($n = 10$) of At-Risk or High-Risk scores had moved into an improved category, such as the tier of Average-High Functioning or the tier of At-Risk, with an average increase of 7.9 $T$-score points, and the remaining participants retained in the same tier. Additionally, 5 out the 6 participants identified by the Average to High Functioning range at both pretest and posttest presented an average increase of 4.2 $T$-score points at posttest. When compared to pretest, 46.7% ($n = 7$) of At-Risk or High-Risk moved into an improved category of risk; 40% ($n = 6$) of them remained in the same category with risk; and 13.3% ($n = 2$) moved to a higher risk category at follow-up.

For waitlist control group participants, 15 were identified in the At-Risk or High-Risk range. At posttest, 23.1% ($n = 3$) of At-Risk or High-Risk participants moved into an improved category of risk; 23.1% ($n = 3$) moved to a category with higher risk; and 53.8% ($n = 7$) remained in the same tier with an average decrease of 3.29 $T$-score points. When compared to pretest, 35.7% ($n = 5$) of At-Risk or High-Risk waitlist control group participants moved into an improved category of risk; 57.1% ($n = 8$) retained in the same category of risk; and 7.1% ($n = 1$) moved down to a higher risk category at follow-up test. Table C.10 presents the tier scores for both groups on SEARS-P Total from pretest posttest to 1-month follow-up.
Table C.10

*Tier Scores on SEARS-P Total for Both Groups with All Available Data*

<table>
<thead>
<tr>
<th>Tier</th>
<th>Intervention Group</th>
<th></th>
<th>Waitlist Control Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest (n = 21)</td>
<td>Posttest (n = 20)</td>
<td>Pretest (n = 22)</td>
<td>Posttest (n = 20)</td>
</tr>
<tr>
<td>Average-High</td>
<td>6</td>
<td>13</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>At-Risk</td>
<td>9</td>
<td>6</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>High-Risk</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

*Note.* All tier scores were based upon participants’ raw score, T-score, and percentile converted from SEARS software.
APPENDIX D

EXTENDED DISCUSSION
I sought to investigate the impact of CCGPT on social-emotional assets of kindergarten children, the difference of CCGPT effect between two-member and three-member groups, and the long-range effect of CCGPT. Specifically, I examined whether participation in 16-sessions of CCGPT promotes development of the overall social-emotional assets of kindergarten children across pretest, posttest, and 1-month follow-up test as measured by the Total scores on SEARS-P and SEARS-T. Statistically, practically, and clinically significant results indicated that parents observed positive changes over time in the children who participated in CCGPT compared to the parents of the children on the waitlist control group. Parents also reported that participants in the intervention group demonstrated statistically significant progress on the subscales of Social Competence and Empathy as compared to the reports of the parents for the children in the waitlist control group. Additionally, while comparing the two-member and three-member CCGPT groups, analyses did not detect any differences on participants’ overall social-emotional assets regarding group size. Although the examination of parent report detected significant and meaningful results, teacher reports did not show statistically significant results.

Teacher Perceptions

Teachers did not report statistically significant differences between the CCGPT and waitlist control groups on overall social-emotional assets. Results on the SEARS-T Total scores indicated that from pretest to posttest to follow-up test, children of both the intervention and waitlist control groups demonstrated gradual improvements to their social-emotional assets.

The lack of statistically significant results on the SEARS-T Total score is consistent with previous research. Garza and Bratton (2005) investigated the effect of CCPT with 29 Hispanic children, using teacher and parent reports of children’s both internalizing and externalizing behaviors. Parents reported a statistically significant improvement in children’s externalizing
behavior after the treatment whereas teachers did not perceive differences. Garza and Bratton (2005) attributed lack of significant results among teachers to challenges in teacher data collection procedures. In addition, Helker and Ray (2009) discussed the difficulty some teachers face in noticing and accepting behavioral changes for children. Aligned with Garza and Bratton’s (2005) conclusions and Helker and Ray’s (2009) discussion, the current study was impacted by several end-of-the-year and beginning-of-the-year factors that might have limited teachers’ sensitivity to individual child changes in challenging classroom environments.

I distributed and collected posttests during the final week prior to a long semester break and the follow-up tests after the first week of the new semester. I made multiple requests to obtain assessments from teachers and observed that some teachers hurriedly completed the assessments during lunch time and planning time. This process might have impeded the teachers from attending carefully to each item, recalling each student’s performance throughout the 8 weeks of CCGPT, and completing the assessments with a consistent and stress-free perspective. Given that the quality of teacher-child relationship influences children’s social and emotional development (Helker, Schottelkorb, & Ray, 2007; Pianta & Stuhlman, 2004), it is also possible that the teachers in the current study developed a stronger sense of closeness with all of their students over time. This closeness between the teachers and all of their students may have contributed to the lack of statistically significant findings.

Parent Perceptions

*Overall Social-Emotional Assets*

Over the course of the present study, the statistical, practical, and clinical significance detected for total social-emotional assets as measured by the SEARS-P indicated the positive impact of CCGPT among the kindergarten children identified as displaying apparent or emerging
deficits in social-emotional development. The medium effect size found in the current study is consistent with the findings in Lin and Bratton (2015) and Ray et al.’s (2015) meta-analytic reviews of CCPT outcomes. The results further correspond to Trostle’s (1988) conclusion about CCGPT improving the social and emotional skills of bilingual Puerto Rican children. In addition, mean differences on all subscales of the SEARS-P indicated that children who participated in CCGPT demonstrated moderate improvement from pretest to posttest, even though a subtle decline was noted at the 1-month follow-up. Alternatively, children who did not receive intervention exhibited a slight deterioration from pretest to posttest before showing improvement at follow-up. This result might suggest that when compared to no treatment, CCGPT served to accelerate children’s overall social-emotional development and a certain level of this growth is sustainable a month after termination.

