GROUP ACTIVITY PLAY THERAPY FOR PREADOLESCENT FEMALES:

EFFECTS ON LOW SELF-ESTEEM

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Research shows that preadolescent females are more prone to negative self-perceptions than their male counterparts which places them at greater risk of developing mental health problems stemming from low self-image. The purpose of this randomized, controlled outcome study was to examine the effectiveness of group activity play therapy (GAPT) compared to an evidenced based social skills/self-esteem group. Participants were 29 fourth and fifth grade girls in two Title I schools in the southwest U.S. referred by teachers and school counselors as presenting with low self-esteem. Participants identified as 45% Latina, 38% Caucasian, 14% African American, and 3% Asian. Children were randomly assigned to either 16 sessions of GAPT (experimental group; \( n = 15 \)) or 13 sessions of an evidenced based social skills/self-esteem group intervention (control group; \( n = 14 \)). Results from a 2 (Group) by 3 (Times) repeated measures ANOVA indicated that, compared to the control group over time, the GAPT group reported statistically significant improvement in self-esteem with a moderate to large treatment effect. Teachers did not report a statistically significant difference between the two groups over time. However, teachers reported noteworthy improvement for children in both treatment groups, with generally stronger improvement for the GAPT group. Overall, results indicate that GAPT may be a promising school-based intervention for preadolescent females suffering with low self-esteem.
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Introduction

Preadolescence is a period of child development, approximately ages 9 to 12 (Harter, 2102), during which numerous and rapid changes are occurring (LeCroy, 2004). These developmental changes can be quite stressful for preadolescents, particularly for children who are already struggling with mental health concerns. Low self-esteem is often at the root of psychological problems for preadolescents who naturally compare themselves to their peers as they strive to fit in (Akos, Ham, Mack, & Dunaway, 2007) and whose developmental task, according to Erikson (1963), is the formation of a sense of industry and competence versus feelings of inferiority (Erikson, 1963). Research shows that, beginning in middle childhood, females are more likely to suffer from low self-esteem than males (Norwood, Murray, Nolan & Bowker, 2011; Birndorf, Ryan, Auinger, & Aten, 2005). Thus female preadolescents are potentially at greater risk for developing mental health issues stemming from poor self-image. Estimates indicate that up to 20% of children have a diagnosable mental health disorder (Mental Health America; MHA, 2014) and less than one-fourth of these children receive appropriate help (National Center for Children in Poverty; NCCP, 2014), leaving far too many youth facing the likelihood of developing more serious problems across their lifespan. Identifying developmentally responsive interventions that address the self-esteem needs of preadolescent females has the potential to enhance their self-perception during a time when they are particularly vulnerable as well as prevent the onset of more serious mental health problems.

One intervention that shows promise for helping preadolescent females identified with low self-esteem is group activity play therapy (GAPT). GAPT is an intervention grounded in the
principles of child-centered play therapy and informed by child development that has been shown effective in decreasing preadolescents’ problem behaviors, increasing their social skills and problem solving abilities, and strengthening peer relationships (Bratton, Ceballos, Ferebee, 2009; Flahive & Ray, 2007; Ojiambo & Bratton, 2014; Packman & Bratton, 2003). However, a review of research found no studies examining the effects of GAPT on self-esteem issues or GAPT studies focused exclusively on preteen females.

*Self-Esteem*

Within the field of mental health, self-esteem is viewed as a significant factor to individuals’ holistic development across the lifespan. Berk (2003) proposed that self-esteem is the most important facet of self-development as evaluations of one’s competencies can influence overall psychological adjustment. Higher levels of self-esteem have been associated with healthier coping skills and overall psychological well-being (Birndorf, Ryan, Auinger, & Aten, 2005; DuBois and Tevendale, 1999; Harter, 2012; Steese et al., 2006; Steiger, Allemand, Robins, & Fend, 2014; Van Den Bergh & Marcoen, 1999). Conversely, compared to the general population, children and adolescents presenting with low self-esteem are more susceptible to bullying and teasing (Kutob, Senf, Crago, & Shisslak, 2010), and are at greater risk of developing a range of concerns across their lifespan including attention problems, depression, anxiety, suicide ideation, eating disorders, and substance abuse (Van Den Bergh & Marcoen, 1999; Steese et al., 2006; Trzensniewski et al., 2006). Many individuals with low self-esteem fail to exhibit symptoms that warrant a diagnosis, however their daily functioning may be impaired. For example, individuals with low self-esteem are prone to develop social anxiety and have difficulty forming satisfying relationships (Acarturk et al., 2009).
Preadolescent females are more likely than their male counterparts to develop a poor self-image due to the tendency to internalize their experiences (Shen & Armstrong, 2008; Bolognini, Plancherel, Bettschart, & Halfon, 1996). According to a report conducted by the Dove Self-Esteem Fund (2008), 75% of girls identified with low self-esteem reported engaging in negative behaviors including “disordered eating, cutting, bullying, smoking, or drinking when feeling bad about themselves” (p. 1). During this turbulent time in their development, preadolescent females are becoming more aware of themselves and their bodies in relation to others, often placing greater value on the opinions of others over their own (Anderson & Choate, 2008; Bratton & Ferebee, 1999). Mental health interventions that build self-esteem and strengthen healthy peer relationships can help preteen girls successfully navigate the often difficult transition from childhood to adolescence (Polce-Lynch, Myers, & Kilmartin, 1998) and serve as a protective factor against future problems.

**Needs of Preadolescent Females**

A review of the literature suggests differences exist among boys and girls regarding development of self-esteem (Bologini et al., 1996). Research shows that, beginning as early as elementary school, females display more symptoms of low self-esteem than males (Norwood et al., 2011; Birndorf et al., 2005). The cognitive and social advances that occur in middle childhood make preadolescents become even more aware of themselves and their abilities and how their abilities compare with others (Harter, 2006). Compared to their male counterparts, females are more vulnerable to experiencing negative self-perceptions due to their tendency to internalize their experiences (Anderson & Choate, 2008). Because of the importance preteen females place on peer relationships and on the opinions and judgments of their peers, they need
to feel accepted in order to establish significant relationships (Paoene, Mallott, & Maldonado, 2008). Establishing close peer relationships “are essential processes that influence all aspects of female identity, self-concept, and psychological health” (Calhoun, Bartolomucci, & McLean, 2005, p. 18). Females connect by sharing their concerns and struggles with each other through a reciprocal process of support and empathic understanding (Letendre & Williams, 2014). Thus, the social needs and preferences of preadolescent females make group interventions especially appropriate for this population.

Group Activity Play Therapy (GAPT)

GAPT is a developmentally sensitive intervention for counseling preadolescents that is grounded in child-centered play therapy (CCPT) principles and informed by theories of child development. CCPT (Landreth, 2012; Axline, 1947) is based on the person-centered theory of Carl Rogers (1951). Consistent with person-centered philosophy, the CCPT/GAPT therapist believes children have the ability to direct their growth given their experience of the freedom to be themselves in the therapeutic relationship (Landreth, 2012, p. 53). A therapeutic relationship characterized by empathic understanding, unconditional positive regard, and congruence is considered the mechanism for change (Bratton, Ray, Edwards, & Landreth, 2009; Raskin & Rogers, 2005). It is through this type of relationship that the child is able to explore past experiences that are incongruent with the self-structure and begin to internalize new experiences that can facilitate a more congruent sense of self (Ojiambo & Bratton, 2014; Landreth, 2012; Ray 2011;).

The development of group activity therapy approaches grew out of the need for an intervention that was suited to the developmental needs and preferences of preadolescents (Redl
& Slavson, 1944; Ginott, 1961). GAPT addresses the needs of preadolescents by incorporating materials, equipment and activities that are tailored specifically for this age group (Bratton, Ceballos, & Ferebee, 2009; Bratton & Ferebee, 1999). As mentioned previously, preadolescents are developing a keen awareness of others and others’ opinions and have a strong need to fit in socially, therefore the group format of GAPT potentially offers added therapeutic value for preteens. GAPT not only provides an environment in which peer relationships can be established and negotiated, preadolescents also have an opportunity to learn prosocial and coping skills in a safe environment in which they can naturally practice with one another.

Controlled outcome studies have demonstrated the beneficial effects of school-based, group activity therapy to treat preadolescents presenting with social-emotional and behavioral difficulties. In a randomized controlled study, Packman and Bratton (2003) examined the efficacy of school-based, group play/activity therapy with 30 preadolescents with learning disabilities who presented with behavioral concerns. Findings indicated statistically significant reductions in problem behaviors in the classroom and moderate to large treatment effects. Ojiambo and Bratton (2014) conducted a randomized, controlled study based on the protocol used in Packman and Bratton (2003) and named the treatment model and the expanded protocol Group Activity Play Therapy (GAPT). Ojiambo and Bratton studied the effects of school-based GAPT with 60 displaced Ugandan orphans, aged 10 to 12 years, exhibiting clinical levels of behavior problems. Teachers and housemothers reported that children in the GAPT condition demonstrated statistically significant reductions in externalizing and internalizing behaviors and indicated a moderate to large treatment effect on all outcomes. In a related randomized study, Flahive and Ray (2007) investigated the effects of group sandtray therapy with 56 preadolescents and found statistically significant beneficial effects on participants’ behavioral problems.
Established in 1996, S.S.GRIN (DeRosier, 2004) is a highly structured curriculum for children struggling in peer relationships and is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence based program (National Registry for Evidence-based Programs and Practices, NREPP, 2011). S.S.GRIN was derived from a variety of scientifically supported programs that demonstrated “social learning and cognitive-behavioral perspectives and incorporates techniques and strategies, as well as methods of teaching, that have been deemed effective for improving children’s peer relationships and behavior” (DeRosier, 2007a, p.2). In particular, DeRosier (2007) created the curriculum to address specific skills that could be generalized across a variety of self and social problems. The goals of S.S.GRIN are to “(1) build basic behavioral and cognitive social skills, (2) reinforce prosocial attitudes and character traits, and (3) build adaptive coping strategies for social problems, such as teasing or isolation” (DeRosier, 2007, p. 262). Social skills outlined in the curriculum include: communication, cooperation, respect, responsibility, empathy, and self-control (DeRosier, 2007a). Topics such as bullying, teasing, and negative self-assumptions are also discussed in group sessions.

Purpose of the Study

The literature suggests that when left untreated, low self-esteem in preadolescence can potentially result in a variety of mental health problems. The purpose of the proposed study was to examine the effects of school-based (GAPT) on the self-esteem of preadolescent females. The examined research question was: Does GAPT improve self-esteem in preadolescent females when compared to S.S.GRIN over time?
Methodology

I utilized a randomized control group design with two treatment conditions (experimental/comparison) and three points of measure (pretest/midtest/posttest) to examine the effectiveness of GAPT compared with an established curriculum-based group intervention, S.S.GRIN, on the self-esteem of fourth and fifth grade females. A priori power analysis using G*Power software determined that a minimum sample of 28 participants would be necessary to find a statistical difference between groups over three points of measure (pre to mid to post). Based on Cohen’s (1992) recommendations, I set the G*power calculation with an alpha level of .05, a moderate effect size (f=.25), and minimum power at .80.

Participant Selection and Recruitment

Participants were females aged 9-11 enrolled in fourth and fifth grade at two Title I elementary schools in the southwest United States referred by teachers and school counselors for symptoms of low self-esteem including lack of confidence regarding academic performance, poor social skills, withdrawal, and showing signs of anxiety or sadness. Criteria for inclusion in this study included the following: (a) Female students were enrolled in 4th and 5th grade; (b) Children were referred by the teacher or school counselor due to exhibiting symptoms of low self-esteem (c) Children understood and spoke English; (d) Parents of children were willing to give consent; (e) Children were willing to give consent (f) Teachers of children were willing to give consent and complete assessments; (g) Children were not receiving other types of mental health services during the study.

Initially, 30 children met criteria and were randomly assigned to equal groups. After a few weeks into the study, one child in the control group requested to no longer be a part of the
study. Thus, 29 participants completed the study; GAPT = 15; S.S.GRIN = 14. An inspection of demographics and pre-study data revealed no differences in completers and non-completers. Participants were 38% fourth graders (n=11) and 62% fifth graders (n=18). Of the 29 participants, 45% identified as Latina, 38% as Caucasian, 14% as African American, and 3% as Asian.

Instrumentation

I utilized two instruments, a teacher report and a child self-report of the same assessment system, to assess the comparative effects of GAPT and S.S.GRIN on the self-esteem of preadolescent females. The Harter Self-Perception Profile for Children (SPPC; Harter, 1985) child self-report was utilized to examine children’s self-perception. For the purpose of this study, the Global Self-Worth subscale was used to operationally define participants’ overall self-esteem. Teacher’s Rating Scale of Children’s Actual Behavior (TRS; Harter, 1985), a companion to the SPPC, was utilized to measure children’s self-esteem as reported by teachers. The TRS does not include a global self-worth scale, and because teacher referrals were primarily for low self-esteem concerns related to social relationships and academic achievement, for the purpose of this study the Scholastic Competence and Social Competence subscales were used to measure teachers’ perceptions of children’s self-esteem.

Harter Self-Perception Profile for Children

The Harter Self-Perception Profile for Children (SPPC, Harter, 1982) was developed to measure children’s perception of self-concept for ages 8 to 15. The SPPC, entitled “What I am like,” is a 36-item, examiner administered questionnaire, comprised of five specific domains
(Scholastic Competence, Physical Appearance, Behavioral Conduct, Social Acceptance, and Athletic Competence) and a separate Global Self-Worth subscale. This assessment takes approximately 15-20 minutes to complete per child. The SPPC first asks children to choose between two statements regarding their competence and select which sentence is “most like me”. For example: “Some kids often forget what they learn” but “Other kids can remember things easily”. Next, children will decide whether the sentence they selected is “really true for me” or “sort of true for me” resulting in a four point scale. Half of the items are reverse worded in order to reduce socially desirable responding as well as the possibility of participants randomly selecting answers. Items are scored such that 1 represents low competency and 4 representing high competency.

The Scholastic Competence subscale measures the child’s perception of his or her competency as applied to schoolwork. The Social Competence subscale measures the child’s perception of his or her competency as having the skills to make friends. The Athletic Competence subscale measures the child’s perception of his or her ability to perform well in sports or athletic games. The Physical Appearance subscale measures the child’s perception of how he or she may feel about their looks, face, body, hair, etc. The Behavioral Conduct subscale measures the child’s perception of his or her behavior and if the child feels as though he or she is acting in ways to avoid being in trouble. The Global Self-Worth subscale is a separate subscale that measures the child’s overall self-esteem. The SPPC also has an importance scale which measures children’s view of the importance of each domain. Harter (1982) reported that the SPPC demonstrates face validity, convergent validity and acceptable reliability using Cronbach’s alphas .71-.84. For the purposes of this study and to answer the research question, only the Global Self-Worth subscale will be used to measure the child’s overall self-esteem.
Teacher’s Rating Scale of Children’s Actual Behavior

Teacher’s Rating Scale of Children’s Actual Behavior (TRS) was developed as a companion to the SPPC to measure the teacher’s perception of the child’s competencies. The TRS, a 15-item questionnaire, is compromised on five scales that mirror the SPPC: Scholastic Competence, Social Competence, Physical Competence, Physical Appearance, and Behavioral Conduct. Global Self-Worth is not included as the items “do not translate into attributes that an objective observer can rate” (p. 10). Teachers rate children on a scale of one to four with one representing low competency and four representing high competency. The assessment takes 15-20 minutes per child to complete. According to Cole et al. (1996), the TSR demonstrated high levels of internal consistency (r=.93 to .97) and demonstrated good test-retest reliability (r=.67 to .73.).

