THE IMPACT OF CHILD-CENTERED GROUP PLAY THERAPY ON SOCIAL SKILLS DEVELOPMENT OF KINDERGARTEN CHILDREN

by

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ABSTRACT

THERESA MARIE KASCSAK. The impact of child-centered group play therapy on social skills development of kindergarten children (Under the direction of DR. PHYLLIS POST)

The development of social adjustment during elementary school is of critical importance because early socialization skills are an important predictor of both future social and emotional functioning. However, an examination of current literature reveals there is limited research utilizing sound research methodology and evaluation protocols for social skills interventions in the play therapy research, specifically as it relates to school counseling interventions. This study sought to determine the impact of child-centered group play therapy on social skills for kindergarten children utilizing an accelerated model of child-centered group play therapy and by utilizing the Social Skills Rating System (SSRS: Gresham & Elliott, 1990) which has not been typically used in play therapy research.

The SSRS was administered to both parents and teachers of the research participants and then the children were randomly assigned to either the experimental (n = 26) and control groups (n = 23). The children in the experimental group were paired into classroom-centric groups of two and received ten sessions of child-centered group play therapy twice a week over a course of five weeks. Upon completion of the ten sessions, the SSRS was re-administered to the teachers and parents. The study used an ANCOVA design to test the significance of the group differences..

Analysis of results showed that neither the teacher nor parent ratings of the SSRS identified significant improvement on either the total social skills score or the associated

subscales. Thus, the study found no evidence that child-centered group play therapy significantly impacts social skills development.

The study highlighted the need for effective interventions and assessment totals for social skills interventions that will benefit all children and not just those children determined to have social skills deficits. Several recommendations are made based on limitations and lessons learned from this study.

ACKNOWLEDGEMENTS

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CHAPTER 1: INTRODUCTION

The development of social adjustment during early elementary school years is of critical importance because early socialization skills are an important predictor of both future social and emotional functioning. Hartup (1992) suggests that the best childhood predictor of adult adjustment is the ability with which a child gets along with peers. Social competence develops as a result of interpersonal interactions (Anthony et al., 2005a) and is measured by peer acceptance and popularity (Rudolph & Asher, 2000), pro-social behaviors (Howes, 2000) and positive peer relationships (Rose-Kasnor, 1997). Children who are socially competent have the ability to regulate and understand their emotions and the feelings of others. The level of social competence strengthens children's long-term social, emotional and cognitive development during childhood (McClellan & Katz, 2001).

Success in elementary school can be defined by the successful transition and integration that occurs during the kindergarten year. The inability of children to develop satisfactory peer relationships, as evidenced by age-appropriate social skill development can have dramatic and enduring effects. Ladd (2000) purports those children who have not achieved minimal social competence before the age of six will have a higher probability of adult dysfunction (Brigman, Lane, Switzer, Lane, & Lawrence, 2001; Kazdin & Johnson, 1994). Early interventions during the Kindergarten year are necessary to decrease the emotional, social, and behavioral problems in young children that are key

risk factors for increased academic problems, grade retention, dropping out, and antisocial behavior in later years (Snyder, 2001; Tremblay, Mass, Pagani, & Vitaro, 1996).

<div align="center">The Importance of Social Skills Development</div>

Social skills are paramount for childhood development. Teachers cite the lack of social skills as a key reason for early academic problems (Brigman et al., 2001). Academic success in elementary school is a key indicator of healthy social skill development. Raver and Snitzer (2002) suggest social competence is a more accurate predictor of academic competence in elementary school than either cognitive abilities or family demographics. An increasing body of research identifies social skills and peer relationships as important predictors of school readiness and academic achievement (Denham & Weisenberg, 2004; Raver, 2004; Smith, 2003). Successful relationships with peers are a positive indicator of school readiness (Coolahan, Fantuzzo, Mendez, & McDermott, 2000). Children identified as academically at risk are potentially more susceptible for displaying deficits in social functioning and do less well in school than their socially adjusted counterparts (Ladd, Kochendorfer, & Coleman, 1997).