The findings indicate that CCGPT may be a viable intervention for facilitating and supporting children’s exploration and expansion of their social and emotional assets in a safe environment through play. Child development experts have historically proposed that children develop social, emotional, and cognitive competencies through play (Frost et al., 2008; Seefeldt & Wasik, 2002). Theoretically, CCGPT enables changes to occur when children perceive conditions of acceptance, empathy, and genuineness as communicated by the therapist and become comfortable exploring who they are, recognizing their feelings and needs, experimenting with new skills and ways of being, and making meaning of these experiences into unique self-concepts (Landreth, 2012; Ray, 2011). Rooted in this theoretical underpinning, the therapist’s facilitations and the presence of other children serve as therapeutic agents during group process. Consequently, children in CCGPT become more attuned to their own and others’ feelings and needs while learning to express themselves in socially acceptable ways (Ray, 2011). Ultimately,
CCGPT seems to create an atmosphere in which children develop and reflect on social and emotional growth through therapeutic relationships with the therapist and group members. Children further connect experiences in CCGPT process and vicarious learning into their daily lives.

*Self-Regulation/Responsibility*

To date, most of the reviewed CCPT studies examined the impact of CCPT on children’s overall externalizing problem behaviors rather than specifically on self-regulation and self-responsibility. Results of several CCPT studies support the positive impact of CCPT in the reduction of externalizing disorders (e.g., Lin & Bratton, 2015; Ray et al., 2015). In specifically examining self-control, Trostle (1988) found that after 10 sessions of CCGPT, teachers reported 3- to 6-year-old bilingual Puerto Rican children in the experimental group as outperforming those in the unstructured free play control group on self-control. However, in McGuire’s (2001) research investigating the effectiveness of CCGPT with 29 kindergarten children experiencing adjustment difficulties, the parent and teacher reports on self-control were not statistically significant. In the current study, non-statistically significant results on the subscale of Self-Regulation/Responsibility failed to support some of the main objectives that CCGPT intends to facilitate for children in the process of change, including increasing self-responsibility and self-control (Ray, 2011; Sweeney et al., 2014). The inconsistency of this study as compared to others on externalizing behaviors seems to reflect the need to further explore the impact of CCGPT on the construct of self-regulation and self-responsibility.

Self-regulation and self-responsibility play an important role in kindergarten success (Berk et al., 2006; Rimm-Kaufman et al., 2000). Vygotsky regarded make-believe play, which is rule-based play, as the primary catalyst for the development of self-regulation (Berk et al., 2006).
Vygotsky (1966) proposed that through make-believe play, the child “learns to follow the line of greatest resistance, for by subordinating themselves to rules, children renounce what they want since subjection to rule and renunciation of spontaneous impulsive action constitute the path to maximum pleasure in play” (pp. 13-14). Unlike free play that appears free and spontaneous, make-believe play inspires children to control for immediate impulses and to subject themselves to the rules of the scene (Berk et al., 2006). Private speech is also a primary vehicle for children to figure out how they should proceed what they want (Berk et al., 2006; Ray, 2011). In Vygotsky’s theory, language serves a process in which culturally adaptive cognitive processes and self-regulation are transmitted and developed (Berk et al., 2006). Hence, make-believe play strengthens children’s internal capacity to manage impulses as well as facilitates their awareness to external expectations of social rules, accompanied by a sense of self-responsibility (Berk et al., 2006). Because the current study did not examine types of play, the impact of make-believe play on self-regulation for the CCGPT participants is unknown.

Although no statistical and practical significance confirmed the impact of CCGPT on kindergarten children’s self-regulation, increased levels of children’s self-regulation within the group play therapy sessions were observed by the therapists. For example, one therapist reported that during the earlier sessions in the treatment process, one boy of a two-boy group showed difficulty regulating his feelings and behaviors when things did not go the way he wanted and tended to express this frustration and anger through displaying verbal and physical aggressions toward the other group member. As sessions progressed, this boy exhibited improved self-regulation as evidenced by being able to verbalize his feelings, to move himself away from the situation, and to find alternative outlets such as bop bag and sandbox to express his feelings.
It is worth noting that participants in the intervention group illustrated a mean $T$-score increase of approximately four points from pretest to posttest on the subscale of Self-Regulation/Responsibility whereas the waitlist group maintained similar $T$-scores from pretest to posttest. These observations suggested that the participants in CCGPT groups made some progress in self-regulation and self-responsibility, but the changes were not substantial enough as perceived by parents to reach statistical significance. Alternatively, the small number of participants might limit the probability of reaching statistical significance. Hence, in the current study, the 16-session CCGPT protocol might have limited effects on facilitating kindergarten children’s development in the area of self-regulation and self-responsibility or other variables, such as type of play or statistical power, might have impacted the results.

**Social Competence**

According to Sweeney at al. (2014), 10 out of 32 group play therapy studies concentrated on children’s social behaviors, suggesting the belief in utilizing group approach to enhance children’s social competence. Literature has also highlighted that children with difficulty with social adjustments might benefit more from group play therapy than from individual therapy (Axline, 1969; Ray, 2011). Consistent with previous CCGPT studies (e.g., Fleming & Synder, 1947; Trostle, 1988; Tyndall-Lind et al., 2001), children in the current study who received CCGPT demonstrated improved social behaviors as evidenced by the statistical, practical, and clinical significance of the Social Competence pre, post, and follow-up scores.