Procedures

Upon attaining human subject approval from the University of North Texas Internal Review Board and Denton Independent School District, I met with administrators and school counselors of the school to discuss the purpose of the study and identify possible participants. School counselors and teachers were asked to identify children who seemed to exhibit symptoms of low self-esteem such as withdrawal, poor social relationships, anxiety or sadness. Teachers and school counselors made referrals for children they believed could benefit from the interventions provided in this study. Consent forms (see Appendix E) in both Spanish and English were given to parents to sign and return for collection. Teachers also signed consent forms to participate. After I received the consent forms, I obtained assent from the participants.

Next, teachers of the referred preadolescents completed the TRS (Harter, 1985) and the
preadolescents were administered the SPPC, entitled “What I am like” (Harter, 1985). Participants were randomly assigned to the experimental group (n = 15) or control group (n = 14) using a random table of numbers. Treatment participants in the experimental and control group were placed into groups of three to four according to school schedule. Bratton et al. (2009) and Ginott (1994) recommended that participants assigned to treatment groups be no more than one year apart and that they not be classmates. Unfortunately, due to school schedule, I could not ensure that participants were not classmates as students were only approved to participate in the intervention during specific times of instruction which were dictated by their homeroom assignment.

Prior GAPT outcome research using group activity therapy formats in school settings confirmed that favorable medium to large treatment effect sizes were achieved in 16 sessions or fewer (Flahive & Ray, 2007; Packman & Bratton, 2003; Ojiambo & Bratton, 2014). Therefore, in the present study, participants in the GAPT condition participated in an average of 16 sessions, once per week for 45 minutes per session. Consistent with the protocol used by Ojiambo and Bratton (2014), session length was adapted to the school schedule and shortened from a 1.5 hour group activity therapy format as suggested in the literature (Bratton & Ferebee, 1999; Schiffer, 1969; Slavson & Redl, 1944) to 45-50 minutes. Participants in the S.S.GRIN condition participated in an average of 13 sessions, once per week for 45 minutes, which is consistent with the S.S.GRIN protocol.

Measures were taken to ensure that teachers, as sources of pre, mid, and post test data, would be blinded to the study: (a) teachers were informed that all students in the study were participating in self-esteem groups; they were not informed of children’s group assignment; (b) all children left the classroom for the same length of time and in the same manner; (c) treatment
facilitators for both conditions were instructed to use identical statements when retrieving children from the classroom such as, “I am here to get Lacy”, and (d) treatment facilitators for both conditions were informed not to discuss the intervention with any teachers at any time until the study was completed.

Experimental Condition: GAPT

GAPT, grounded in CCPT theory and procedures (Landreth, 2012), was designed as a developmentally appropriate counseling intervention to meet preadolescents’ unique social, emotional and cognitive needs. Counselors followed to the GAPT protocol (Ojiambo & Bratton, 2014; Ojiambo, 2011) found in Appendix G. The protocol includes unstructured activities as well as semi-structured activities offered by the therapist to facilitate connections among group members. The GAPT protocol allows flexibility for group members to use materials how they choose (Ojiambo & Bratton, 2014). Consistent with Rogers’ Person-Centered framework, principles influencing the GAPT process include

a) trust in preadolescents’ capacity for positive self-growth, and their ability to set their own goals and work toward their own progress, and b) the significance of the therapeutic relationship in facilitating clients’ released potential for movement toward personal growth and a relationship in which the therapist experiences and communicates genuineness, empathy, and unconditional positive regard. (Ojiambo & Bratton, 2014, p. 11)

Sessions were conducted in a specially-equipped room at the school following recommendations for setting up the space and materials as outlined in Packman and Bratton (2003) and Ojiambo and Bratton (2014). Session structure included self-directed and group-directed activities in addition to semi-structured, and as needed, therapist-offered activities. Approximately 10 minutes were designated for group member sharing, closure, and transition back to the classroom. Materials and activities were chosen to meet the developmental needs of
preadolescents (Bratton & Ferebee, 1999; Ojiambo & Bratton, 2014; Packman & Bratton, 2003). Appendix H contains the list of materials and toys used by Ojiambo and Bratton. Bratton and Ferebee (1999) provided a comprehensive list of materials, equipment and toys appropriate for preadolescent groups. During the 16 session intervention, counselors used reflections and responses characteristic of a child-centered approach, as evidenced by adherence to the GAPT protocol (Appendix G) and the GAPTSC (Appendix F). The protocol is briefly summarized as follows:

Session 1. The first session focused on group members developing a sense of comfort and safety by first introducing participants to the playroom, followed by allowing participants time to explore the playroom and materials and to connect with the counselor and other group members.

Session 2 through 6. The next five sessions followed the format described by Ojiambo and Bratton (2014). Semi-structured activities were presented as needed (approximately 20 minutes) followed by time for group directed/self-directed activities (approximately 20 minutes) and ending with sharing and closure of activities (approximately 10 minutes). Semi-structured activities were be offered with the purpose of “(a) facilitating psychological contact, (b) releasing preadolescents’ inner-directed and constructive potential for growth, and (c) encouraging preadolescents’ expression of unique, personal-social-cultural experiences” (Ojiambo & Bratton, 2014, p. 359). Furthermore, semi-structured activities were offered for the purpose of reducing anxiety within group members, creating an atmosphere of safety, providing opportunities for group members to connect and form relationships, and introducing members to expressive art materials. Because self-directed activities are at the heart of a child-centered approach, group members were free to decide on their participation in activities as well as change the course and process at any time (Ojiambo & Bratton, 2014; Bratton, Dillman Taylor, & Akay, 2014).
Packman and Bratton (2003) suggested additional benefits of self-directed activity as providing preadolescents with opportunities to understand themselves and others, problem-solve, make decisions, learn self-control, and develop internal resources that can serve as a protective factor after the group has ended.

Sessions 7 through 16. Similar to Ojiambo and Bratton’s (2014) findings, the preadolescents needed less structure over the next 10 sessions. Once participants felt a sense of safety and acceptance within the group and were more comfortable with materials, they required less structure and reliance on the therapist. Thus, during the final 10 weeks of intervention, participants spent more time in group directed and self-directed activity. However, the format was determined by the needs of the group members. Ojiambo and Bratton reported that, in their study, by Session 7 participants no longer required therapist-offered activities to engage in the therapeutic process. However, in the present study, from time to time, some group members would request an activity from the counselor. GAPT provides flexibility to consider the individual and collective needs of group members, while also allowing for self-directed and group directed activities as they naturally occur. One example of an activity that was therapist offered emerged in Session 10 with a group of fifth grade girls. The girls brought up concerns about transitioning to middle school the next fall, but they were having difficulty expressing their thoughts and feelings, particularly regarding fears around making new friends. The counselor suggested that they might use the miniature figures or puppets to illustrate their thoughts and concerns. As a group, the girls decided to use the figures and sandtray to create a scene depicting the first day of middle school. Sandtray was an activity that the counselor had introduced to group members in Session 3. With minimal suggestion from the counselor, they were able to draw on their experience and comfort level with the medium to creatively use the medium to
express their present concerns.

The GAPT intervention was provided by two advanced doctoral level female counselors trained in child-centered play therapy (CCPT). Prior to the study, additional training was provided regarding the GAPT protocol as well as the developmental needs of preadolescent females. According to Garcia, Lindgren, and Pintor (2011), knowledge of preadolescent females’ physical, social, emotional, psychological, and spiritual development is important when facilitating a group in order to establish an environment of acceptance, empathic understanding, and safety. To guarantee treatment fidelity to the GAPT protocol and for the purpose of weekly supervision, I video recorded all sessions and retained recordings for the duration of the study. For the purpose of treatment fidelity checks, 10% of session videos were randomly selected for viewing by an expert in the GAPT protocol who used the Group Activity Play Therapy Skill Checklist (GAPTSC; Bratton, 2011; Appendix G) to verify protocol adherence. Sessions were equally drawn from the two GAPT therapists and sessions were reviewed in their entirety. Sessions adhered to the GAPT protocol with an average of 93% adherence to protocol per session across two facilitators.

Control Condition: S.S.GRIN

During the study, the 14 control group participants received the S.S. GRIN intervention. S.S. GRIN was originally designed to be implemented for 10 weeks for 60 minutes per session, but allows for extending sessions to fit time format and cover all content. Due to school schedule, participants in the S.S. GRIN condition participated in an average of 13 sessions, once per week for 13 weeks for 45 minutes per session. Sessions were conducted in a room at the school following recommendations for space and materials as outlined in S.S. GRIN protocol.
Per protocol, the group leader followed the manual with session scripts and instructions for each session. Leaders are encouraged to alter the script in order to personalize the information towards the participants; however, text is bolded for “recommended verbatim material” (DeRosier, 2007, p. 63).

Sessions are highly structured and address specific social and self-esteem issues including respect, positive role models, taking responsibility, communicating, point of view, friendship, cooperation, and feelings. Participants are provided workbooks that they bring each week to session. Workbooks include session material and content for each week.

During the first session, the group leader discussed confidentiality, presented the group rules, and encouraged members to join in the development of group rules. The group leader also explained the S.S.GRIN reward system. Weekly, the group leader followed session guidelines by beginning each session with a review of the previous session’s content. The group leader would then introduce the next prosocial skill or topic as provided by the curriculum.

Participants were given stickers each week they brought their workbook as well as a ticket to place in the ticket board. Participants could lose tickets for not following the group rules or misbehavior but could have the opportunity to earn back their tickets throughout the remainder of the session. Small prizes were given at the end of each session if all members were able to keep their tickets. Moreover, larger and medium prizes were given at the end of the program if participants kept most or all of their tickets (e.g. 10 tickets = one large prize/two medium prizes; 6-9 tickets = one medium prize).

The S.S.GRIN intervention was provided by one advanced master’s level female student counselor who was certified in the S.S.GRIN protocol and participated in training regarding the needs of preadolescent females. To guarantee treatment fidelity to the S.S.GRIN protocol and for
the purpose of weekly supervision, the counselor video recorded all sessions and retained recordings for the duration of the study. For the purpose of treatment fidelity checks, 10% of videos were randomly selected for viewing by a practitioner trained in the S.S.GRIN protocol who utilized the S.S.GRIN manual to verify protocol adherence. Sessions were reviewed in their entirety. Sessions adhered to the S.S.GRIN an average of 100% adherence to protocol per session.

Data Collection

Teachers and participants completed the TRS and SPPC, respectively, prior to the study. I was available to teachers and children during the collection of data to answer any questions. To ensure integrity of data collection, teachers were given the option to complete assessments in a setting free from distraction. Participants were also provided a setting free from distraction in order to complete the SPPC. The TRS and SPPC was collected at midpoint testing and again immediately following the intervention following the same procedures for pretest. To maintain confidentiality, all assessments, client notes, and identifying information were coded numerically then stored in a locked filing cabinet in the faculty supervisor’s office area.

Data Analysis

For each dependent variable, I analyzed the data in SPSS using a 2 (group) by 3 (repeated measures) ANOVA to determine if the GAPT and control groups changed differently across time. I also examined the data in SPSS to ensure the data met assumptions for sphericity, normality, and homogeneity of variance for conducting repeated measures ANOVA. In the analysis, the independent variable was treatment group type (experimental/control) and the
dependent variables were scores on the SPPC Global Self-Worth, and TRS Scholastic and Social scales. An alpha level of .05 was established to test for significant mean differences (Thompson, 2002). Partial eta squared effect size ($\eta^2$) was calculated as an indicator of the magnitude of the difference between the two groups due to treatment. I followed Cohen’s (1988) guidelines to interpret effect sizes as .01 = small effect; .06 = moderate effect; .14 = large effect.

Results

To answer the research question, “Will GAPT increase the self-esteem of preadolescent females identified as having low self-esteem when compared to S.S.GRIN?,” I conducted repeated measures ANOVAs on the dependent variables, SPPC Global Self-Worth, TRS Scholastic, and TRS Social to analyze group differences, changes across times, and the possible interaction effect of group membership with change across time, which was the primary focus of this study.

Child Self-Report: SPCC Global Self-Worth

Table 1 presents pre, mid, and posttest means and standard deviations for the experimental and control group on the Global Self-Worth subscale of the SPCC. An increase in scores on the SPPC indicated improvement in self-esteem.

Results for the repeated measures ANOVA indicated that the dependent variable, SPPC Global Self-Worth, revealed a statistically significant interaction effect of Time (pretest, midpoint, and posttest) X Treatment Group (experimental, comparison), $F(2, 52)= 3.214$, $p=.048$ (partial $\eta^2=.110$) in favor the GAPT intervention. Findings indicate that GAPT demonstrated a moderate to large treatment effect on children’s self-reported self-esteem when compared to the
control group. Additionally, the results indicated a statistically significant main effect for time, $F(2, 52)= 9.487, p<.000$ (partial $\eta^2= .267$) indicating that when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in self-esteem overtime.

Table 1

*Mean Scores on the Global Self-Worth scale of the SPPC*

<table>
<thead>
<tr>
<th>SPPC Global Self-Worth</th>
<th>Experimental GAPT ($n=15$)</th>
<th>Control S.S.GRIN ($n=13$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Mid</td>
</tr>
<tr>
<td>$M$</td>
<td>2.90</td>
<td>3.33</td>
</tr>
<tr>
<td>$SD$</td>
<td>.93</td>
<td>.79</td>
</tr>
</tbody>
</table>

*Note.* One child in the control group was not available for posttesting due to extended illness at the end of the study, thus 28 children were included in this analysis.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within group performance. Results of the one-way ANOVA for the GAPT group indicated that GAPT demonstrated statistically significant improvement in self-esteem from pre to mid to post test; $p< .001$, partial $\eta^2 = .456$, and the treatment effect was large. Results of the one-way ANOVA for the S.S.GRIN treatment group did not reveal a statistically significant improvement from pre to mid to post test; $p=.112$, partial $\eta^2 = .167$; yet, the treatment effect was large. Although the effect size for both conditions are considered large, the treatment effect for GAPT is almost three times as great as for S.S.GRIN. A visual analysis of the graph of the mean scores for the GAPT and S.S.GRIN treatment groups on the SPPC (see Figure 1) supports the greater improvement of the GAPT intervention over the
S.S.GRIN condition.