A key indicator for determining the adequacy of social skills is the degree to which children get along with their peers. Children who cannot form sustainable peer relationships will miss out on opportunities to learn social skills (Asher, Renshaw, & Hymel, 1982). There are also concerns that decreased social skills place children at a higher risk for aggressive behaviors (Webster-Stratton & Lindsey, 1999). Prevention efforts focused on reducing aggressive behaviors at the beginning of children's academic careers is a beneficial and cost-effective means of preventing the progression from

possible early onset conduct issues to future delinquent behaviors and academic failure (Webster-Stratton, & Reid, 2004; Webster-Stratton & Taylor, 2001).

Finally, limiting factors for social development, such as socio-economic status, may exacerbate social skills development (Oden, 1987). Low income children have a higher than ten percent expected rate of exhibiting impairments in emotional and behavioral functioning than their middle class peers (Anthony, Anthony, Morell, & Acosta, 2005b) and disproportionately higher rates of academic problems (O'Hara, 1996). Additionally, research indicates that young children from low-income families have a greater risk for poor developmental and educational outcomes than their higher income peers (Brooks-Gunn, Duncan, & Aber, 1997; Duncan & Brooks-Gunn, 1997) and may show higher levels of emotional regulation difficulties (Corapci, 2004). The successful transition to the formal school environment can be especially difficult for children with the combined risks of socioeconomic disadvantages and social skills deficits (Campbell, Shaw, & Gilliom, 2000; Raver & Knitzer, 2002). This risk is exacerbated particularly for those children of ethnic minority communities (McLoyd, 1998). Because this study will utilize students drawn from a school population where approximately 80% of the student qualify for free and reduced lunch based on parent socio-economic status, the impact of social skills for children who may be socio-economically disadvantaged should be addressed.

<center>Play-Based Interventions</center>

The transition to kindergarten exposes children to a new environment in which they need to successfully demonstrate social skills. For some, it may be the first experience a child has with large groups, and the associated peer group play is a

significant task in the development of social competence (Corapci, 2004). Play is a developmentally appropriate way to teach children social skills (Chaloner, 2001). As such, social skills interventions should provide activities for children to engage in both structured peer group play and extemporaneous child-initiated social play (Coolahan et al., 2000; McClellan & Katz, 2001; Mendez, McDermott, & Fantuzzo, 2002).

Children in need of increased social skills can benefit from group play therapy. (Homeyer, 2000). Group play therapy is an adaptation of play therapy that provides opportunities for social interaction between children in a therapeutic setting. It is an ideal intervention for social skill development and is a practical solution for treating emotional, social, and learning impairments during childhood (Shectman, Gilat, Fos, & Fisher, 1996). As a treatment modality, group play therapy provides therapists with the opportunity to serve children simultaneously and take advantage of the benefits of group counseling (Homeyer, 2000). Universality is an important factor in the group play therapy process in which children discover that they have similar experiences to their peers (Homeyer, 1999; Yalom, 1995). Another key factor is the indirect learning that occurs as group members observe one another in play.

Because language and cognitive skills are not fully developed in young children, verbal self-expression is naturally hindered (Landreth, 2002). Kindergarten age children may incur greater benefit from a nondirective play therapy group because psycho-educational groups are typically above the cognitive developmental levels of this age group (Jones, 2002). Child-centered group play therapy is rooted in child-centered play therapy and is a non-directive and developmentally appropriate counseling intervention for working with children (Jones, 2002).

Need and Purpose

An examination of the entire body of social skills literature indicates there is a paucity of research utilizing sound research methodology and evaluation protocols. This study will utilize both a well-researched intervention (child-centered group play therapy) and valid and reliable assessment tool (Social Skills Rating System, Gresham & Elliott, 1990), which will enhance the body of research. Specifically focusing on the variable of social skills will also add to the body of both play therapy and child-centered group play therapy research. Additionally, this study will provide an additional body of research in support of school counseling interventions.