Social relations are influential in kindergarten children’s cognitive and emotional development (Frost et al., 2008; Seefeldt & Wasik, 2002). Developmentally, kindergarten children begin to and prefer to socialize with children over adults as they transition from preschool to kindergarten and from the home to the school environment (Frost et al., 2008;
McWayne et al., 2012). Through interactions with peers, kindergarten children learn to adapt to new tasks, to cooperate, to recognize their own abilities, and to understand others’ feelings and thoughts (Denham, 1998; Forst et al., 2008). As Ginott (1961) stressed, “in return for peer acceptance, a child is motivated to change behavior” (p. 17). Groups accordingly are a crucial socializing influence in children development (Erikson, 1963; Frank & Zilbach, 1968).

Literature has asserted the importance of play in enhancing social development in children (e.g., Berk et al., 2006; Frost et al., 2008; Landreth, 2012; Piaget, 1999; Ray, 2011; Seefeldt & Wasik, 2002; Vygotsky, 1966). Especially, group play therapy is an approach that reflects children’s everyday world and meets their need for social acceptance (Axline, 1979; Ginott, 1961; Landreth & Sweeney, 1999; Ray, 2011; Sweeney et al., 2014). CCGPT offers a less threatening environment for children to engage in new experiences because of the company of other group members (Ginott, 1961; Landreth & Sweeney, 1999; Ray, 2011). By observing each other in the process of CCGPT, group members increase vicarious learning and learn that certain social skills are needed to maintain peer relationship (Ray, 2011). Interactions and experiences develop along with the therapeutic relationships between the therapist and the group members seem to facilitate children’s development of social competence.

The evidence of the effectiveness of CCGPT on social competence was observable by the therapists. For example, a girl of a three-member group (one girl and two boys) presented in therapy as anxious and fearful. According to the teacher, she rarely interacted with classmates and demonstrated a quiet and moody demeanor. In the first session, the girl did not initiate play but stood next to the therapist and quietly observed other group members. She did not respond while being invited to join the other group members in play. During the middle of the therapy process, she began her own play and actively talked to the therapist without interacting with
group members. Toward the end of the therapy, the girl started not only playing with the two boys in a cooperative way but also began to verbalize her needs. Her progress in socializing and feeling safe throughout the process of CCGPT mirrors the process in which children move toward appropriate social interactions in play to gain acceptance. The change in the girl’s behavior was theoretically induced by the empathy and acceptance provided by the therapist as well as by the interactions she had with the other group members. Hence, the result for the Social Competence subscale validates the use and effectiveness of CCGPT on promoting kindergarten children’s social skills.

*Empathy*

To date, no study in review was designed to explore the effectiveness of play therapy on empathy. The statistical and practical significance found in the post hoc analysis provides preliminary evidence for supporting the use of CCGPT on enhancing kindergarten children’s empathy. Empathy is a crucial interpersonal ability that affords social-emotional development as well as prevents impairment throughout childhood and adolescence (Ezpeleta, Granero, de la Osa, & Guillamon, 2000; Eisenberg & Miller, 1987; Findlay, Girardi, & Coplan, 2006). Children with appropriate empathy may be aware of, considerate of, or able to appreciate the situation of another, leading them to act on these feelings (Ray, Stulmaker, Lee, & Silverman, 2013). However, literature has revealed that most children are capable of conceptually understanding empathy but may not emotionally experience empathy (Dadds et al., 2009). Responding to this phenomenon, Ray et al. (2013) proposed that providing an environment for children to experience empathy and express emotions in actuality might lead to the advancement of empathy, a conjecture supported by the results of the current study.
CCPT is embedded in the tenet that children experience self-direction, grow in self-acceptance, and eventually release the self-actualizing tendency when the therapist provides empathy, unconditional positive regard, and congruence (Axline, 1969; Landreth, 2012; Ray, 2011). Landreth and Sweeney (1999) asserted that all children have the need to feel understood and accepted and share more of themselves while experiencing this safety and acceptance. Conveying empathetic understanding to children could potentially be one of the most vital attitudes within the therapeutic relationship because children continuously engage in the therapeutic relationship as a result of feeling understood (Landreth, 2012). In the process of CCGPT, children not only experience a consistent acceptance and understanding from the therapist but also have opportunities to expand their capacity to recognize, consider, and understand group members’ feelings and opinions through therapists’ facilitations (Axline, 1969; Ray, 2011; Sweeney et al., 2014). Additionally, supporting the empathic role that group members serve in group play process, Ray (2011) asserted that group members’ approach to each other is “one of genuineness and naturally felt empathy, especially when children have experienced similar contexts, personality characteristics, or presenting issues” (p. 192).

Consequently, CCGPT offers group members with experiences of empathy as well as opportunities to provide empathy for each other.

For example, one boy of a three-member group started CCGPT with the tendency to focus on his own play and appeared indifferent when other group members exhibited feelings of frustration, anger, and sadness. Over the course of CCGPT, this boy began to show his curiosity when he heard the therapist’s reflections regarding a group member’s struggle or negative feelings. An incident occurred toward the end of the therapy in which the boy physically moved closer and actively offered to help a group member who was crying because the child had
stepped on and broken his own glasses. The boy demonstrated his increased level of empathy as evidenced by becoming aware of other group member’s feelings and needs by offering help to comfort the group member. Therefore, as compared to the waitlist control group, it is evident that participants in the CCGPT group were in an environment that provided multiple opportunities to experience and translate the experiences of empathy provided by the therapist and group members into their interpersonal skills in subsequent relationships that contributed to a greater level of perceptible empathy.