Figure 1. Mean scores for SPPC Global Self-Worth Scale from pre to mid to post test.

Teacher Report: TRS Scholastic and Social

Teacher report of perception of participants’ self-esteem was measured by the TRS Scholastic and Social subscales. Tables 2 and 3 present the pretest, midpoint, posttest means and standard deviations for the experimental and control group on the Scholastic subscale and the Social subscale of the TRS, respectively.

TRS Scholastic. Results for the repeated measures ANOVA indicated that the dependent variable, TRS Scholastic, did not reveal a statistically significant interaction effect of Time (pretest, midpoint, and posttest) X Treatment Group (experimental, comparison), $F(2, 54)=.469$, $p=.628$ (partial $\eta^2 = .017$) and the treatment effect was small. These results indicated that according to teacher report, children who participated in the experimental group (GAPT) did not
demonstrate a statistically significant increase in scores on the TRS Scholastic overtime when compared to children who participated in S.S.GRIN.

Table 2

Mean Scores for TRS Scholastic

<table>
<thead>
<tr>
<th>TRS Scholastic</th>
<th>Experimental GAPT (n = 15)</th>
<th>Control S.S.GRIN (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Mid</td>
</tr>
<tr>
<td>M</td>
<td>2.22</td>
<td>2.64</td>
</tr>
<tr>
<td>SD</td>
<td>.73</td>
<td>.84</td>
</tr>
</tbody>
</table>

Additionally, the results indicated a statistically significant main effect for time, \(F(2, 54)= 7.006, p<.002\) (partial \(\eta^2 = .206\)). These results indicate that when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in self-esteem from pre, to mid, to post test.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within group performance. Results of the one-way ANOVA for the GAPT treatment group indicated that GAPT demonstrated a statistically significant improvement in self-esteem from pre to mid to posttest; \(p= .011\), partial \(\eta^2 = .278\), and the effect size was large. Results of the one-way ANOVA for the S.S.GRIN condition did not reveal a statistically significant difference from pre to mid to posttest; \(p=.149\), partial \(\eta^2 = .136\), yet the effect size was large. Although the effect size for both conditions are considered large, the treatment effect for GAPT is twice as large as for S.S.GRIN. A visual analysis of the graph of the mean scores for the GAPT and S.S.GRIN treatment groups on the TRS Scholastic (see Figure 2) supports the greater improvement of the GAPT intervention over the S.S.GRIN condition.
Table 3

Mean Scores for the TRS Social

<table>
<thead>
<tr>
<th>TRS Social</th>
<th>Experimental GAPT (n = 15)</th>
<th>Control S.S.GRN (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Mid</td>
</tr>
<tr>
<td>M</td>
<td>3.03</td>
<td>2.97</td>
</tr>
<tr>
<td>SD</td>
<td>.54</td>
<td>.55</td>
</tr>
</tbody>
</table>

TRS Social. Results for the repeated measures ANOVA indicated that the dependent variable, TRS Social, was not statistically significant for the interaction effect of Time (pretest, midpoint, and posttest) X Treatment Group (experimental, comparison), $F(2, 54)=.712, p=.495$ (partial $\eta^2 = .026$). These results indicated that according to teacher report, children who participated in the experimental group (GAPT) did not demonstrate a statistically significant increase in TRS Social scores from pre to mid to post test, when compared to children who were
in the S.S.GRIN comparison group. Effect size calculation indicates that when compared to SSGRIN, the GAPT group demonstrated a small treatment effect. Additionally, the results from the repeated measures split-plot ANOVA indicate a statistically significant main effect for time, $F(2, 54)=5.210, p<.009$ (partial $\eta^2= .162$). These results indicate that when participants from the experimental and control conditions were grouped together, participants demonstrated a statistically significant improvement in self-esteem from pre to mid to post test.

![Estimated Marginal Means of TRF_SOCIAL](image)

**Figure 3.** Mean scores for TRS Social Scale.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within group performance. Results of the one-way ANOVA for the GAPT treatment group did not reveal a statistically significant difference from pre to mid to post test; $p=.064$, partial $\eta^2= .178$; yet, the treatment effect was large. Results of the one-way ANOVA for the S.S.GRIN group did not reveal a statistically significant
difference from pre to mid to posttest; \( p=.073 \), partial \( \eta^2 = .182 \); yet, the treatment effect was also large. Although a visual analysis of the graph of the mean scores for the GAPT and S.S.GRIN treatment groups on the TRS Social (see Figure 3) appear to support the greater improvement of the GAPT intervention over the S.S.GRIN condition from pre to post treatment, effect size calculations indicate that both interventions accounted for approximately the same amount of the explained variance in the dependent variable that can be attributed to intervention.

Discussion

Low self-esteem is often at the root of psychological problems for preadolescents who naturally compare themselves to their peers as they strive to fit in (Akos, Ham, Mack, & Dunaway, 2007) and is associated with long term negative consequences if not addressed when symptoms first emerge (Van Den Bergh & Marcoen, 1999; Steese et al., 2006; Trzensniewski et al., 2006). Research supports that, as early as elementary school, females are more likely to suffer from low self-worth than their male counterparts (Norwood, Murray, Nolan & Bowker, 2011; Birndorf, Ryan, Auinger, & Aten, 2005); thus female preadolescents are potentially at greater risk for developing mental health issues stemming from poor self-image. The statistical and practical significance of the present study’s findings support GAPT as a promising counseling intervention to improve self-esteem in preadolescent females. Compared to the control condition, GAPT demonstrated statistically significant and moderate to large treatment effects on improving students’ self-perception of their self-worth. Teacher report of their perception of the pre-teens’ self-esteem specific to scholastic and social competence was less conclusive.
Child Self-Report

Children who received GAPT reported a statistically and practically significant increase in self-esteem compared to those who received SSGRIN. In addition, effect sizes for within group change from pre to post indicated that the preadolescents participating in GAPT demonstrated three times as much improvement as the participants in SSGRIN. These results are consistent with the GAPT research literature regarding the use and impact of group activity/play-based interventions with preadolescents (Ojiambo & Bratton, 2014; Flahive & Ray, 2007; Packman & Bratton, 2003). Although no previous GAPT studies focused on self-esteem, the present findings were comparable to results from CCPT research in which CCPT demonstrated a statistically significant improvement in self-esteem (Baggerly, 2004; Smith & Landreth, 2003; Post, 1999; Kot, S., Landreth, & Giordano, 1998).

Several components of the study could have contributed to GAPT’s moderate to large treatment effect on participants’ self-esteem. First, GAPT is a developmentally responsive intervention as it incorporates toys and materials appropriate for preadolescents. The provision of materials and activities that met the maturational needs and preferences of this age group may have allowed the participants to communicate their thoughts, experiences and needs more fully.

Second, theoretical approach may have contributed to the significant improvement in the experimental group. Consistent with person-centered theory, the GAPT experience provides “an atmosphere of permissiveness and acceptance” along with a therapist who genuinely cares for and accepts the child for who she is and believes the child is capable (Landreth, 2012, p. 58). An environment in which children are accepted allows them to explore their own capabilities and create a belief in themselves (Green & Kolos, 2010; Landreth, 2012). Children who exhibit behaviors of low self-esteem may perceive themselves as incompetent based on the evaluations
and reactions of significant others (Landreth, 2012). Through the attitudinal qualities of empathic understanding, unconditional acceptance and congruence provided by the GAPT therapist, children may have been able to “internalize…and recognize areas of competence…” and “…begin to accept themselves” (Green & Kolos, 2010, p.53).

Additionally, the group component of this experience allows for children to learn about and explore interactions with others and develop interpersonal skills. This is important as preadolescent females place a great importance on peer relationships (Anderson & Choate, 2008) and on the opinions and judgments of their peers (Paoene et al., 2008). Preadolescent females need to feel accepted and safe in order to establish significant relationships (Paoene et al., 2008) and the GAPT experience can provide that opportunity. These results suggest that GAPT may be an important intervention to consider when working with preadolescent females as participants are able to connect to one another as they share their concerns (Calhoun et al., 2005).

It is also important to note the success of GAPT in 45 to 50 minutes instead of the 1.5 hour format recommended by earlier proponents (Bratton et al., 1999; Bratton et al., 2009; Slavson & Redl, 1944; Schiffer, 1969). These findings along with the findings from school based studies by Ojiambo and Bratton (2014) and Packman and Bratton (2003) suggest that GAPT can be effectively conducted within time and constraints present in most settings particularly in schools.

Teacher Report

Overall, teacher report of children’s increase in self-esteem was mixed and indicated that teachers viewed both groups as improved overtime, with greater improvement for the GAPT group on Scholastic Competence and similar improvement for GAPT and SSGRIN on Social
Competence. For Scholastic Competence, the treatment effect for within group change indicated that the treatment effect was twice as large for GAPT than for SSGRIN. For Social Competence, the treatment effect for within group change indicated that the treatment effect was similar between both groups.

Although teachers reported observable change in students’ self-esteem specific to scholastic and social competencies, the results indicated that teachers did not observe as much change as the participants self-reported on their overall sense of self-worth. This could be attributed to the difficulty in assessing self-esteem of others. Harter (2006) suggested that self-esteem is an internal evaluation of self and that preadolescents are able to recognize their strengths and are capable of self-evaluations. It is plausible that the preadolescents in this study experienced greater improvement in their perceptions of self-worth before teachers were able to observe the same level of change.

**Teacher Anecdotal Data**

During informal teacher consultations, teachers of children from both GAPT and SSGRIN reported improvement in grades, increased confidence, better interpersonal skills, and better ability to regulate emotions. Teachers also requested that the groups be held annually as they reported the groups as being beneficial for their students.

**Limitations and Recommendations for Research**

Limitations to this study exist and should be considered before interpreting results. First, generalization of results is limited to preadolescent children in the participating sites. The small sample size may have contributed to the lack of statistically significant interaction effects on
teacher variables. The use of a larger sample size and replication of the study in multiple sites are needed to strengthen reliability, increase confidence in the present findings, and establish GAPT as an evidence-based treatment.

A further limitation is that it is possible that factors and stressors other than low self-esteem may influence participants’ perception of themselves and could skew assessment results. For example, the intervention was administered during a time in the school semester where participants were preparing for state-wide testing that assessed for academic performance. However, the use of randomized assignment to groups was designed to control for such extraneous factors. Although consistent with the respective protocols, participants in the GAPT experimental group received treatment for a longer duration (n= 16 weeks) compared to the SSGRIN comparison group (n= 13 weeks).

Additional limitations include the lack of additional sources of measurement such as parents and independent raters. However, as noted previously, self-esteem may be a difficult construct to observe and measure by others. Another limitation of this study could be the use of children’s self-report. As participants became familiar with the assessment items they may have been inclined to choose socially acceptable answers thus interfering with study findings.

Implications for Practice

The findings from the present study hold particular implications for school-based mental health professionals. The results support that GAPT can be successfully and effectively applied to the school setting. Providing interventions such as GAPT in schools potentially allows all children suffering from low self-esteem to get the help they need. In addition, the group format of GAPT allows counselors to serve more children than traditional individual counseling. Due to
the importance preteens place on peer relationships, the group component of GAPT may be especially suited to this population. Preteens can be afforded an opportunity to develop self and social competencies including the development of healthy peer relationships and the acquisition of prosocial communication skills (Bratton et al., 2009; Ojjiamo & Bratton, 2014; Packman & Bratton, 2003).

Conclusion

Positive self-worth is viewed as a significant factor to individuals’ holistic development across the lifespan (Harter, 2012); whereas low self-esteem can negatively impair daily and long-term functioning (Acarturk et al., 2009). Preadolescent females are more prone to negative self-perception (Norwood et al., 2011) and thus at greater risk of developing mental health problems stemming from low self-image. GAPT provides a developmental responsive intervention that allows for early treatment at a time when preadolescent females are vulnerable to low self-image as they begin to compare themselves to others. Early intervention serves a protective factor against the onset of more severe and potentially costly behaviors across a child’s lifetime such as depression, eating disorders, suicidal ideation, substance abuse and other behavioral issues (Van Den Bergh & Marcoen, 1999; Steese et al., 2006; Trensniewski et al., 2006). Findings from the present study demonstrate the beneficial effects of school-based GAPT on the self-esteem of preadolescent females, and provide further support for existing research on the use of GAPT with preadolescents as an effective and developmentally appropriate modality. Furthermore, study findings have the potential to inform mental health practitioners who work with this population regarding best practices for helping preadolescent females create a healthy self-image and develop more satisfying peer relationships.
References


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APPENDIX A

EXPANDED LITERATURE REVIEW
Self-Esteem

Self-esteem has been a construct of interest to mental health professionals and educators for over a century. James (1890) and Cooley (1902) were among the first to define self-esteem. James (1890) described self-esteem as a relationship between individuals’ ambitions for themselves and their ability to meet goals successfully. James concluded that if individuals are able to meet their goals successfully, then they are likely to have higher self-esteem. However, Cooley (1902) viewed self-esteem as socially influenced by the opinions and perceptions of others important to the individual. Contemporary theorists have taken a more holistic perspective in defining the construct. According to Steiger et al. (2014), self-esteem is defined as “an individual’s global evaluation of his or her overall worth as a person” (p. 325). Rosenberg (1979) stated that an individual with high self-esteem is “fundamentally satisfied with the type of person he is, yet he may acknowledge his faults while hoping to overcome them” (p. 31).

Within the field of mental health, self-esteem is viewed as a significant factor to individuals’ holistic development across the lifespan. Berk (2003) proposed that self-esteem is the most important facet of self-development as evaluations of one’s competencies can influence overall psychological adjustment. Contemporary research supports this idea, with results consistently showing a relationship between individuals’ level of self-esteem and their mental health and well-being (Birndorf, Ryan, Auinger, & Aten, 2005; DuBois and Tevendale, 1999; Steese et al., 2006; Steiger, Steiger, Allemand, Robins, & Fend, 2014; Van Den Bergh & Marcoen, 1999).

High self-esteem is typically related to healthier coping skills and a decrease in the prevalence of depression among children and adults (Birndorf, Ryan, Auinger, & Aten, 2005). Individuals with high self-esteem likely evaluate themselves realistically in addition to accepting
and respecting themselves (Berk, 2003). Longitudinal studies have shown that individuals with higher levels of self-esteem were more likely to demonstrate positive mood, healthier coping skills, academic achievement, and an overall positive sense of self (DuBois & Tevendale, 1999).

Conversely, compared to the general population, children and adolescents presenting with low self-esteem are more susceptible to bullying and teasing (Kutob, Senf, Crago, & Shisslak, 2010), and are at greater risk of developing a range of concerns across their lifespan including depression, anxiety, suicide ideation, eating disorders, substance abuse (Van Den Bergh & Marcoen, 1999; Steese et al., 2006). In extreme cases, low self-esteem can lead “to a demoralizing cycle that culminates in violent behavior” (Crenshaw & Lee, 2010, p. 143).