Significance of the Study

This study is significant because it will address the viability of using small group counseling with young children to determine the impact on social skills development. It will add to the body of literature for social skills relative to kindergarten age children as current research is more often geared towards children already diagnosed with emotional, behavioral and/or academic problems. Additionally, this study will add to the play therapy research by utilizing the Social Skills Rating System (SSRS: Gresham & Elliott, 1990), which has not typically been used as an assessment tool despite its validity and reliability. Furthermore, this study will address the effectiveness of child-centered group play therapy as a viable school counseling intervention.

Research Question

The purpose of this study is to assess the impact of child-centered group play therapy on kindergarten children's social skills development as determined by both parent and teacher assessments. The overall research question is: What is the impact of

child-centered group play therapy on social skills for kindergarten children? The research

hypotheses are:

1. Kindergarten children who receive child-centered group play therapy will be rated

    higher by teachers for social skills (assertion, cooperation and self-control) than

    children who do not participate.

2. Kindergarten children who receive child-centered group play therapy will be rated

    higher by parents for social skills (assertion, cooperation, self-control and

    responsibility) than children who do not participate.

<div align="center">Assumptions</div>

The assumptions of the study are:

1. The teachers, parents and students will respond honestly to both the pre- and

    post-test surveys.

2. The random assignment of the children to the control and experimental groups

    will ensure the optimal guarantee of the equality of the individual play groups.

3. The child-centered play therapy groups will receive the same treatment because

    the author will lead all of the groups.

<div align="center">Delimitations</div>

The delimitations of the study are:

1. Participants in the study are children who attend kindergarten in public schools.

2. The focus of the study is the development of pro-social skill development during

    the kindergarten school year.

Limitations

The limitations of the study are:

1. The children in the control group may experience changes in their behaviors because of the effects of classroom modeling from their peers participating in the experimental group.

2. The study involves the participation of kindergarten children, which potentially limits the ability to generalize the effectiveness to other grades.

3. The only children who are participating in the research project are those children whose parents sign the informed consent. There is an additional potential limitation created by parents who do not complete ratings questionnaire.

4. The teachers will be aware of which children are receiving the treatment intervention, which could influence their final ratings.

Threats to External and Internal Validity

This study will examine groups of children who attend the same elementary school. External validity refers to the approximate truth that can be drawn from generalizing research results. Therefore, a threat to external validity would be an error in the explanation of the causes of the generalizability (Trochim, 2006). Since there are no inclusion criteria for participation except being in kindergarten, the results are expected to generalize to other kindergarten children of similar demographics. Internal validity refers to the degree to which observed differences between responses on a dependent variable are directly related to the independent variables and not to an uncontrolled variable (Patton, 2002). The main threat to internal validity is that the teachers will know which children are participating in the experimental group.

Operational Definitions

Social Skills is defined as the overall and subscale scores (Cooperation, Assertion,

Responsibility, and Self-Control) of both the parent and teacher versions of the

Social Skills Rating Scale (SSRS: Greshman & Elliott, 1990).

Cooperation is defined as the subscale scores of both the parent and teacher versions of

the SSRS and measures behaviors such as helpfulness and compliance (Greshman

& Elliott, 1990).

Assertion is defined as the subscale score of both the parent and teacher versions of the

SSRS and measures initiating and responding behaviors (Greshman & Elliott,

1990).

Responsibility is defined as the subscale score of the parent version of the SSRS and

measures behaviors that demonstrate the ability to communicate with adults and

regard property and work (Greshman & Elliott, 1990).

Self-Control is defined as the subscale scores of the parent and teacher versions of the

SSRS and measures behaviors related to both conflict and non-conflict situations

(Greshman & Elliott, 1990).

Group will be defined as two children who are paired in groups according to the scores of

the teacher version of the Problem Scales of the SSRS (Gresham & Elliott, 1990).