Group Size

Result of the current study indicated that both the two-member and three-member groups exhibited improvement in overall social-emotional assets over time, which supports Landreth and Sweeney’s (1999) and Ray’s (2011) suggestions that two or three members per CCGPT group is effective and beneficial. Group sizes have been inconsistent throughout previous group play therapy studies. Some included two group members (e.g., Baggerly, 2004) whereas some included up to six members per group (e.g., DeMaria & Cowden, 1992). Therapeutic impact of group size is rarely discussed in play therapy literature. Ray (2011) stressed that group size is important in CCGPT given that CCGPT promotes full movement of each child; however, the intensity of verbal and nonverbal expressions may be elevated with more group members. The therapist’s capability to engage with and attune to all group members as well as to communicate the core conditions may be limited when groups have more members (Ray, 2011).

Ginott (1961) stressed that group play therapy “provides many opportunities for testing the stability of the therapist and for bringing even the most accepting adult to the brink of his endurance” (p. 128). Ray (2011) highlighted the advanced commitment that group play therapy requires of therapists including a certain level of comfort with simultaneous activities,
interactions, and dynamics happening between children and with the therapist as well as the belief that children can be therapeutic agents for one another. In the current study, all group members appeared to experience a secure level of acceptance from the therapist and each other, regardless group size. Therapists demonstrated the ability to facilitate opportunities for group members to explore individuals’ strengths and challenges related to self-regard. They provided a permissive environment where they could direct themselves and the group through interactions, thereby leading to growth and change. Most importantly, the therapists seemed to be able to access to their internal resources and communicate conditions and attitudes while accepting and managing multiple group interactions within the presence of three group members.

It is important to note that although the analytical results did not detect differences between the two-member and three-member groups, the therapists observed a two versus one in the group dynamic across all of the three-member groups. Play therapists could engage in two-person groups in order to avoid this dynamic. If engaging in three-person groups, therapists might need to mindfully facilitate group members’ awareness of each other and of overall group interactions during the therapy process. Further investigation on the appropriateness and impact of three-member CCGPT groups is needed.

Long-Range Effects of CCGPT

To date, none of the reviewed studies examined the long-range effects of play therapy. In a meta-analysis and systematic review of 23 studies exploring the effectiveness of CCPT in elementary schools, Ray et al. (2015) identified the absence of knowledge in long-range effects of CCPT and emphasized the crucial need for investigation. The results of the current study served as exploratory evidence of the sustainability of the effects of CCGPT on kindergarten
children’s overall social-emotional assets and the areas of social competence and empathy 1 month after termination.

The examination of mean differences of the CCGPT group across three points of time revealed that the mean scores at follow-up were lower than posttest, ranging from 1.36 points T-score to 3.67 points T-score. The mean scores at follow-up were still moderately higher than the mean scores at pretest indicating overall improvement across the study. Data collection procedures may have impacted follow-up results. I distributed and collected follow-up assessments 1 month after the termination of CCGPT, which was around a week after the winter break. It is possible that participants were in the transition from the winter break to the beginning of new school year during the follow-up period. Given that regular routines are important in establishing children’s stability and predictability in relation to overall growth (Brody & Flor, 1997; Keltner, 1990; Sytsma, Kelley, & Wymer, 2001), the decrease in mean scores at follow-up might be a reflection of participants’ adjustment to resuming routines. Additionally, despite research showed that statistically significant effects of CCPT are reached at approximately 12 sessions (Ray et al., 2015), optimal changes are reached from 30 to 40 sessions (Bratton et al., 2005; LeBlanc & Ritchie, 2001). This implication regarding the duration of CCPT might suggest that more CCGPT sessions are needed to carry out and stabilize the effects of CCGPT. Furthermore, an increase in the mean scores of the waitlist control group at follow-up was noticeable and might have been impacted by passage of time during which children are likely to show some growth as a result of maturation (Rubin & Bellamy, 2012). Consequently, it may be worth further exploration on the long-range effects of CCGPT with longer duration of therapy and appropriate timing for follow-up data collection.

Limitations of the Study
Despite the current findings offering valuable information regarding the effectiveness of CCGPT with kindergarten children displaying apparent or emerging difficulties with social-emotional assets, limitations are important to consider in interpreting results. Participants in the current study represented a specific age range and came from three Title I local elementary schools at which Hispanic students made up the majority of the participants in the southwest United States. With this limited practice setting, population, and sample size, the results may not be reflective or applicable to children across different ages, genders, geographical, or demographic backgrounds (Heppner, 2008; Rubin & Bellamy, 2012).

The real world setting of the current study supported the application of using CCGPT in the schools but also contributed to several limitations. Conducting the current study in three schools limited the possibility of enacting true random assignments because the participants were first stratified by school. Nevertheless, demographic characteristics appeared to be equally represented in the intervention and waitlist control group. Moreover, it may be possible that when the participants displayed inappropriate behaviors related to social-emotional skills in schools, teachers and school personnel provided immediate learning opportunities to correct the behaviors. This additional exposure might have influenced the findings. Although parents and teachers were not notified about group assignments, they might have become aware about their children’s participation in CCGPT, leading to rater bias (Rubin & Bellamy, 2012).