Because of potential severity of symptoms, the American Psychiatric Association included aspects of low self-esteem as diagnostic criterion for some mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, DSM-V (Frey, 2014) including personality disorders such as borderline, avoidant, and depressive personality. Although many individuals with low self-esteem fail to exhibit symptoms that warrant a diagnosis, their daily functioning may be significantly impacted. For example, individuals with low self-esteem are prone to develop social anxiety and have difficulty forming satisfying relationships (Acarturk et al., 2009). Steiger et al. (2014) concluded from a review of several theories regarding the association between depression and self-esteem that individuals with more negative self-perception are more likely to develop depressive symptoms when compared to individuals who do not report low self-esteem. Steiger et al. (2014) proposed that individuals with low self-esteem might be less likely to seek positive feedback from their peers thus reinforcing negative thoughts regarding their self-worth.
Development of Self-Esteem

Children begin to form self-evaluations around the ages of 6 and 7 (Berk, 2013). As children develop, self-esteem becomes more complex as it is not a fixed characteristic (Berk, 2003; Frey, 2014). According to Berk (2013) “the structure of self-esteem depends on evaluative information available to children and their ability to process that information” (p. 461). Harter (2012) identified four domains of self-evaluation, i.e. academic competence, social competence, physical/athletic competence, and physical appearance that children incorporate into their overall self-esteem. Berk (2013) supported Harter’s view of multiple domains of self-esteem and proposed that children place greater importance on certain areas of self-evaluation over others. Similarly, Klomsten, Skaalvik, and Espenes (2004) found that children tend to place greater importance on physical appearance and that their evaluation of their appearance is closely associated with global self-esteem.

Self-esteem tends to decline during late elementary school years as children begin to receive additional feedback regarding their abilities (Berk, 2013). The cognitive limitations present in early and middle childhood are often what shield children from perceiving themselves more negatively and therefore allows for a higher self-esteem. However, as children advance both cognitively and socially, awareness of capabilities begin to emerge (Harter, 2006). Harter (2006) explained that the cognitive and social advances that occur in middle childhood make preadolescent children become more aware of themselves and their abilities and how those abilities may differ from others. More specifically stated, “a child’s new-found capacity to utilize social comparison, for the purpose of self-evaluation, will mean that the vast majority who cannot be at the top of the ladder of success will experience lower self-esteem” (Harter, 2006, p. 146). Furthermore, the child may perceive she is not valued by significant people once she
begins to have the ability to perceive others’ opinions and evaluations of her. If she internalizes these opinions or beliefs, she can develop low self-regard (Landreth, 2012; Wilkins, 2010).

Needs of Preadolescent Females

A review of the literature suggests differences exist among boys and girls regarding development of self-esteem (Bologini, Plancherel, Bettschart, & Halfon, 1996). Research shows that, beginning as early as elementary school, females are more likely to suffer from low self-esteem than males (Norwood et al., 2011; Birndorf et al., 2005). Females are more vulnerable to experiencing negative self-perceptions due to their tendency to internalize their experiences. Because of the importance preteen females place on peer relationships (Anderson & Choate, 2008) and on the opinions and judgments of their peers, they need to feel accepted and safe in order to establish significant relationships (Paoene, Mallott, & Maldonado, 2008). Establishing close peer relationships “are essential processes that influence all aspects of female identity, self-concept, and psychological health” (Calhoun, Bartolomucci, & McLean, 2005, p. 18). Females connect by sharing their concerns and struggles with each other through a reciprocal process of support and empathic understanding (Letendre & Williams, 2014). Thus, the social needs and preferences of preadolescent females make group interventions especially appropriate for this population.

Group Activity Play Therapy

Grounded in child-centered play therapy (CCPT) principles, group activity play therapy (GAPT) is a developmentally appropriate intervention for counseling preadolescents (Ojiambo & Bratton, 2014). CCPT (Landreth, 2012; Axline, 1947) is based on the person-centered theory of Carl Rogers (1951). Consistent with person-centered philosophy, the CCPT therapist believes children have the ability to direct their growth given their experience of the freedom to be
themselves in the therapeutic relationship (Landreth, 2012, p. 53). A therapeutic relationship characterized by genuineness, empathic understanding, and unconditional positive regard is considered the mechanism for change (Bratton, Ray, Edwards, & Landreth, 2009; Raskin & Rogers, 2005). It is through this type of relationship that the child is able to explore past experiences that are incongruent with the self-structure and begin to internalize new experiences that can facilitate a more congruent sense of self (Ojiambo & Bratton, 2014; Landreth, 2012; Ray 2011;).

The development of humanistically-oriented group activity therapy approaches grew out of a realization that traditional non-directive play therapy procedures and materials may be viewed by preadolescents as childish and undesirable for their developmental needs and preferences (Redl & Slavson, 1944; Ginott, 1961). Activity therapy addresses the needs of preadolescents by incorporating materials, equipment and activities that are tailored specifically for this age group (Bratton, Ceballos, & Ferebee, 2009; Bratton & Ferebee, 1999). Additionally, Rubin (1984) discussed the therapeutic benefit of incorporating expressive media for preadolescents as using this type of media can aid in symbolic expression. Although Slavson and Redl (1944) did not identify as child-centered therapists, they adhered to a non-directive, humanistic framework to allow members to express themselves freely through self-directed activity. Within the past decade, researchers and practitioners have shown a renewed interest in the activity group format proposed by Slavson and Redl to apply humanistic and CCPT principles to counseling preadolescents (Bratton, Dillman Taylor, Akay, 2014; Ojiambo & Bratton, 2014; Bratton et al., 2009; Paoene et al., 2008; Shen & Armstrong, 2008; Flahive & Ray, 2007; Packman & Bratton, 2003). The term, Group Activity Play Therapy (GAPT) was
coined by Ojiambo and Bratton (2014) to reflect their child-centered group activity play therapy protocol (Appendix G) as a distinct modality for preadolescents.

Although research is limited, a handful of well-designed, controlled outcome studies have demonstrated the beneficial effects of applying group CCPT and humanistic frameworks to treat preadolescents presenting with social-emotional and behavioral difficulties. In a randomized controlled study, Packman and Bratton (2003) utilized a school-based, humanistic group play/activity therapy model for 30 preadolescents with learning disabilities who presented with behavioral concerns. The researchers found a statistically significant overall reduction in problematic behaviors in the classroom and moderate to large treatment effects. For the purpose of the intervention, participants were placed in groups of three to four based on their individual needs and personality characteristics. Packman and Bratton followed CCPT principles and procedures based on their belief in the importance of the therapeutic relationship in facilitating change within individuals and the capacity for preadolescents to self-direct their growth. They found that through self-directed and therapist-facilitated activities, participants were able to form mutually satisfying relationships and work together as a group as they developed self-control through testing limits and experiencing others’ perceptions of their behaviors.

Ojiambo and Bratton (2014) conducted a randomized, controlled study based on the protocol used in Packman and Bratton (2003) and named the treatment model Group Activity Play Therapy (GAPT). The researchers examined the effectiveness of GAPT with 60 displaced Ugandan orphans, aged 10 to 12 years, exhibiting clinical levels of behavior problems. Teachers and housemothers, blinded to participant group assignment, reported that experimental group children demonstrated statistically significant reductions (p <.025) in externalizing and internalizing behavior problems compared to the active control (Reading Mentoring). GAPT
demonstrated moderate to large treatment effects on all outcomes. The results of this study are especially promising because of the consistency of findings from two sources of measurement for each outcome variable and the use of procedures to blind assessors to the study.

In another randomized, controlled study, Flahive and Ray (2007) investigated the effectiveness of a 10 week, humanistically-oriented play-based counseling group utilizing sandtray media with 56 preadolescents identified by parents or teachers as exhibiting behavioral problems. Flahive and Ray, guided by general CCPT principles, allowed an unstructured period for group members to make their sandtray scenes followed by time for processing their creations. Results from teacher report revealed statistically significant differences in total, externalizing, and internalizing problems between the sandtray group and control group over time, while parents reported statistically significant differences only on externalizing problems. The group sandtray intervention demonstrated moderate treatment effects on all outcome variables. Of note, the results reflected worsening of the control group over the 10 week treatment period, while the experimental group showed small improvements or stayed the same. The authors concluded that the intervention was effective in preventing participants from experiencing an increase in behavioral problems.

Social Skills Group Intervention

Peer relationships can have a great impact on a child’s social, emotional, and academic functioning in addition to negatively affecting a child’s self-esteem (DeRosier, 2004). In an effort to reduce these types of problems, DeRosier (2007) developed S.S.GRIN. Established in 1996, Social Skills Group Intervention (S.S.GRIN) is a highly structured curriculum for children struggling in peer relationships (DeRosier, 2004) and is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidenced based program (National
Registry for Evidenced-based Programs and Practices, 2011). S.S.GRIN was derived from a variety of scientifically supported programs that demonstrated “social learning and cognitive-behavioral perspectives and incorporates techniques and strategies, as well as methods of teaching, that have been deemed effective for improving children’s peer relationships and behavior” (DeRosier, 2007a, p.2). In particular, DeRosier (2007) created the curriculum to address specific skills that could be generalized across a variety of social problems. The goals of SSGRIN are to “(1) build basic behavioral and cognitive social skills, (2) reinforce prosocial attitudes and character traits, and (3) build adaptive coping strategies for social problems, such as teasing or isolation” (DeRosier, 2007, p. 262). Social skills outlined in the curriculum include: communication, cooperation, respect, responsibility, empathy, and self-control (DeRosier, 2007a). Topics such as bullying, teasing, and negative self-assumptions are also discussed in group sessions.

DeRosier (2004) conducted a longitudinal study that tracked “the peer relationships and school-based adjustment of children from third through fifth grades” (p. 196). In order to evaluate the curriculum, children identified as being “highly disliked, socially anxious, and bullied…” were deemed eligible for receiving treatment (p. 196). 187 third grade children were randomly assigned to the treatment group and the remaining 194 children were assigned to a no-treatment control group. Children that participated in the treatment group demonstrated “greater peer liking” and “…enhanced self-esteem, greater social-efficacy, and lower social anxiety over time” (p. 199). The researcher also found that children that were assigned to be in the control group demonstrated poorer self-esteem and more negative views of their ability to connect with others (p. 199).
DeRosier and Marcus (2005) conducted a 1 year follow-up to the previous study. They found that children in the treatment group “showed more positive functioning” and were “significantly less disliked by peers and less aggressive with peers at follow-up” (p. 145). The researchers also found group differences between gender as “TX girls showed more positive adjustment in the areas of peer-liking, aggression, victimization, self-efficacy, and social withdrawal” (p. 148). Moreover, children considered aggressive in the treatment group performed better than those in the control group.

As part of Safe Schools/Healthy Students Initiative, DeRosier (2007) recruited 943 fourth grade students to participate in the SSGRIN. Out of 943 students, 139 students were identified as having peer problems through results obtained from a confidential peer-nomination technique that allowed students to nominate peers based on specific criteria thus being eligible to participate in the SSGRIN. (DeRosier, 2007, p. 261). Students that participated in SSGRIN received more positive reports from their peers and were “less aggressive to peers and were less picked on or bullied by peers” (p. 228.) Additionally, students that received the treatment demonstrated an increase in social motivation and a decrease in problems related to social anxiety and depression (p. 270).

Bostick and Anderson (2009) conducted a study in which they examined the effectiveness of SSGRIN for forty-nine third grade students identified as having social skill deficits. The researchers provided the groups over the span of 3 years. After completing the intervention, statistical results indicated students reported feeling less anxious regarding their relationships and demonstrated improved academic performance.

DeRosier, Swick, Davis, McMillen, and Matthews (2010) conducted a study comparing the SSGRIN with an adapted version of the SSGRIN (SSGRIN –HFA) for children with high
functioning autism spectrum disorders. The researchers adapted this curriculum to have 15 sessions and “address the specific social deficits of children with high functioning ASD” (p. 1043). Fifty-five students were recruited for this study with ages falling between 8 to 12 years old. Parents of the participants were also included in the study and participated in four parent-child sessions to assist the child throughout their progress. Statistical results of this study indicated that participants significantly improved in social skills and social awareness.
APPENDIX B

EXTENDED METHODOLOGY
I utilized a randomized control group design with two treatment conditions (experimental/comparison) and three points of measure (pretest/midtest/posttest) to examine the effectiveness of GAPT compared with an established curriculum-based group intervention, SSGRIN with fourth and fifth grade females exhibiting low self-esteem. Included in this chapter is the research question, definition of terms, instrumentation, participant selection, procedures, and data analysis.

Research Question

The purpose of the study was to examine the effects of school-based Group Activity Play Therapy (GAPT) on self-esteem of preadolescent females. This comparison study addressed one primary research question: Does GAPT improve self-esteem in preadolescent females compared to a control group over time?

Definition of Terms

*Self-Esteem* refers to one’s overall negative or positive global evaluation of him or herself (James, 1890; Harter, 2012). In the current study, self-esteem was operationalized as the global self-concept score on the child self-assessment of the Self Perception Profile for Children (Harter, 1985).

*Preadolescence* refers to a period of time in development between the ages of 9 and 12 (Harter, 2012).

*Group Activity Play Therapy (GAPT)* refers to a developmentally appropriate therapeutic small group modality to be used with preadolescents (Bratton, Ceballos, Ferebee, 2009). Activities include free play and the use of expressive arts activities within a group process (Ojiambo & Bratton, 2014). The materials and toys included in GAPT are selected to fit the developmental needs of preadolescent children.
Social Skills Group Intervention (SSGRIN) refers to an evidenced based social skills curriculum to be used with children in grades 3 through 5 (DeRosier, 2002; NREP, 2011). The curriculum is highly structured and teaches coping strategies and covers topics of communication, respect, and building healthy relationships and self-esteem.

Participant Selection and Recruitment

Participants were 9-11 females enrolled in fourth and fifth grade at two Title I elementary schools in the southwest United States referred by teachers and school counselors for low self-esteem and displayed symptoms such as lacking confidence, poor social skills, withdrawal, and showing signs of anxiety or sadness. Criteria for inclusion in this study included the following: (a) Female students were enrolled in 4th and 5th grade; (b) Children were referred by the teacher or school counselor due to exhibiting symptoms of low self-esteem (c) Children understood and spoke English; (d) Parents of children were willing to give consent; (e) Children were willing to give consent (f) Teachers of children were willing to give consent and complete assessments; (g) Children were not receiving other types of mental health services during the study.

A priori power analysis using G*Power software determined that a minimum sample of 28 participants would be necessary to find a statistical difference between groups over three points of measure (pre to mid to post). Based on Cohen’s (1992) recommendations, I set the G*power calculation with an alpha level of .05, a moderate effect size (f=.25), and minimum power at .80. Initially, 30 participants met criteria; however, one child requested to no longer be a part of the study and one child had extended absences and was not available for post testing. Thus, 29 participants completed the study. An inspection of demographics and pre-study data revealed no differences in completion and non-completion. Participants were 38% fourth graders
(n=11) and 62% fifth graders (n=18). Of the 29 participants, 45% identified as Latina, 38% as Caucasian, 14% as African American, and 3% as Asian.