Summary

Chapter One provided a brief synopsis on the importance of social competence in

early childhood development. It also advanced a rationale for the need, purpose and

significance of the study. The research question to be addressed by the study was outlined

along with the assumptions, delimitations and limitations of the study. Key concepts and

variables to be discussed in this study are operationally defined. Chapter Two will

provide a thorough examination of the current and seminal research related to social

skills and play therapy literature. Chapter Three will address the methodology,

participants, procedures, instruments and data analysis used in the study. Chapter Four

provides descriptive information about the participants and the results of the study,

including the statistical analysis. Chapter Five provides a discussion of the study results,

the limitations and recommendations for future research.

CHAPTER 2: REVIEW OF RELATED LITERATURE

The purpose of this study is to examine the impact of child-centered group play therapy on social skills for kindergarten students. The first part of the chapter focuses on social skills while the latter is devoted to the intervention and is divided into several sections. It begins with an examination of two models of social development relative to children in this age group. This is followed by a section which examines the current social skills research with particular attention paid to academic achievement and emotional functioning. The focus of the third section is to highlight the current social skills research that is being used in the school environments. The interventions are divided into classroom based and small group interventions. A section has also been devoted to a limited examination of the social skills research as it relates to children deemed at risk due to being economically disadvantaged because of the socioeconomic make-up of the school from which participants are being selected. The second half of the chapter begins with a discussion of the history and theory of play therapy. The rationale for group therapy will be followed by a thorough review of the play therapy and group play therapy research specific to use in schools. The final section will present a supportive argument for the use of child-centered group play therapy as an effective intervention for social skills development based on the current literature.

Models of Development

Many theoretical models posit their individual theories of development. Most will agree that children learn from others with their development based on their early childhood experiences. A brief explanation of models that explain social interaction will be considered.

Erikson's (1963) model of psychosocial development describes kindergarten age children moving from the initiative versus guilt stage into the industry versus inferiority stage. In the earlier stage, children are highly dependent on the parents and children to guide them as they navigate the world. As children start elementary school they are gaining independence and opportunities for increased social experiences. Erikson believes that children need and enjoy play but they eventually learn that there are other activities (e.g. sports, games, music lessons, school) requiring their attention (1963). Successfully moving through the later psychosocial stages of development is dependent upon successfully navigating childhood relationships and experiences.

Social learning theory (Bandura, 1977) holds that most of children's learning comes through interacting and observing others. Children imitate the behaviors of others, including their newly observed behaviors, into their personal repertoire. This vicarious learning is not random and instead is their attempt to reproduce the behaviors they have observed. Shaping is the attempt to refine their new behaviors until they are completing an activity satisfactorily. Bandura (1977) does not believe that new behaviors need to require direct reinforcement to be maintained and that the vicarious reinforcement is sufficient. Early childhood peer relationships and social interactions are critical to social skills development.

While these theories provide a foundation for understanding, research is needed to more clearly describe the development of social skills. Cognitive processes in children are created through ongoing social interactions with parents early in life resulting in pro-social skills and positive peer interaction (Crick & Dodge, 1994). However, typically developing elementary-school age children often use aggression in social circumstances. As children mature, this behavior evolves into cooperative play and problem solving (Abell, Fraser, & Galinsky, 2001). Earlier longitudinal studies suggest that some children may not grow out of this coercive style of interaction (Farrington, 1991; Loeber & Farrington, 2001) requiring outside interventions to decrease the risk of possible negative developmental outcomes, such as peer rejection, poor performance in school, substance abuse, adolescent pregnancy or parenthood, and legal involvement (Kazdin, 1995; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Loeber & Farrington, 2001).

Social Skills Research

Academic Achievement

The empirical literature has long supported a link between children's social skill deficits and a variety of behavioral and learning difficulties (Elliott, Sheridan, & Gresham, 1989; Parker & Asher, 1987). Early social skills interventions are important because academic, emotional, social, behavioral and cognitive competencies are all predictors of positive school adaptation (McIntyre, Blacher, & Baker, 2006). In an effort to explain the causal relationship between academic underachievement and problematic behaviors, Hinshaw (1992) offered three possible explanations: (a) students who are unable to perform academic tasks will choose to act out toward others in order to escape

the task; (b) students may be so involved in disruptive, nonacademic activities that they are not academically engaged and miss important educational content; or (c) both domains influence each other.