Only two assessments by parents and teachers were used to measure the impact of CCGPT on kindergarten children’s social-emotional assets. The study’s construct validity might have been threatened by mono-operation bias and mono-method bias (Heppner et al., 2008). However, other methods of data collection, such as in-class observation forms are theoretically inconsistent with the foundation of the strength-based approach embedded in SEARS, and most
kindergarten children have not developed the cognitive maturity level to comprehend and answer self-report assessments that require interpersonal and intrapersonal insights (Merrell, 2011). As a result, collecting data from only the parents and teachers of participants may be appropriate and applicable for the study of kindergarten children. Furthermore, given that parent-child relationships (Frost et al., 2008) and teacher-child relationships (Baker, 2006; Pianta, Steinberg, & Rollins, 1995; Pianta & Stuhlman, 2004) are influential in children’s social-emotional development, reports from parents and teachers might reflect changed perceptions toward the children in relation to their relationships with the children rather than the truly objective changes in the children’s behaviors.

The use of a non-treatment group is another limitation of the present study. The statistical differences detected between the CCGPT group and the waitlist control group might be due to the use of any intervention rather than the specific use of CCGPT. Therefore, a larger replication study including a treatment comparison group may be needed to validate the findings of the current study as directly related to CCGPT. Additionally, the length of the intervention might limit the effects on the intervention group. Given that the optimal effect of CCPT is about 30 to 40 sessions (Bratton et al., 2005; LeBlanc & Ritchie, 2001), CCGPT might need to be conducted over a longer duration to demonstrate statistically significant results for self-regulation and self-responsibility as well as to stabilize the long-range effect of CCGPT.

Recommendations for Future Research

Based upon the findings and limitations of the current and previous studies, I present several recommendations for future research:

1. The present study was limited regarding setting, sample size, and participants’ age and geographical and demographical backgrounds. An investigation of the possible
effects of CCGPT on children’s social-emotional assets with samples of children of representative age groups in the elementary school system, more demographically diverse populations, and larger sample sizes is needed. It may be helpful to aim study at a younger population, such as pre-kindergarten, to continue to explore the possible preventative effects of using CCGPT to promote social-emotional assets.

2. Due to the inconsistent findings between the parent and teacher reports in the current study, future researchers could include both parent and teacher reports to validate the effects of CCGPT from different perspectives. Previous research has indicated the impact of parent-child and teacher-child relationships on children’s social-emotional development; therefore, it may be worth investigating other variables such as parent-child relationship and teacher-child relationship as potential mediators or influencers of parents’ and teachers’ ratings regarding the effects of CCGPT on children’s social-emotional assets to determine the true, direct, and independent effects of CCGPT.

3. Literature and research highlighted the correlation between children’s social-emotional competence and their academic success. In addition to examining the effect of CCGPT on social-emotional assets, it may be worth examining children’s academic performance as a dependent variable to further support the use of CCGPT with children.

4. The current study provided exploratory evidence to support the long-range effect of CCGPT. Future researchers are encouraged to administer follow-up assessments over longer periods of time to determine long-range effects of CCGPT on children’s social-emotional assets. To ensure integrity regarding data collection procedures, future researchers are advised to control for the environments in which teachers
complete instruments and to be mindful about timing within the school year for instrument distribution and collection.

5. Although the analyses did not detect statistically significant differences between the two-member and three-member groups, the two-versus-one group dynamic in the three-member groups was consistently noticeable. To further detect the therapeutic aspects of group size for CCGPT, future researchers are urged to use larger samples to explore whether and how individuals’ play behaviors as well as groups’ dynamics and interactions differ by CCGPT group size. It may be beneficial to examine the correlation between different types of play behavior (e.g., individual play, parallel play, cooperative play, sociodramatic play, etc.) in the CCGPT process and children’s progress in social-emotional assets as measured by parents and teachers. In addition, knowing therapists’ experiences with two-member and three-member groups could enable the exploration of the therapeutic aspect of group size from the therapists’ perspectives.

6. Due to the lack of statistically significant results on the subscale of Self-Regulation/Responsibility, specifically investigating the effects of CCGPT on this construct with a larger sample size and longer length of intervention may advance the understanding and application of this therapeutic approach with children.

7. The present study did not include a treatment comparison group to confirm the effect of CCGPT on children’s social-emotional assets. An examination of the impact of CCGPT versus other treatment interventions, such as curriculum guidance in relation to social-emotional skills or Social-Emotional Learning programs, could produce increased evidence for using CCGPT.
Implications for Practice

Research and literature have recognized the effectiveness of CCPT with young children experiencing a variety of challenges (Bratton et al., 2005; Landreth, 2012; Ray 2011; Ray et al., 2015). CCPT, embedded in the belief that the therapeutic relationship is primarily facilitative of change, is designed to provide children with a developmentally appropriate intervention. Currently, several schools have incorporated social-emotional learning (SEL) programs by applying direct instruction and experiential activities in classrooms to improve children’s social and emotional development (Greenberg et al., 2003; Kramer et al., 2010; Rivers & Brackett, 2011).

The current study brings hope and assurance for the application of CCGPT, a relational approach that is centered on children’s natural way of communication, to work with children for social-emotional growth. In CCGPT, the therapist develops relationships with each child, facilitates relationships among children, and has opportunities to observe children holistically through their interactions with each other. CCGPT seems to provide an environment for children where they are able to express and explore themselves within safe and accepting relationships, to develop congruence between self-regard and their environments, and to gain appropriate social skills, empathy, self-regulation, and self-responsibility.

Bratton (2010) asserted that play therapy meets the developmental needs of diverse and at-risk children in school settings. In Ray et al.’s (2015) meta-analysis reviewing CCPT in schools, 10 of 23 studies provided CCPT in group format, and both individual CCPT and CCGPT appeared to be effective modalities. Consistent with the literature and research, the current study provided concentration and evidence to support the appropriate implementation of CCGPT with kindergarten children in school settings. The present study was conducted across
three Title I elementary schools, and as reported by parents, kindergarten children who received
30-minute play sessions twice a week for 8 weeks demonstrated statistically significant
improvement in overall social-emotional assets. This short-term success with the counseling
experience in three schools suggests CCGPT offers an applicable intervention for school
counselors or other school mental health professionals to utilize with children who display
concerning or problematic social-emotional development.