Instrumentation

I utilized two instruments, one teacher report and one child self-report of the same assessment system, to assess the comparative effects of GAPT and SSGRN on the self-esteem of preadolescent females. The Harter Self-Perception Profile for Children (SPPC; Harter, 1985) child self-report was utilized to examine children’s self-perception. For the purposes of this study, the Global Self-Worth subscale is the only scale reported for overall self-esteem. Teacher’s Rating Scale of Children’s Actual Behavior (TRS; Harter, 1985), a companion to the SPPC, was utilized to measure children’s self-esteem as reported by teachers. The TRS does not include a global self-worth scale, and because teacher referrals were primarily for low self-esteem concerns related to social relationships and academic achievement, for the purpose of this study the Scholastic Competence and Social Competence subscales were used to measure teachers’ perceptions of children’s self-esteem.

Harter Self-Perception Profile for Children

The Harter Self-Perception Profile for Children (SPPC, Harter, 1982) was developed to measure children’s perception of self-concept for ages 8 to 15. The SPPC, entitled “What I am like,” is a 36-item, examiner administered questionnaire, comprised of five specific domains (Scholastic Competence, Physical Appearance, Behavioral Conduct, Social Acceptance, and Athletic Competence) and a separate Global Self-Worth subscale. This assessment takes approximately 15-20 minutes to complete per child. The SPPC first asks children to choose between two statements regarding their competence and select which sentence is “most like me”. For example: “Some kids often forget what they learn” but “Other kids can remember things
easily”. Next, children will decide whether the sentence they selected is “really true for me” or “sort of true for me” resulting in a four point scale. Half of the items are reverse worded in order to reduce socially desirable responding as well as the possibility of participants randomly selecting answers. Items are scored such that 1 represents low competency and 4 representing high competency.

The Scholastic Competence subscale measures the child’s perception of his or her competency as applied to schoolwork. The Social Competence subscale measures the child’s perception of his or her competency as having the skills to make friends. The Athletic Competence subscale measures the child’s perception of his or her ability to perform well in sports or athletic games. The Physical Appearance subscale measures the child’s perception of how he or she may feel about their looks, face, body, hair, etc. The Behavioral Conduct subscale measures the child’s perception of his or her behavior and if the child feels as though he or she is acting in ways to avoid being in trouble. The Global Self-Worth subscale is a separate subscale that measures the child’s overall self-esteem. The SPPC also has an importance scale which measures children’s view of the importance of each domain. Harter (1982) reported that the SPPC demonstrates face validity, convergent validity and acceptable reliability using Cronbach’s alphas .71-.84. For the purposes of this study and to answer the research question, only the Global Self-Worth subscale will be used to measure the child’s overall self-esteem.

Teacher’s Rating Scale of Children’s Actual Behavior

Teacher’s Rating Scale of Children’s Actual Behavior (TRS) was developed as a companion to the SPPC to measure the teacher’s perception of the child’s competencies. The TRS, a 15-item questionnaire, is compromised on five scales that mirror the SPPC: Scholastic Competence, Social Competence, Physical Competence, Physical Appearance, and Behavioral
Conduct. Global Self-Worth is not included as the items “do not translate into attributes that an objective observer can rate” (p. 10). Teachers rate children on a scale of one to four with one representing low competency and four representing high competency. The assessment takes 15-20 minutes per child to complete. According to Cole et al. (1996), the TSR demonstrated high levels of internal consistency (r= .93 to .97) and demonstrated good test-retest reliability (r= .67 to .73.).

Procedures

Upon attaining human subject approval from the University of North Texas Internal Review Board and Denton Independent School District, I met with administrators and school counselors of the school to discuss the purpose of the study and identify possible participants. School counselors and teachers were asked to identify children who seemed to exhibit symptoms of low self-esteem such as withdrawal, poor social relationships, anxiety or sadness. Teachers and school counselors made referrals for children they believed could benefit from the intervention provided. Consent forms (see Appendix E) in both Spanish and English were given to parents to sign and return for collection. Teachers also signed consent forms to participate. After I received the consent forms, I obtained assent from the participants.

Next, teachers of the referred preadolescents completed the TRS (Harter, 1985) and the preadolescents were administered the SPPC, entitled “What I am like” (Harter, 1985). Participants were randomly assigned to the experimental group (n=15) or control group (n=14) using a random table of numbers. Treatment participants in the experimental and control group were placed into groups of three to four according to school schedule. Bratton et al. (2009) and Ginott (1994) recommended that participant assigned to treatment groups be no more than one year apart and that they not be classmates. Unfortunately, due to school schedule, I could not
ensure that participants were not classmates as students were only approved to participate in the intervention during specific times which were dictated by their homeroom assignment.

Prior GAPT outcome research using group activity therapy formats in school settings confirmed that favorable medium and large treatment effect sizes were achieved in 16 sessions or fewer (Flahive & Ray, 2007; Packman & Bratton, 2003; Ojiambo & Bratton, 2014). Therefore, in the present study, participants in the GAPT condition participated in an average of 16 sessions, once per week for 45 minutes per session. Consistent with the protocol used by Ojiambo and Bratton (2014), session length was adapted to the school schedule and shortened from a 1.5 hour group activity therapy format as suggested in the literature (Bratton & Ferebee, 1999; Schiffer, 1969; Slavson & Redl, 1944) to 45-50 minutes. Participants in the SSGRIN condition participated in an average of 13 sessions, once per week for 45 minutes. Measures were taken to ensure that teachers, as sources for assessment data, would be blinded to the study: (a) they were not informed of children’s group assignment; (b) all children left the classroom for the same length of time and in the same manner, (c) treatment facilitators for both conditions were instructed to use identical statements when retrieving children from the classroom, “I am here to get Lacy”, and (d) treatment facilitators for both conditions were informed not to discuss the intervention with teachers until the study was completed.

Experimental Condition: GAPT

GAPT, grounded in CCPT theory and procedures (Landreth, 2012), was designed as a developmentally appropriate counseling intervention to meet preadolescents’ unique social, emotional and cognitive needs. Counselors followed to the GAPT protocol (Ojiambo & Bratton, 2014; Ojiambo, 2011) found in Appendix G. The protocol includes unstructured activities as well as semi-structured activities offered by the therapist to facilitate connections among group
members. The GAPT protocol allows flexibility for group members to use materials how they choose (Ojiambo & Bratton, 2014). Consistent with Rogers’ Person-Centered framework, principles influencing the GAPT process include

a) trust in preadolescents’ capacity for positive self-growth, and their ability to set their own goals and work toward their own progress, and b) the significance of the therapeutic relationship in facilitating clients’ released potential for movement toward personal growth and a relationship in which the therapist experiences and communicates genuineness, empathy, and unconditional positive regard (Ojiambo & Bratton, 2014, p. 11).

Sessions were conducted in a specially-equipped room at the school following recommendations for setting up the space and materials as outlined in Packman and Bratton (2003) and Ojiambo and Bratton (2014). Session structure included self-directed and group-directed activities in addition to semi-structured, and as needed, therapist-offered activities. Approximately 10 minutes were designated for group member sharing, closure, and transition back to the classroom. Materials and activities were chosen to meet the developmental needs of preadolescents (Bratton & Ferebee, 1999; Ojiambo & Bratton, 2014; Packman & Bratton, 2003). Appendix H contains the list of materials and toys used by Ojiambo and Bratton. Bratton and Ferebee (1999) provided a comprehensive list of materials, equipment and toys appropriate for preadolescent groups. During the 16 session intervention, counselors used reflections and responses characteristic of a child-centered approach, as evidenced by adherence to the GAPT protocol (Appendix G) and the GAPTSC (Appendix F). The protocol is briefly summarized as follows:
Session 1. The first session focused on group members developing a sense of comfort and safety by first introducing participants to the playroom, followed by allowing participants time to explore the playroom and materials and to connect with the counselor and other group members.

Session 2 through 6. The next five sessions followed the format described by Ojiambo and Bratton (2014). Semi-structured activities were presented as needed (approximately 20 minutes) followed by time for group directed/self-directed activities (approximately 20 minutes) and ending with sharing and closure of activities (approximately 10 minutes). Semi-structured activities were be offered with the purpose of “(a) facilitating psychological contact, (b) releasing preadolescents’ inner-directed and constructive potential for growth, and (c) encouraging preadolescents’ expression of unique, personal-social-cultural experiences” (Ojiambo & Bratton, 2014, p. 359). Furthermore, semi-structured activities were offered for the purpose of reducing anxiety within group members, creating an atmosphere of safety, providing opportunities for group members to connect and form relationships, and introducing members to expressive art materials. Because self-directed activities are at the heart of a child-centered approach, group members were free to decide on their participation in activities as well as change the course and process at any time (Ojiambo & Bratton, 2014; Bratton, Dillman Taylor, & Akay, 2014).

Packman and Bratton (2003) suggested additional benefits of self-directed activity as providing preadolescents with opportunities to understand themselves and others, problem-solve, make decisions, learn self-control, and develop internal resources that can serve as a protective factor after the group has ended.

Sessions 7 through 16. Similar to Ojiambo and Bratton’s (2014) findings, the preadolescents needed less structure over the next 10 sessions. Once participants felt a sense of safety and acceptance within the group and were more comfortable with materials, they required
less structure and reliance on the therapist. Thus, during the final 10 weeks of intervention, participants spent more time in group directed and self-directed activity. However, the format was determined by the needs of the group members. Ojiambo and Bratton reported that, in their study, by Session 7 participants no longer required therapist-offered activities to engage in the therapeutic process. However, in the present study, from time to time, some group members would request an activity from the counselor. GAPT provides flexibility to consider the individual and collective needs of group members, while also allowing for self-directed and group directed activities as they naturally occur. One example of an activity that was therapist offered emerged in Session 10 with a group of fifth grade girls. The girls brought up concerns about transitioning to middle school the next fall, but they were having difficulty expressing their thoughts and feelings, particularly regarding fears around making new friends. The counselor suggested that they might use the miniature figures or puppets to illustrate their thoughts and concerns. As a group, the girls decided to use the figures and sandtray to create a scene depicting the first day of middle school. Sandtray was an activity that the counselor had introduced to group members in Session 3. With minimal suggestion from the counselor, they were able to draw on their experience and comfort level with the medium to creatively use the medium to express their present concerns.

The GAPT intervention was provided by two advanced doctoral level female counselors trained in child-centered play therapy (CCPT). Prior to the study, additional training was provided regarding the GAPT protocol as well as the developmental needs of preadolescent females. According to Garcia, Lindgren, and Pintor (2011), knowledge of preadolescent females’ physical, social, emotional, psychological, and spiritual development is important when facilitating a group in order to establish an environment of acceptance, empathic understanding,
and safety. To guarantee treatment fidelity to the GAPT protocol (Appendix G) and for the purpose of weekly supervision, I video recorded all sessions and retained recordings for the duration of the study. For the purpose of treatment fidelity checks, 10% of session videos were randomly selected for viewing by an expert in the GAPT protocol who used the Group Activity Play Therapy Skill Checklist (GAPTSC; Bratton, 2011; Appendix F) to verify protocol adherence. Sessions were equally drawn from the two GAPT therapists and sessions were reviewed in their entirety. Sessions adhered to the GAPT protocol with an average of 93% adherence to protocol per session across two facilitators.

Control Condition: S.S.GRIN

During the study, the 14 control group participants received the S.S. GRIN intervention. S.S. GRIN was originally designed to be implemented for 10 weeks for 60 minutes per session, but allows for extending sessions to fit time format and cover all content. Due to school schedule, participants in the S.S. GRIN condition participated in an average of 13 sessions, once per week for 13 weeks for 45 minutes per session. Sessions were conducted in a room at the school following recommendations for space and materials as outlined in S.S. GRIN protocol. Per protocol, the group leader followed the manual with session scripts and instructions for each session. Leaders are encouraged to alter the script in order to personalize the information towards the participants; however, text is bolded for “recommended verbatim material” (DeRosier, 2007, p. 63).

Sessions are highly structured with specific social and self-esteem issues being addressed as the main topic. The first session is geared for the members and leader to become familiar with one another. The remaining sessions included session content such as: respect, positive role models, taking responsibility, communicating, point of view, friendship, cooperation, and
feelings. The last session focused on reviewing the topics discussed throughout the program.

Participants were provided workbooks that included session material and content for each week.

During the first session, the group leader discussed confidentiality, presented the group rules, and encouraged members to join in the development of group rules. The group leader also explained the S.S.GRIN reward system. Weekly, the group leader followed session guidelines by beginning each session with a review of the previous session’s content. The group leader would then introduce the next prosocial skill or topic as provided by the curriculum.

Participants were given stickers for each time they brought their workbook as well as a ticket to place in the ticket board. Participants could lose tickets for not following the group rules or misbehavior but could have the opportunity to earn back their tickets throughout the remainder of the session. Small prizes were given at the end of each session if all members were able to keep their tickets. Moreover, larger and medium prizes were given at the end of the program if participants kept most or all of their tickets (e.g. 10 tickets = one large prize/two medium prizes; 6-9 tickets= one medium prize). Each week, the group facilitator followed the protocol by reviewing previous session content and introducing a new topic for the week.

The S.S.GRIN intervention was provided by one advanced master’s level female student counselor who was certified in the S.S.GRIN protocol and participated in training regarding the needs of preadolescent females. To guarantee treatment fidelity to the S.S.GRIN protocol and for the purpose of weekly supervision, the counselor video recorded all sessions and retained recordings for the duration of the study. For the purpose of treatment fidelity checks, 10% of videos were randomly selected for viewing by a practitioner trained in the S.S.GRIN protocol who utilized the S.S.GRIN manual to verify protocol adherence. Sessions were reviewed in their
entirety. Sessions adhered to the S.S.GRIN with an average of 100% adherence to protocol per session.

Data Collection

Teachers and participants completed the TRS and SPPC, respectively, prior to the study. I was available to teachers and children during the collection of data to answer any questions. To ensure integrity of data collection, teachers were given the option to complete assessments in a setting free from distraction. Participants were also provided a setting free from distraction in order to complete the SPPC. The TRS and SPPC was collected at midpoint testing and again immediately following the intervention, following the same procedures for pretest. To maintain confidentiality, all assessments, client notes, and identifying information were coded numerically then stored in a locked filing cabinet in the faculty supervisor’s office area.