In addition, CCGPT appears to be a viable and practical option for enhancing children’s
social skills and empathy. As stated by Axline (1969) and Ginott (1961), group play therapy
may be more beneficial than individual play therapy for children whose difficulties are related to
social adjustment. Group play therapy represents a microcosm of children’s real world and
offers them with the opportunity to observe, be with, and interact with each other in a permissive
environment. This experience supports increases to children’s sense of security, accelerates their
readiness for self-expression, facilitates recognition of self and others, and allows for reality
testing as part of strengthening social skills (Axline, 1969; Ray, 2011).

The environment of CCGPT appears particularly beneficial for children to develop
empathy. Through empathy communicated by the therapist, children feel understood and
accepted. Through reflections stated by the therapist, children become aware of their feelings as
well as the feelings experienced by other group members. With more perceived experiences of
empathy, children are more able to develop empathy for other people (Ray et al., 2013).
Consequently, rather than providing cognitive guidance or lessons to teach children the concept
of empathy, CCGPT may be an applicable intervention that allows children to understand
empathy through direct experience which thereby promotes the capacity to offer empathy to
others.
Another implication for practice is the consideration of group size. The current study supports the effectiveness of both two-member and three-member CCGPT groups. This finding suggests that assigning up to three children per group can facilitate social-emotional competence improvements. Nevertheless, as the intensity of noise, mess, and activity can possibly increase with more group members, therapists could face more challenges in the group format than in the individual format (Ginott, 1961; Ray, 2011). It is imperative for therapists to be aware of whether they are providing empathy, acceptance, and genuineness to all group members consistently while acknowledging their level of control is significantly limited during the process of CCGPT.

In addition to attitudinal quality, setting limits can be an area of concern for therapists working with larger groups (Ray, 2011). While protecting the safety of group members and maintaining the structure of the playroom, therapists can encounter a dilemma between trusting group members to solve problems on their own versus worrying that group members’ interactions will become non-therapeutic or harmful. Hence, therapists must continue self-exploration and supervision in order to ensure the ability to confidently and comfortably convey unconditional positive regard for all group members within the group process. Furthermore, therapists are encouraged to prepare themselves to address difficulties with scheduling and appropriate group composition when assigning more members to a group.

Finally, the development of a formal treatment manual for CCGPT is necessary because CCGPT represents a combination of CCPT and group therapy. Therapists have different therapist roles between the two formats. The formats target different client populations. Play therapist training, structure of the playroom, and verbal skills needed by therapists differ between CCPT and CCGPT. Throughout the current study, I essentially followed the CCPT treatment
manual proposed by Ray (2011) and made essential and appropriate modifications, such as adapting the structure of the playroom as well as the skills checklist. To advocate the use of CCGPT and maintain the integrity and fidelity of CCGPT implementation, the development of manual with a protocol and a skills checklist is needed.

Conclusion

Social-emotional well-being serves as critical foundation for not only childhood development but also for development during the life course. Given that only 40% of children enter kindergarten with the appropriate social-emotional skills that lead to academic and relationship success, it is important to develop prevention programs or interventions to facilitate their social-emotional competence before they enter formal schooling. This exploration of the impact of CCGPT on kindergarten children with difficulties in developing social-emotional assets attempted to augment the body of literature regarding CCGPT and to provide preliminary evidence to support the lasting effects of CCGPT with the consideration of group size in the therapeutic outcomes.

The effects of CCGPT on 43 kindergarten children identified as lacking of social-emotional assets were examined by comparing parent and teacher reports of the children participating in the intervention and waitlist control groups. The statistical findings indicated that children who participated in CCGPT increased their overall social-emotional assets over children who did not receive any treatment across pretest to posttest and to 1-month follow-up test, as reported by parents. Particularly, the children participating in the CCGPT group demonstrated statistically significant improvement in the areas of social competence and empathy. The results also demonstrated that CCGPT accelerated participants’ social-emotional development when compared with the waitlist control group from pretest to posttest. However,
teachers did not report statistically significant differences between the two groups. This finding could be associated with some teachers having limited ability to observe and perceive change in the participating students or with the teachers experiencing increased satisfaction in their relationships with all of their students within their whole classrooms. Moreover, the current study supported that a certain level of the effects of CCGPT lasted 1 month after the intervention. CCGPT further demonstrated equally effectiveness for the two-member and three-member groups.

CCPT helps children reach their full potential for learning by releasing them from emotional struggles and limitations (Axline, 1969). CCGPT allows children to build interpersonal and intrapersonal insights and skills with natural media as they develop their senses of belonging with group members and experience consistent, accepting, and empathetic understanding from the therapist. The safety and relationships fostered in the CCGPT process enable children to experience self-discovery and self-realization. Children in the current study seemed to benefit from CCGPT, demonstrating CCGPT’s viability as a treatment for enhancing kindergarten children’s social-emotional development. As this was the first study designed to investigate CCGPT with kindergarten children struggling with social-emotional assets in the elementary school setting and due to the limitations discussed previously, it is important that future researchers replicate the current study with larger sample sizes and with attention to how parent-child relationships, teacher-child relationships, length of therapy, types of play, and group dynamics could interact with CCGPT outcomes.
APPENDIX E

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

**Title of Study:** Impact of Child-Centered Group Play Therapy on Social-Emotional Assets of Kindergarten Children

**Principal Investigator:** Dee Ray, Ph.D., LPC-S, NCC, RPT-S, University of North Texas, Department of Counseling and Higher Education.

**Student Investigator:** Yi-Ju Cheng, M.Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling and Higher Education.

**Purpose of the Study:**
You are being asked to allow your child to participate in a research study which involves determining if group play therapy is effective in helping children improve the way they act, feel, and interact with others at school. The study will also look at whether group play therapy for children helps decrease social, emotional, and behavioral problems at home as observed by parents.

**Study Procedures:**
Your child will be asked to participate in group play therapy. Group play therapy is a counseling intervention combining the advantages of play therapy and group process. Play therapy is designed for children to express themselves in their natural way of playing with toys. Some elementary-age children have difficulty working through problems with words, so play therapy can help facilitate the process by providing a play environment from which they can work through those issues that may limit their academic progress. Through the interactions with other group members and therapist, we hope your child will become more aware of their own and others’ feelings, thoughts, and needs, as well as learn to interact in socially appropriate ways.

Your child decides what materials to play with and what to discuss in play therapy. Your child will not be asked any questions that are not intended to facilitate his/her awareness or growth. Your child will not be forced to play. The play sessions will be video-recorded. The research team will observe the recordings to ensure the quality of play therapy services and the integrity of the study.

For this study, your child will be placed in one of two groups:

**Group 1:** Children in this group will begin group play therapy immediately and will receive two 30-minute sessions of group play therapy each week for 8 weeks.

**OR**
Group 2: Children in this group will not receive any intervention during the 8 weeks of the study. Children in this group will begin group play therapy in January and will receive at least 8 sessions of group play therapy.

You will be asked to complete a brief assessment which requires approximately 10 minutes to complete. The assessment will be sent home to you through your child for you to complete. The assessment will need to be completed at three points in the study, beginning and end of the 8 week period, and one month after the end of the study. The entire study will require approximately 30 minutes of your time to complete assessments.

Your permission also allows your child’s homeroom teacher to fill out an assessment which asks the teacher to report perceptions of your child’s social and emotional development within the classroom environment. The assessment will be delivered to your child’s teacher by therapist. Your child’s teacher will be asked to complete this instrument before and after the 8 week period, and one month after the end the study.

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

1. Anything that is said or done during group play therapy is considered confidential, meaning that the therapist will not reveal anything that happens in the session to another school official or adult. However, if your child discloses child abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report it to the appropriate authority.

2. When your child participates in group play therapy, he or she will be pulled from another school activity upon the approval of the teachers. It is possible that your child might miss an academic or extracurricular experience. However, whenever you or your child’s teacher observes any academic concerns due to your child’s participation in group play therapy, you or your child’s teacher may request to withdraw your child from the study.

3. Because play therapy is a counseling method, your child may experience emotions that could be strong for him or her. The therapist will help your child express and work through these emotions. If any harmful effects upon your child are noted, the therapist will consult with the principal investigator, discuss with you and the child’s teacher, and then stop therapy for your child following your agreement. Harmful effects would include inability to maintain self-control or being so upset that your child is unable to behave appropriately in the group environment.

Benefits to the Subjects or Others:
Possible positive outcomes for children participating in the project may include being more aware of their own and others’ feelings, thoughts, and needs; learning to interact in appropriate ways; increasing ability to develop a sense of responsibility; forming and maintaining relationships; and exhibiting less problem behaviors. The results of this study may provide
school counselors across the nation with knowledge that helps them enhance children’s social-emotional development so that children are happier and more successful in public school.

**Compensation for Participants:** You will receive $10 cash at the end of the study when you have completed the three assessment instruments (pre, post, and one-month follow-up).

**Procedures for Maintaining Confidentiality of Research Records:**
All information will be kept in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Only the research team will have access to the locked cabinet. Names of parents and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the research team will have a list of the participants’ names. The play sessions will be video-recorded. The research team will observe the recordings to ensure the quality of the study. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other specific information will not be revealed when video recordings are shown in educational settings. However, you may choose to withdraw your consent at any time and the video recordings of your child will not be used.

**Questions about the Study:** If you have any questions about the study, you may contact Dr. Dee Ray at (940) 565-2066 or Dee.ray@unt.edu.

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

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

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

Printed Name of Parent or Guardian

Signature of Parent or Guardian  Date
Title of Study: Impact of Child-Centered Group Play Therapy on Social-Emotional Assets of Kindergarten Children

Investigator: Dee Ray, PhD, LPC-S, NCC, RPT-S, University of North Texas (UNT) Department of Counseling and Higher Education.

Student Investigator: Yi-Ju Cheng, M.Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling and Higher Education.

Purpose of the Study: You are being asked to participate in a research study which involves determining if group play therapy is effective in helping kindergarten children improve the way they act, feel, and interact with others at school. Through interactions with other group members and the therapist in group play therapy, children may have opportunities to become aware of their own others’ feelings, thoughts, and needs, as well as learn to interact in a socially appropriate ways. This study aims to explore whether participating in group play therapy helps children decrease social, emotional, and behavioral problems at school as observed by teachers and parents.

Study Procedures: After parents provide permission for their child’s participation in this study, each participating child will be assigned to one of two groups: Group 1 - Children in this group will begin group play therapy immediately and will receive two 30-minute sessions of group play therapy each week for 8 weeks or Group 2 - Children in this group will not receive any intervention during the 8 weeks of the study. Children in this group will begin group play therapy in January and will receive at least 8 sessions of group play therapy.