Data Analysis

For each dependent variable, I analyzed the data in SPSS using a 2 (group) by 3 (repeated measures) split plot ANOVA to determine if the GAPT and control groups changed differently across time (3 points of measure). I also examined the data in SPSS to ensure the data met assumptions for sphericity, normality, and homogeneity of variance for conducting repeated measures ANOVA. In the analysis, the independent variable was treatment group type (experimental/control) and the dependent variables were scores on the SPPC Global Self-Worth scale, and TRS Scholastic and Social Competence scales. A repeated-measures ANOVA model has been found to be an effective framework in the evaluation of the impact of an intervention across time (Brown, Costigan, & Kendziora, 2008). An alpha level of .05 was established to test for significant mean differences (Thompson, 2002). Partial eta squared effect size ($\eta^2$) was calculated as an indicator of the magnitude of the difference between the two groups due to
treatment. I followed Cohen’s (1988) guidelines to interpret effect sizes as .01 = small effect; .06 = moderate effect; .14 = large effect.
APPENDIX C

EXTENDED RESULTS
Introduction

For each dependent variable, the Self-Perception Profile for Children (SPPC) Global Self-Worth subscale and the Teacher’s Rating Scale of Children’s Actual Behaviors (TRS) Scholastic and Social Competence scales, a two (group) by two (repeated measures) split plot ANOVA was performed in PASW to analyze group differences, changes across times, and the possible interaction effect of group membership with change across time, which was the primary focus of this study. This repeated measures approach was used to measure change between groups over time. The three levels of time were pre to mid to post test for each dependent variable. Significant differences between the means across time were tested at the .05 alpha levels. Prior to conducting the analysis, dependent variables were inspected to screen data for sphericity, normality and homogeneity of variance. The SPPC and TRS were administered prior to treatment, at the midpoint, and at the end of the intervention. An increase in scores on the SPPC and TRS indicated improvement in self-esteem. Partial eta squared (\( \eta^2 \)) effect sizes were calculated to assess the magnitude of difference between the two groups over time due to treatment. I followed Cohen’s (1988) guidelines to interpret effect sizes as .01 = small effect; .06 = moderate effect; .14 = large effect.

Research Question Analyses

In order to answer the research question, “Will GAPT increase the self-esteem of preadolescent females identified as having low self-esteem when compared to S.S.GRIN?” Child self-report was measured by the Self-Perception Profile for Children (SPPC). Specifically, Table C.1 presents the pretest, midpoint, posttest means and standard deviations for the experimental and control group on the Global Self-Worth subscale of the SPPC.
Child Self-Report: SPPC Global Self-Worth

Table C.1

Mean Scores on the Global Self-Worth subscale for the Self-Perception Profile for Children (SPPC)

<table>
<thead>
<tr>
<th>SPPC Global Self-Worth</th>
<th>Experimental GAPT ($n = 15$)</th>
<th>Control SSGRIN ($n = 13$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Mid</td>
</tr>
<tr>
<td>$M$</td>
<td>2.90</td>
<td>3.33</td>
</tr>
<tr>
<td>$SD$</td>
<td>.93</td>
<td>.79</td>
</tr>
</tbody>
</table>

*Note:* One child in the control group was not available for posttesting due to extended illness at the end of the study, thus 28 children were included in this analysis.

Results for the repeated measures split-plot ANOVA indicated that the dependent variable, SPPC Global Self-Worth, revealed a statistically significant interaction effect of Time (pretest, midpoint, and posttest) X Treatment Group (experimental, comparison), $F(2, 52) = 3.214, p = .048$ (partial $\eta^2 = .110$) in favor of the GAPT intervention. Findings indicate that GAPT demonstrated a moderate to large treatment effect on children’s self-reported self-esteem when compared to the control group. Additionally, the results indicated a statistically significant main effect for time, $F(2, 52) = 9.487, p < .000$ (partial $\eta^2 = .267$) indicating that when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in self-esteem overtime.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within group performance. Results of the one-way ANOVA for the GAPT group indicated that GAPT demonstrated statistically significant improvement in self-esteem from pre to mid to post test; $p < .001$, partial $\eta^2 = .456$, and the treatment effect was large. Results of the one-way ANOVA for the S.S.GRIN treatment group did not reveal a statistically significant improvement from pre to mid to post test; $p = .112$, partial
\(\eta^2 = .167;\) yet, the treatment effect was large. Although the effect size for both conditions are considered large, the treatment effect for GAPT is almost three times as great as for S.S.GRIN. A visual analysis of the graph of the mean scores for the GAPT and S.S.GRIN treatment groups on the SPPC (see Figure C.1) supports the greater improvement of the GAPT intervention over the S.S.GRIN condition.

*Figure C.1.* Mean scores for SPPC Global Self-Worth Subscale from pre to mid to post test.

Teacher Report: TRS Scholastic and Social Competence

Teacher report was measured by the Teacher’s Rating Scale of Child’s Actual Behavior (TRS). Specifically, Tables C.2 and C.3 presents the pretest, midpoint, posttest means and standard deviations for the experimental and control group on the Scholastic scale and the Social Scale of the TRS, respectively.
Table C.2

*Mean Scores for the TRS Scholastic Scale*

<table>
<thead>
<tr>
<th>TRS Scholastic</th>
<th>Experimental GAPT (n = 15)</th>
<th>Control SSGRIN (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Mid</td>
</tr>
<tr>
<td><em>M</em></td>
<td>2.22</td>
<td>2.64</td>
</tr>
<tr>
<td><em>SD</em></td>
<td>.73</td>
<td>.84</td>
</tr>
</tbody>
</table>

TRS Scholastic. Results for the repeated measures split-plot ANOVA indicated that the dependent variable, TRS Scholastic, did not reveal a statistically significant interaction effect of Time (pretest, midpoint, and posttest) X Treatment Group (experimental, comparison), $F(2, 54)=.469, p=.628$ (partial $\eta^2 = .017$) and indicates a small treatment effect size. These results indicated that according to teacher report, children who participated in the experimental group (GAPT) did not demonstrate a statistically significant increase in scores on the TRS Scholastic over time when compared to children who were in the evidenced-based social skills/self-esteem comparison group. Additionally, the results from the repeated measures split-plot ANOVA indicate a statistically significant main effect for time, $F(2, 54)= 7.006, p<.002$ (partial $\eta^2 = .206$). These results indicate that when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in self-esteem from pre, to mid, to post test.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within group performance. Results of the one-way ANOVA indicated that the GAPT treatment group demonstrated a statistically significant improvement in self-esteem from pre to mid to post test; $p= .011$, partial $\eta^2 = .278$, and the effect
size was large. Results of the one-way ANOVA indicated that the S.S.GRIN condition did not reveal a statistically significant difference from pre to mid to post test; p=.149, partial $\eta^2 = .136$, yet the effect size was large. Although the effect size for both conditions are considered large, the treatment effect for GAPT is almost two times as great as for S.S.GRIN. A visual analysis of the graph of the mean scores for the GAPT and S.S.GRIN treatment groups on the TRS Scholastic (see Figure C.2) supports the greater improvement of the GAPT intervention over the S.S.GRIN condition.

![Figure C.2 Mean scores for TRS Scholastic Scale.](image)

**Table C.3**

*Mean Scores for TRS Social subscale*

<table>
<thead>
<tr>
<th>TRS Social</th>
<th>Experimental GAPT (n = 15)</th>
<th>Control SSGRIN (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Mid</td>
</tr>
<tr>
<td>$M$</td>
<td>3.03</td>
<td>2.97</td>
</tr>
<tr>
<td>$SD$</td>
<td>.54</td>
<td>.55</td>
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</tbody>
</table>
Results for the repeated measures split-plot ANOVA indicated that the dependent variable, TRS Social, was not statistically significant for the interaction effect of Time (pretest, midpoint, and posttest) X Treatment Group (experimental, comparison), $F(2, 54)=.712$, $p=.495$ (partial $\eta^2 = .026$). These results indicated that according to teacher report, children who participated in the experimental group (GAPT) did not demonstrate a statistically significant increase in TRS Social scores from pre to mid to post test, when compared to children who were in the S.S.GRIN comparison group. The effect size of .026 for interaction indicates a small to medium effect size according to Cohen’s (1988) guidelines. Additionally, the results from the repeated measures split-plot ANOVA indicate a statistically significant main effect for time, $F(2, 54)=5.210$, $p<.009$ (partial $\eta^2 = .162$). These results indicate that when participants from the experimental and control conditions were grouped together, participants demonstrated a statically significant improvement in self-esteem from pre to mid to post test.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within group performance. Results of the one-way ANOVA indicated that the GAPT treatment group did not reveal a statistically significant difference from pre to mid to post test; $p=.064$, partial $\eta^2 = .178$; yet, treatment effect was large. Results of the one-way ANOVA indicated that the TRS Social for the SSGRIN condition did not reveal a statistically significant difference from pre to mid to post test; $p=.073$, partial $\eta^2 = .182$ yet the treatment effect was also large. Although a visual analysis of the graph of the mean scores for the GAPT and S.S.GRIN treatment groups on the TRS Social (see Figure C.3) appear to support the greater improvement of the GAPT intervention over the S.S.GRIN condition from pre to post treatment, effect size calculations indicate that both interventions accounted for
approximately the same amount of the explained variance in the dependent variable that can be attributed to intervention. Therefore, children in both groups performed similarly over time.

Figure C.3 Mean scores for TRS Social Scale.
APPENDIX D

EXTENDED DISCUSSION
I sought to determine the efficacy of GAPT with preadolescent females identified as having low self-esteem compared to children in an evidenced based social skills/self-esteem curriculum group. Specifically, this study examined the effect of GAPT treatment on increasing self-esteem as measured by the Self-Perception Profile for Children (SPPC) and the Teacher’s Rating Scale of Children’s Actual Behavior (TRS). Low self-esteem is often at the root of psychological problems for preadolescents who naturally compare themselves to their peers as they strive to fit in (Akos, Ham, Mack, & Dunaway, 2007) and is associated with long term negative consequences if not addressed when symptoms first emerge (Van Den Bergh & Marcoen, 1999; Steese et al., 2006; Trzensniewski et al., 2006). Research supports that, as early as elementary school, females are more likely to suffer from low self-worth than their male counterparts (Norwood, Murray, Nolan & Bowker, 2011; Birndorf, Ryan, Auinger, & Aten, 2005); thus female preadolescents are potentially at greater risk for developing mental health issues stemming from poor self-image. The statistical and practical significance of the present study’s findings support GAPT as a promising counseling intervention to improve self-esteem in preadolescent females. Compared to the control condition, GAPT demonstrated statistically significant and moderate to large treatment effects on improving students’ self-perception of their self-worth. Teacher report of their perception of the pre-teens’ self-esteem was less conclusive.

Child Self-Report

Children who received GAPT reported a statistically significant increase in self-esteem compared to those who received S.S.GRIN. Additionally, findings also revealed that GAPT demonstrated a large treatment effect from pre to post treatment and demonstrated three times as much improvement as the participants in SSGRIN. These results support the literature regarding
the use and impact of group activity/play-based interventions with preadolescents (Ojiambo & Bratton, 2014; Flahive & Ray, 2007; Packman & Bratton, 2003). Although no previous GAPT studies focused on self-esteem, these findings were comparable to results from CCPT research in which CCPT demonstrated a statistically significant improvement in self-esteem (Baggerly, 2004; Smith & Landreth, 2003; Kot, S., Landreth, & Giordano, 1998).

Several components of the study could have contributed to GAPT’s moderate to large treatment effect on participants’ self-esteem. First, GAPT is a developmentally responsive intervention as it incorporates toys and materials appropriate for preadolescents. The provision of materials and activities that met the maturational needs and preferences of this age group may have allowed the participants to communicate their thoughts, experiences and needs more fully.

Second, theoretical approach may have contributed to the significant improvement in the experimental group. Consistent with person-centered theory, the GAPT experience provides “an atmosphere of permissiveness and acceptance” along with a therapist who genuinely cares for and accepts the child for who she is and believes the child is capable (Landreth, 2012, p. 58). An environment in which children are accepted allows them to explore their own capabilities and create a belief in themselves (Green & Kolos, 2010; Landreth, 2012). Children who exhibit behaviors of low self-esteem may perceive themselves as incompetent based on the evaluations and reactions of significant others (Landreth, 2012). Through the attitudinal qualities of empathic understanding, unconditional acceptance and congruence provided by the GAPT therapist, children may have been able to “internalize…and recognize areas of competence…” and “…begin to accept themselves” (Green & Kolos, 2010, p.53).

Additionally, the group component of this experience allows for children to learn about and explore interactions with others and develop interpersonal skills. This is important as
preadolescent females place a great importance on peer relationships (Anderson & Choate, 2008) and on the opinions and judgments of their peers (Paone et al., 2008). Preadolescent females need to feel accepted and safe in order to establish significant relationships (Paone et al., 2008) and the GAPT experience can provide that opportunity. These results suggest that GAPT may be an important intervention to consider when working with preadolescent females as participants are able to connect to one another as they share their concerns (Calhoun et al., 2005).

It is also important to note the success of GAPT in 45 to 50 minutes instead of the 1.5 hour format recommended by earlier proponents (Bratton et al., 1999; Bratton et al., 2009; Slavson & Redl, 1944; Schiffer, 1969). These findings along with the findings from school based studies by Ojiambo and Bratton (2014) and Packman and Bratton (2003) suggest that GAPT can be effectively conducted within time and constraints present in most settings particularly in schools.

Teacher Report

Overall, teacher report of children’s increase in self-esteem was mixed and indicated that teachers viewed both groups as improved overtime with greater improvement for the GAPT group on Scholastic Competence and similar improvement for GAPT and S.S.GRIN on Social Competence. For Scholastic Competence, the treatment effect for within group change indicated that the treatment effect was twice as large for GAPT than for S.S.GRIN. For Social Competence, the treatment effect for within group change indicated that the treatment effect was similar between both groups.

Although teachers reported observable change in students’ self-esteem specific to scholastic and social competencies, the results indicated that teachers did not observe as much change as the participants self-reported on their overall sense of self-worth. This could be
attributed to the difficulty in assessing self-esteem of others. Harter (2006) suggested that self-esteem is an internal evaluation of self and that preadolescents are able to recognize their strengths and are capable of self-evaluations. It is plausible that the preadolescents in this study experienced greater improvement in their perceptions of self-worth before teachers were able to observe the same level of change.

Additionally, a decrease in scores occurred at the midpoint. During this time, participants were preparing for state-wide testing that assessed for academic performance. The participants often discussed feelings of anxiety and fear surrounding their desire to pass and many participants reported failing previous testing. Participants were also informed that moving to the next grade level was dependent upon a passing score. School climate and atmosphere also appeared to be tense as teachers were working to prepare the students. This finding could indicate that as children were getting closer to their testing dates, more energy was being directed towards passing exams instead of peer relationships.

Teacher Anecdotal Data

During informal teacher consultations, teachers of children from both GAPT and S.S.GRIN reported grade improvement, increased confidence, better interpersonal skills, and increased recognition of and better ability to regulate emotions. Teachers also requested that the groups be held annually as they reported the groups as being beneficial for their students.

Limitations and Recommendations for Research

Limitations to this study exist and should be considered before interpreting results. First, practitioners can apply GAPT in similar situations, although generalization of results is limited to preadolescent children in the participating sites. A larger sample size and replication of the study in multiple sites would strengthen reliability.
A further limitation is that it is possible that factors and stressors other than low self-esteem may influence participants’ perception of themselves and could skew assessment results as the intervention was administered during a time in the school semester where participants were preparing for state testing that assessed for academic performance. Moreover, consistent with protocol, participants in the experimental group received treatment for a longer duration (n=approximately 16 weeks) compared to the SSGRIN comparison group (n=approximately 13 weeks).

An additional limitation would be a lack of additional sources of measurement such as parents and independent raters. However, as noted previously, self-esteem may be a difficult construct to observe and measure by others. Because of this, it is also important to acknowledge that students may appear to be functioning normally but due to internalizing symptoms may also be overlooked as these behaviors may not be as overt. A final limitation of this study could be the use children’s self-report as participants become familiar with the instruments they may be inclined to choose socially acceptable answers thus interfering with study findings.

Implications for Practice

Results from this study support the use and effectiveness of GAPT with preadolescents identified with low self-esteem. However, more research is needed to utilize GAPT as an evidence-based intervention for preadolescents exhibiting low self-esteem.

GAPT provides a developmental responsive intervention for children, thereby being a preventative measure for more severe and potentially costly behaviors across a child’s lifetime such as depression, eating disorders, suicidal ideation, substance abuse and other behavioral issues (Van Den Bergh & Marcoen, 1999; Steese et al., 2006; Trensniekski et al., 2006). Due to the importance preteens place upon peer relationships, the group component of GAPT can assist
in strengthening and improving relationships among peers as preadolescents have the opportunity to practice and learn new social skills (Polce-Lynch et al., 1998). GAPT appears to be a promising option as an intervention for school-based mental health practitioners who work with this population as GAPT can be applied in the schools where all children have access and allows for more students to be served simultaneously as this intervention may be difficult to implement in a community setting. Additionally, GAPT may help to improve positive feelings about one’s self and therefore be helpful as preadolescence is an age when self-esteem begins to decline as preteens become aware of their own abilities and limitations compared to others (Anderson & Choate, 2008). Furthermore, GAPT can aid in the development of learning new social and coping skills (Bratton et al., 2009; Ojiambo & Bratton, 2014; Packman & Bratton, 2003).

This study demonstrated positive results for the use of GAPT on the self-esteem of preadolescent females, however, further replication studies with larger sample sizes are needed. Furthermore, the use of independent raters as another source of measure may have also been helpful to examine the effectiveness of GAPT. However, self-esteem can be difficult to measure as it is not always observable.

Conclusion

The results of this research demonstrate the beneficial effects of GAPT on the self-esteem of preadolescent females. Self-report from participants indicated an improvement in self-esteem groups with a greater improvement in the GAPT intervention over time. Although teacher reports did not demonstrate statistically significant findings, they reported an improvement in self-esteem related to academic and social competence. These results support previous research on
the use of GAPT with preadolescents as an effective and developmentally responsive intervention.

Results of this study are promising as practitioners, particularly school counselors, can utilize this as an effective intervention for preadolescents as early intervention serves as protective factor against the onset of more severe and potentially costly behaviors across a child’s lifetime such as depression, eating disorders, self-harm, suicidal ideation, substance abuse and other behavioral issues (Van Den Bergh & Marcoen, 1999; Steese et al., 2006; Trensniekwski et al., 2006). Furthermore, study findings have the potential to inform mental health practitioners who work with this population regarding best practices for helping preadolescent females create a healthy self-image and develop more satisfying peer relationships.
APPENDIX E

INFORMED CONSENT FORMS
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:** Effects of School-Based Group Activity Therapy on the Self-Esteem of Preadolescent Females

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

**Lead Student Research Assistant:** Dina Yousef, 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 daughter to participate in a research study to explore the effectiveness of small group counseling interventions aimed at enhancing the self-esteem and confidence of preadolescent females, 9 – 11 years old. Recent research shows that the number of young girls who suffer from low self-esteem, lack of self-confidence and poor body image is on the rise and considered an area of growing concern for their future social, emotional, and academic success. A recent study by Dove Corporation found that 75% of girls with low self-esteem reported engaging in negative behaviors in adolescence.

**Study Procedures:**
Upon your consent and your daughter’s agreement, your child will be randomly assigned to participate in one of two small group activity interventions designed to promote girls’ self-acceptance, self-confidence, and overall self-esteem. In both group interventions, activities and interactions between group members and the counselor will provide your daughter with the opportunity to become more self-aware and self-accepting as well as more aware and understanding of others’ feelings, thoughts, and needs. Your child will not be asked any questions that are not intended to facilitate her self-awareness or awareness of her interactions within the group. Most children find the activities enjoyable, however, your daughter’s participation in activities or discussions is voluntary. Groups will be comprised of 3 to 4 girls each.
Groups will meet once per week for 45 minutes for approximately 14 weeks either before or after school or during non-academic times during the school day approved by school administrators and teachers. Group sessions will be video-recorded in order for the counselor to be supervised to ensure the quality of services.

Again, for the purpose of this study, your daughter will be placed in one of two intervention groups:

**Group 1: Group Activity Therapy (GAT)** is a research-based, semi-structured counseling intervention designed to be responsive to the developmental needs of preadolescents. Counselors provide a counseling environment in which preadolescents feel supported, accepted, and encouraged as they gain insight into themselves. A variety of expressive art materials and age-appropriate games and creative materials are provided to allow preadolescents a non-threatening means of expressing concerns about themselves, peer relationships, and other struggles that preadolescents face, while also providing opportunities among group members for engaging in pro-social skill development, cooperation, strength-based coping strategies, and problem solving.
**Group 2: Self-esteem/Social Skills Group Intervention, S.S. GRINS**, is a research-based, structured educational program that uses developmentally appropriate activities and discussions designed to teach children prosocial skills and enhance their communication, cooperation, and confidence. Counselors provide a counseling environment in which preadolescents feel supported, accepted, and encouraged as they gain insight into themselves.

Your permission allows your daughter to fill out two assessments that ask her to rate how she views herself in relation to her peers, school work, and physical appearance. Your permission also allows your child’s homeroom teacher to fill out two assessments that ask the teacher to report his/her perception of your daughter’s self-esteem and confidence in relation to her peers. Your daughter’s assigned counselor will deliver the assessments to your child’s teacher and administer the two child-assessments to your daughter prior to the groups starting, again after week 7 (midpoint of the intervention), and again at the completion of the study.

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

1. Anything that is said or done during the counseling groups is considered confidential, meaning that the counselor 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 counselor is required by law to report it to the appropriate authority.
2. It is possible your daughter will be pulled from an extracurricular experience that she enjoys (times are decided by the teacher and principal’s approval). To minimize this risk, groups will also be offered before and after school. In no circumstance will students miss academic content or preparation for STAAR testing. Still, it is possible that participants may miss an activity that they enjoy and feel excluded from the activity. In such cases, the counselor or PI will consult with you and your daughter to determine if it is in the child’s best interest to remain in the group.
3. Because these groups are counseling interventions, your daughter may experience thoughts and emotions that could be strong or difficult for her. The counselors are experienced and trained to help your child express and work through these emotions. If any potential harmful effects upon your daughter are noted, the counselor will consult with the principal investigator/supervisor. If it is determined by the counselor and supervisor that remaining in the group would not be beneficial or could be harmful to your child, the counselor will meet with you to provide an appropriate referral (for example, at your request your daughter may be moved to individual counseling at the school or referred to community-based services). Harmful effects would include inability to maintain self-control or being so upset that your child has difficulty behaving normally.

**Benefits to the Subjects or Others:**
Possible positive outcomes for children participating in the project may include increase in self-acceptance, self-awareness, self-confidence, and overall self-esteem as well as increase in understanding of others’ feelings, thoughts, and needs. Additional benefits include increase in social skills, cooperation, strength-based coping strategies and problem solving. The results of this study may provide school counselors across the nation with knowledge that helps them enhance children’s social-emotional development so that children are happier and more successful in public school.
Compensation for Participants: There is no compensation for participating in this study.

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

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

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

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

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

__________________________
Printed Name of Child

__________________________
Printed Name of Parent or Guardian

__________________________  _________________________
Signature of Parent or Guardian  Date
Antes de que usted confirme la participación de su hija en este estudio, es importante que usted lea y entienda la siguiente explicación sobre el propósito y beneficios de este estudio y como es que se llevara a cabo.

**Título del estudio:** Efectos de la terapia basada en actividades grupales en la escuela para la autoestima de preadolescentes femeninas.

**Investigador Principal:** Dra. Sue Bratton, Counselor y Supervisor Profesional con Licencia (LPC-S), Terapeuta de Juego y Supervisor certificado (RPT-S), University of North Texas, Department of Counseling & Higher Education.

**Principal líder y asistente de investigación:** Dina Yousef, M. Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling & Higher Education.

**Propósito del estudio:** Se le pide su permiso para permitir que su hija participe en un estudio de investigación con la finalidad de explorar la efectividad de la intervención de counseling en grupos pequeños que pretenden mejorar la autoestima y autoconfianza de preadolescentes mujeres, de entre 9 y 11 años de edad. Estudios recientes sugieren que el numero de niñas jóvenes que sufren de una abaja autoestima, falta de autoconfianza y una pobre percepción de su autoimagen esta en aumento, por lo que se considera una área de preocupación creciente para su futuro social, emocional y éxito académico.

**Procedimientos del estudio:** Una vez que usted y su hija hayan dado su consentimiento para participar en este estudio, ella será asignada aleatoriamente para participar en uno de los dos grupos pequeños de intervención diseñados para promover la auto-aceptación, auto-confianza y autoestima en general. En ambos grupos de intervención, las actividades e interacciones entre los miembros del grupo y el consejero proveerán a su hija la oportunidad de ser mas autoconsciente y aceptarse a sí misma, así como mas consciente y comprensiva de los sentimientos, pensamientos y necesidades de los demás. No se le preguntara a su hija ningún tipo de preguntas que no sean con la intención de facilitar su concientización personal y con los miembros del grupo. La mayoría de los niños encuentran las actividades como placenteras, sin embargo, la participación de su hija en las actividades y discusión grupal es voluntaria. Los grupos estarán compuestos de entre 3 a 4 niñas cada uno. Los grupos se reunirán una vez a la semana por un tiempo aproximado de 45 minutos por 14 semanas, ya sea antes, después o durante algún tiempo de no actividad académica en la escuela que será aprobado tanto por el personal administrativo como por los profesores. Las sesiones grupales será video grabadas con el propósito de que el consejero sea supervisado para asegurar la calidad de los servicios.

Recuerde que, para fines de este estudio su niña será asignada en uno de los dos grupos de intervención:

**Group 1:** Grupo de Terapia de Actividad (GTA) es una intervencion en counseling semi-estructurada basada en investigación empírica y diseñada para responder a las necesidades de desarrollo de pre-adolescentes. El consejero provee un ambiente en el que el pre-adolescente se siente apoyado, aceptado y motivado a crear cambios por sí mismo. Se proporciona también una gran variedad de materiales de arte expresivo, juegos apropiados para su edad y materiales para la creatividad con el fin de proveer a los preadolescentes un medio para expresar sus preocupaciones sobre si mismos, relaciones interpersonales con sus pares, así como otras problemáticas que enfrentan. Al mismo tiempo brinda oportunidades entre los miembros del grupo para abordar el desarrollo de habilidades sociales, cooperación, estrategias de afrontamiento y la resolución de problemas.
Grupo 2: Autoestima/Grupo de habilidades sociales, S. S. GRINS (por sus siglas en Ingles) es un programa educacional estructurado, basado en investigación empírica, que utiliza actividades apropiadas para el desarrollo y discusiones diseñadas para enseñar a los niños habilidades sociales para mejorar la comunicación, cooperación y autoconfianza. Los Consejeros proveen un ambiente en el que los preadolescentes se sienten apoyados, aceptados y motivados para generar cambios por si mismos.

Su consentimiento da permiso para que su hija conteste dos instrumentos que le piden calificar como se ve ella misma en relación a sus compañeros, trabajo escolar y apariencia física. Su consentimiento también permite que su maestro de salón conteste dos cuestionarios do cuestionarios que piden que el maestro reporte la percepción de la autoestima de su niña y autoconfianza en relación con sus compañeros. El consejero de su hija entregara los cuestionarios a los maestros y aplicara los cuestionarios correspondientes a su hija previo a que comience el grupo y nuevamente después de 7 semanas (a la mitad de la intervención) y finalmente al finalizar del estudio.

Riesgos previsibles: No hay riesgos significantes previsibles como resultado de la participación en este estudio. La participación de su hija es completamente voluntaria. Usted podrá retirar a su hija en cualquier momento durante el transcurso del estudio. Algunos posibles riesgos puede incluir uno o mas de los siguientes:

1. Todo lo que se dice o hace durante los grupos de counseling es considerado confidencial, lo que significa que el consejero no revelara nada de lo que pase en las sesiones a algún personal de la escuela o adulto. Sin embargo, si su hija revela algún tipo de abuso, negligencia, explotación o intento de dañar a otra persona, el consejero esta obligado, por ley, a reportar el incidente a la autoridad correspondiente.

2. Es posible que su hija sea sacada de alguna situación extracurricular que disfrute (los horarios son decididos por el maestro bajo el permiso del director). Para minimizar este riesgo, los grupos también se ofrecerán antes y después del horario de escuela. Bajo ninguna circunstancia el estudiante perderá clases de contenido académico o de preparación para el examen STAR. Aun así, quizás los participantes pierdan alguna actividad que disfrutan y se sientan excluido de ella. En este último caso, el consejero el investigador consultara con usted y su hija para determinar si es del mejor interés de la niña permanecer en el grupo o no.

3. Debido a que estos grupos son intervenciones de counseling, su niña quizás experimente pensamientos y emociones que pueden ser fuertes o difíciles para ella. Los consejeros están experimentados y capacitados para ayudar a su niña a expresar y trabajar en dichas emociones. En caso de existir algún posible efecto negativos sobre su hija, el consejero consultara con el investigador principal. En caso de que el consejero y el supervisor determinen si la permanencia de su hija puede ser benéfica o no, el consejero se entrevistara con usted para proveer referencias apropiadas (por ejemplo, si usted lo solicita si hija probablemente sea pasada a consejería individual ya sea en la escuela o en algún servicio de la comunidad). Efectos dañinos pueden incluir inestabilidad para mantener auto control o estar muy molesta que su hija tenga dificultades para comportarse normalmente.

Beneficios para los participantes u otros: Posibles cambios positivos para su niña por participar en este proyecto pueden incluir una mejora en su auto aceptación, auto consciencia, autoconsciencia y autoestima en general, así como un incremento en la comprensión de los pensamientos, sentimientos y necesidades de los demás. Beneficios adicionales pueden incluir una mejora en el desarrollo de habilidades sociales, cooperación y estrategias de afrontamiento y solución de problemas. Los resultados de este estudio pueden proveer a los consejeros escolares a lo largo de la nación con conocimiento que los ayude a mejorar el desarrollo social-emocional de los niños de tal forma que sean mas felices y exitosos en las escuelas publicas.
Compensación para los participantes: No habrá ninguna compensación por participar en este estudio.