You will be asked to complete a brief assessment for each participating child in your classroom at three points in the study: the beginning of the 8-week period, end of 8-week period and one month after the end of the study. It will take approximately 10 minutes to complete the assessment, totaling 30 minutes of your time for the entire study.

Foreseeable Risks: No foreseeable risks are involved in this study.

Benefits to the Subjects or Others: Possible positive outcomes for children participating in the project may include being more aware of their own and others’ feelings, thoughts, and needs; learning to interact in socially appropriate ways; increasing ability to develop a sense of responsibility; forming and maintaining relationships; and exhibiting less problem behaviors. The results of this study may provide school counselors across the nation with knowledge that
helps them enhance child’s social-emotional development so that children are happier and more successful in public school.

**Compensation for Participants:** You will receive $10 cash at the end of the study when you have completed the three assessment instruments (pre, post, and one-month follow-up).

**Procedures for Maintaining Confidentiality of Research Records:** All information will be kept in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Only the research team will have access to the locked cabinet. Names of teachers, parents, and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the research team will have a list of the participants’ names. You may choose to withdraw your consent at any time and the data you provided will not be used.

**Questions about the Study:** If you have any questions about the study, you may contact Dr. Dee Ray at (940)565-2066 or dee.ray@unt.edu.

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

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

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

________________________________________________________
Printed Name of Participant

________________________________________________________
Signature of Participant    __________________________
Date
For the Investigator or Designee:
I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

____________________________________                    ____________
Signature of Investigator or Designee                    Date
Participant Recruitment Letter to Teachers

Dear Teacher,

The University of North Texas is currently offering free play therapy services for children at SCHOOL NAME as a part of a research study. We would like your help in determining if your students may benefit.

This study will look at whether group play therapy helps promote children’s social-emotional assets and competencies. We are specifically looking for kindergarten students who lack of social-emotional assets or show emerging signs of social-emotional deficits. The descriptions of such struggles include the following areas:

- **Social skills and competencies** (e.g., making friends, maintaining relationships with peers and adults, being able to talk to different people, being comfortable in big groups, etc.)
- **Self-regulation** (e.g., self-management, expressing disagreement with others without being upset, being able to control one’s own behaviors, etc.)
- **Self-responsibility** (e.g., accepting responsibility, making good decisions, thinking before acting, etc.)
- **Empathy** (e.g., being able to understand others’ thoughts, feelings, and situations, cares what happened to other people, etc.)

If your students qualify for the study they will participate in group play therapy sessions during the school day. You will also be asked to complete short assessment on three occasions, at the beginning of the study, at the end, and one month after the completion of intervention. Parents will also be asked to fill out the assessment.

If you would like your students to participate, please read and sign the attached teacher informed consent form. An additional copy of the informed consent form is enclosed for you to keep. If you have questions please contact:

**Counseling Program at UNT**
Yi-Ju Cheng
940-5652066 or YiJu.Cheng@unt.edu

Please feel free to let us know if you have any questions. We are looking forward to working with you!
## Group Play Therapy Skills Checklist (GPTSC)

Therapist: _________________________ Observer: _________________________ Date: _____________

Child A/Age/Gender: ________________ Child B/Age/Gender: ________________ Child C/Age/Gender: ________________

<table>
<thead>
<tr>
<th>Therapist Nonverbal Communication</th>
<th>Too Much</th>
<th>Appropriate</th>
<th>Need More</th>
<th>None</th>
<th>Therapist Responses/Examples</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lean Forward/Open</td>
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<td>Appeared Interested/Engaged</td>
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<td>Relaxed/Comfortable</td>
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<td>Tone/Expression Congruent with Children’s Affect</td>
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<td>Tone/Expression Congruent with Therapist’s Responses</td>
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<td>Succinct/Interactive</td>
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<td>Tolerance for Noise/Messiness/Intense activity</td>
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<td>Use Second-Person</td>
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<td>Overall Rate of Responses</td>
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<td>Balanced Responses</td>
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<td>Attuned to Group Dynamics</td>
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<td>Attuned to Individuals</td>
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<thead>
<tr>
<th>Therapist Responses</th>
<th>Too Much</th>
<th>Appropriate</th>
<th>Need More</th>
<th>None</th>
<th>Therapist Responses/Examples</th>
<th>Other Possible Responses</th>
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<tr>
<td>Tracking Behavior</td>
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<tr>
<td>Reflecting Content</td>
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<td>Reflecting Feelings</td>
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<td>Reflecting Meanings</td>
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<td>Facilitating Decision Making/Responsibility</td>
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<td>Facilitating Creativity/ Spontaneity</td>
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<td>Esteem Building/ Encouraging</td>
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<td>Facilitating Relationships among Children</td>
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<tr>
<td>Facilitating Relationships with Therapist</td>
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<th>Therapist Responses</th>
<th>Too Much</th>
<th>Appropriate</th>
<th>Need More</th>
<th>None</th>
<th>Therapist Responses/Examples</th>
<th>Other Possible Responses</th>
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<td>Reflecting Group Interactions/Bridging Play Behaviors among Children</td>
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<td>Limit Setting</td>
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<tr>
<td>Non-CCGPT Response</td>
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Other Observations

Identified Group Themes

Identified Individual Themes

Child A:

Child B:

Child C:

Therapist’s Strengths

Areas for Growth

Note. Group play therapy skills checklist (GPTSC) was adapted from D.C. Ray’s (2011) *Advanced Play Therapy: Essential Conditions, Knowledge, and Skills for Child Practice* (pp. 310-311).