Procedimientos para mantener la confidencialidad de los archivos: A los participantes se les asignara un numero de código previo al estudio. Toda la información de los participantes, incluyendo los cuestionarios serán guardados solamente con un numero de código. Toda la información será almacenada en un archivero asegurado en una locación en el Centro de Terapia de Juego (Center for Play Therapy) dentro del programa de Counseling en la la University of North Texas. Solo el grupo de investigadores será quien tenga acceso a la lista de los nombres de los participantes y los números de código almacenados en el archivero asegurado. Los nombres de los padres ni de las niñas será revelados en ninguna publicación o discusión de este material. Las sesiones de actividad serán video grabadas. El investigador principal/ supervisor observara las video grabaciones para asegurar la calidad de los servicios que su niña recibirá. Al finalizar este estudio, posiblemente los videos sean mostrados en presentaciones profesionales con propósitos educativos. La información de identidad personal tal como nombre, lugar de residencia y otra información específica no será revelada cuando las videograbaciones sean mostradas en escenarios educativos. Sin embargo, si así lo desea usted puede retirar su consentimiento en cualquier momento y las video grabaciones de su hija no serán mostradas.

Preguntas acerca de este estudio: Si tiene usted alguna pregunta acerca de este estudio, puede ponerse en contacto con la Dra. Sue Bratton al (940)-565-3468 o a Sue.Bratton@unt.edu

Revisión para la protección de los participantes: Este estudio de investigación ha sido revisado y aprobado por el Comité Institucional de Revision (Institutional Review Board, IRB) de la UNT. Este comité puede ser contactado al (940)-565-4643 para cualquier duda perteneciente a los derechos de los participantes.

Derechos de los participantes del estudio: Su firma en la parte inferior indica que ha leído o que se le han leído todo lo anterior y que usted confirma todo lo siguiente:

- Usted entiende los posible beneficios y riesgo potenciales o incomodidades de este estudio.
- Usted entiende que usted no tiene que dar permiso a su niño para participar en este estudio y que su negativa a permitir a su hija a participar o su decisión de retirarla del estudio no tendrá ninguna penalización o perdida de derechos o beneficios. El personal de este estudio puede detener la participación de su hija en cualquier momento.
- Usted entiende porque el estudio se llevara a cabo y como se realizara.
- Usted entiende los derechos como padre o tutor de un participante de la investigación y consiente voluntariamente que su hija participe en este estudio.
- Usted entiende que puede conservar una copia de esta forma.

______________________________________________
Nombre de la niña

_______________________________________________
Nombre del padre o tutor legal

________________________________________________     __________________________________
Firma del padre o tutor legal      Fecha
Teacher Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** The Effects of School-Based Group Activity Therapy on the Self-Esteem of Preadolescent Females

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

**Lead Student Research Assistant:** Dina Yousef, 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 to explore the effectiveness of school-based, small group counseling interventions aimed at enhancing the self-esteem and confidence of preadolescent females, 9 – 11 years old. Recent research shows that the number of young girls who suffer from low self-esteem, lack of self-confidence and poor body image is on the rise and considered an area of growing concern for their future social, emotional, and academic success. A recent study by Dove Corporation found that 75% of girls with low self-esteem reported engaging in negative behaviors in adolescence. Eating disorders, depressions, social anxiety, and generally not feeling positive about one’s self are just a few of the concerns that can develop from low self-esteem if not addressed early.

Study Procedures: After parents provide permission for their daughter’s participation in this study, each participating child will be assigned to one of two research-supported counseling groups that use a combination of developmentally appropriate activities and discussion: Group 1 - Group Activity Therapy (GAT) or Group 2 - Self-esteem/Social Skills Group Intervention (S.S. GRINS). In both interventions, groups will be comprised of 3 to 4 girls to a group. Groups will meet once per week for 45 minutes for approximately 14 weeks either before or after school or during non-academic times during the school day approved by school administrators and teachers.

You will be asked to complete two brief assessments on each child in your class that participates in the study. The assessment will be delivered to you by the student’s assigned counselor. You will be asked to complete the assessment at three points in the study: prior to the study beginning, midpoint (approximately after 7 weeks), and after the end of the study. It will take approximately 30 minutes to complete the two assessments each time, for a total of approximately 1 hour and 30 minutes of your time over the entire study.

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

**Benefits to the Subjects or Others:** Possible positive outcomes for children participating in the project may include increase in self-acceptance, self-awareness, self-confidence, and overall self-esteem as well as increase in understanding of others’ feelings, thoughts, and needs. Additional benefits include increase in social skills,
cooperation, strength-based coping strategies and problem solving. The results of this study may provide school counselors across the nation with knowledge that helps them enhance children’s social-emotional development so that children are happier and more successful in public school.

Compensation for Participants: NA

Procedures for Maintaining Confidentiality of Research Records: Information obtained from the instruments will be recorded with a code number rather than name. 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. 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. Sue Bratton at (940)565-3864 or Sue.Bratton@unt.edu.

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

______________________________    ________________
Signature of Participant (Teacher)  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
Student Assent Form

You are being asked to be part of a research project being done by the University of North Texas Counseling Program that may help girls 9 to 11 years old feel more confident, appreciate their strengths, and feel better about themselves.

You will be asked to attend a 45 minute activity group once a week with 2 to 3 other girls for approximately 14 weeks. During the groups, you will have the opportunity to participate in a variety of activities and discussions with other girls your age. Your sessions will be video-recorded so my teacher can help me do my best job as a counselor.

Before the activity groups begin, you will also be asked to fill out 2 questionnaires that will take about 30 minutes. To help me understand if the group is helpful to you, you will be asked to fill out the questionnaires two more times.

Anything that you say or do during the group is confidential, meaning that your counselor will not tell what happens during the group to school officials or another adult unless you tell your counselor that you have been hurt by someone or think someone might hurt you or if you tell your counselor that you are thinking of hurting someone.

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

________________________
Printed Name of Child

_________________________    _______________
Signature of Child      Date

__________________________    ________________
Signature of Research Assistant    Date
APPENDIX F

GROUP ACTIVITY PLAY THERAPY CHECKLIST
<table>
<thead>
<tr>
<th>ACTIVITY/PLAY THERAPY SKILLS</th>
<th>RANGE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Work – Average - Excellent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Reflected non verbal content 1……2……3……4……5 _________________________

2. Reflected verbal content 1……2……3……4……5 _________________________

3. Reflected feelings/intent/wishes 1……2……3……4……5 _________________________

4. Facilitated and/or acknowledged therapist/child relationship 1……2……3……4……5 _________________________

5. Facilitated decision making & responsibility 1……2……3……4……5 _________________________

6. Facilitated spontaneity and creativity 1……2……3……4……5 _________________________

7. Facilitated self-esteem and confidence 1……2……3……4……5 _________________________

8. Conveyed understanding/identified themes/larger meaning of child’s play and or words 1……2……3……4……5 _________________________

9. Limit setting 1……2……3……4……5 _________________________

**GROUP ACTIVITY PLAY THERAPY SKILLS**

10. Appropriate focus on individual needs of each child (includes use of child’s name – 1st person) 1……2……3……4……5 _________________________

11. Appropriate focus on the relationship needs between 2 or more children

   a. Facilitated interaction between children 1……2……3……4……5 _________________________

   b. Facilitated connection between children 1……2……3……4……5 _________________________

   c. Facilitated cooperation/problem solving between children 1……2……3……4……5 _________________________

**THERAPIST NON-VERBAL LANGUAGE**

12. Comfortable/open/interested 1……2……3……4……5 _________________________
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Fully present/genuine use of self</td>
<td>1-5</td>
</tr>
<tr>
<td>14.</td>
<td>Immediate/Spontaneous</td>
<td>1-5</td>
</tr>
<tr>
<td>15.</td>
<td>Facial expression and voice tone matches child/children’s affect</td>
<td>1-5</td>
</tr>
<tr>
<td>16.</td>
<td>Voice tone congruent with response</td>
<td>1-5</td>
</tr>
<tr>
<td>17.</td>
<td>Tolerant of noise/messiness</td>
<td>1-5</td>
</tr>
</tbody>
</table>

Note responses not consistent with skills listed:
APPENDIX G

GROUP ACTIVITY PLAY THERAPY PROTOCOL
GAPT was designed as a developmentally responsive intervention for preadolescents based on child-centered play therapy (CCPT, Landreth, 2002) principles and procedures. In response to preadolescent’s unique social, emotional and cognitive developmental needs, the GAPT intervention provided an integration of unstructured and semi-structured activities. Each session was intended to be approximately 45 to 50 minutes. Structure for the sessions included approximately 20 minutes of a semi structured activity offered by the therapist as needed as a possible way to begin group, approximately 20 minutes of self-directed or group-directed activity chosen by group members, and approximately 10 minutes for closure and sharing.

Presentation of GAPT counseling structure

Session 1

Participants were introduced to the playroom and the structure of the counseling relationship as: “This is our special play room. In here you can talk or play with any of the materials and toys in a lot of the ways you would like. I will not share with your teacher or house mother what you share or do here unless if I think you or others are not safe. It is okay for you if you choose to share what you individually share in here but it is not okay for you to share what other members of the group share during our time together.” I showed them all the materials in the playroom to help them be comfortable getting started. The aim of the first session was to allow group members to explore the playroom and materials, develop a sense of safety, and begin to connect with the therapist and each other.
Session 2-6

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

Presentation of semi-structure activity

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

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

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

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

**Presentation of Self-directed Activities**

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

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

**Presentation of Counseling Structure for Closure**

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

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

**Sessions 7-16**

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

Drawing Activity

Rationale for Drawing


Materials:

- paper
- pencils
- colored pencils
- crayons
- markers
- pens

Procedure:

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

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

Play Dough/Model Magic Creature

Rationale for Play Dough/Model Magic Creation:

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

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

Procedure:

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

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

**Group Puppetry**

Rationale for Group Puppetry

Using group puppetry provides a catalyst for self-exploration and group interaction. This semi-structured activity does not focus on a completed product, but provides an opportunity to reduce group anxiety, facilitate comfort of group interaction verbally and non-verbally, and group cooperation and collaboration. Puppets also provide children with opportunity to express their thoughts and feelings symbolically and concretely.

Materials:
Variety of puppets, including human and animal figures, both realistic and fantasy, and culturally diverse. While many puppets have a tendency to be "cute", it is important to provide scary puppets so that the preadolescents have the opportunity to express a variety of experiences and feelings.

A puppet theater is also needed for group puppetry. The puppet theater allows preadolescents the opportunity to be invisible while the character speaks.

Procedure:

a. Selection of Puppets. The first step in the use of puppetry with preadolescents is selection of the puppets. The therapist places a pile of puppets on the floor and introduces the activity by saying, "Here are some puppets, look through them and pick out one that you would like to play with. You can decide if you would like to play with the puppets or play or use other materials in the playroom”.

b. Introduction of puppets: The therapist then asks the group members to give their puppet a name and introduce the character to the group.

c. Story formulation: The therapist then asks the group to tell any story of their choice using the puppets. The group is reminded that a story has a beginning, middle, and end. Therapist gives children time to plan their story and choose how they would like to share their story during the puppet show.

d. Therapist interaction with puppets: During the fourth step, the therapist interacts briefly with each character in the story, reflecting content and feelings portrayed in the puppet show while the child maintains the emotional distance provided by the puppet and the puppet theater.

Note: While the semi-structured activity is introduced, if the preadolescents do not want to participate in the activity, the therapist is accepting of this decision. In contrast, if the
preadolescents choose to continue the activity beyond what is presented, the therapist is also accepting of that choice as well (Packman & Bratton, 2003).

**Sandtray Play Therapy**

Rationale for Sandtray play:

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

**Materials:**

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

**Procedure:**

1. Therapist introduces the activity by saying, “Here is a collection of miniatures/small toys (pointing to the shelves) and this is a sandtray where you can create a “story’ or a “picture” of your world or life in the sand. You may use as many or as few as you like. Take a few minutes to look at the miniatures/small toys and pick a few that interests you. Place them in the sandtray (pointing to the sandtray). Then add as many as you like to create a world, anything in your life in the sand (Homeyer & Sweeney, 2011; Flahive and Ray, 2007).

2. Therapist notices process of creating scenes. Later therapist facilitates participant’s description of their scenes or telling of stories about their scenes. Therapist invites group members to share
their stories about their creations in the sand. Group members are not required to share.

Participants can choose to share or not to share.

**Group Collage**

Rationale for Group Collage:

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

Materials:


Procedure:

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

Therapist notices process of creating collages. Therapist facilitates participants’ description/sharing of their collage. Group members are not required to share. Participants can choose to share or not to share. Therapist tentatively shares observations of the process/creation. Therapist encourages participants to connect with the experience/creation.
APPENDIX H

LIST OF TOYS AND MATERIALS FOR EXPRESSIVE ARTS ACTIVITIES FOR GROUP ACTIVITY PLAY THERAPY
<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markers</td>
<td>Puppets and puppet theatre</td>
</tr>
<tr>
<td>Crayons</td>
<td>Assortment of beads, feathers, yarn</td>
</tr>
<tr>
<td>Colored pencils</td>
<td>Assortment of lace, ribbons, buttons</td>
</tr>
<tr>
<td>Water colors</td>
<td>Pipe cleaners</td>
</tr>
<tr>
<td>Glue sticks</td>
<td>Multi-colored poms</td>
</tr>
<tr>
<td>Elmer’s glue</td>
<td>Large foam sheets</td>
</tr>
<tr>
<td>Glitter glue</td>
<td>Assorted colors of tissue paper</td>
</tr>
<tr>
<td>Scissors</td>
<td>Pencils</td>
</tr>
<tr>
<td>Paper plates</td>
<td>Paper clips</td>
</tr>
<tr>
<td>Paper bags</td>
<td>Stapler</td>
</tr>
<tr>
<td>White drawing paper</td>
<td>Animal figures</td>
</tr>
<tr>
<td>Various colors of construction paper</td>
<td>Medical kit</td>
</tr>
<tr>
<td>Paint</td>
<td>Plastic knife</td>
</tr>
<tr>
<td>Play dough</td>
<td>Dart guns</td>
</tr>
<tr>
<td>Glitter</td>
<td>Plastic cell phones</td>
</tr>
<tr>
<td>Assorted Magazines</td>
<td>Musical instruments</td>
</tr>
<tr>
<td>Assorted fabrics</td>
<td>Blocks</td>
</tr>
<tr>
<td>News print/ paper</td>
<td>Building toys</td>
</tr>
<tr>
<td>Modeling clay</td>
<td>Dress up clothes</td>
</tr>
<tr>
<td>Assorted plastic form items</td>
<td>Dolls, cars and other real life toys</td>
</tr>
<tr>
<td>Sand bottles</td>
<td>Scotch Tape</td>
</tr>
<tr>
<td>Sand tray miniatures</td>
<td>Colored/patterned masking tape</td>
</tr>
</tbody>
</table>