Researchers have estimated that 25 to 85% of children with a social adjustment problem have beginning reading skill deficits (Beitchman et al., 1998; Greenbaum, Johnson, & Petrila, 1996). Dual impairments can produce drastic outcomes. For example, researchers have also found that children with social adjustment problems and auditory comprehension delays demonstrate more explosive antisocial behavioral patterns than those with social adjustment problems only (Baker & Cantweil, 1985; Cohen, 2001). After the age of five, these children are at serious risk of emotional and behavioral disorders, and dismal academic outcomes such as language learning disabilities, reading failure, grade retention, dropout, and demoralization (Beitchman et al., 1998; Cohen, 2001; Silva, Williams, & McGee, 1987; Tomblin, Zhang, Buckwalter, & Catts, 2000).

Approximately 50% of children diagnosed with ADHD have considerable problems in their social relationships with other children because many of the behavioral symptoms associated with ADHD contribute to social skills problems (Barkley, 2006). Behaviors such as difficulty taking turns, interrupting and intruding on other and the appearance of not listening when spoken to (American Psychiatric Association, 2000) can result in peer rejection (Mrug, Hoza, & Gerdes, 2001), low levels of social competence (Antshel & Remer, 2003) and exhibiting aggressive behaviors (Nixon, 2001). Self-regulation may be closely related to social skills, which are necessary to negotiate adult and peer relationships with both playing important roles in early educational experiences (McIntyre, Blacher, & Baker, 2006). Child self-regulatory skills and parent and teacher

ratings of social skills were evaluated at 36 months of age to determine if they could predict positive school adaptation in five and six year olds. One study examined children considered to have an Intellectual Disability (ID) compared to their typically developing (TD) peers (McIntyre, Blacher, & Baker, 2006). While the results indicated that children with ID had less positive early childhood experiences and were at greater risk for positive school adaptation, they also provide evidence that social skills are predictive of positive school outcomes regardless of developmental or adaptive functioning (McIntyre, Blacher, & Baker, 2006). This research supports an underpinning of this study that is all children can benefit from social skills interventions.

Hamre, Pianta, Downer and Mashburn (2008) studied preschool teachers' judgments of relational conflict among children as indicators of their academic and social adjustment. Results indicated that over half of the variance in teachers' reports of conflict could be explained by ratings of children's problem behaviors. This examination highlights the importance on the child-teacher relationship in determining the academic and social adjustment.

The research in this section demonstrates the importance of social skills and academic success and the necessity of providing early childhood interventions to support and enhance social competence. It further highlights the need for children to be able to meet teacher expectations of social functioning, as teacher perceptions are a key indicator of school success. Because of this important relationship, this study will utilize teacher ratings to determine the effectiveness of the intervention.

Emotional Functioning

The ability with which children can get along with their peers is an important predictor of emotional functionality as an adult (Hartup, 1992). This section will not only address the relationship between early childhood social skills and emotional functioning but also the importance of early intervention.

The ability to interact successfully with peers and adults is an important developmental accomplishment for children (Elliott, McKevitt, & DiPerna, 2002). Successful interactions are dependent on children's abilities to demonstrate appropriate social skills to be able to effectively experience satisfying social interactions with the school, home, and community (Santoro, Armstrong, & Massey, 2002).

Elementary school social competence with peers is significant as it relates to future adaptive and non-adaptive behavior in adolescence (Howes, 2000). In an effort to demonstrate long-term effects of early elementary school experiences, researchers studied the effects of teacher-child relationships in preschool in order to predict outcomes in the second grade. Hierarchical multiple regression was used with four year old preschoolers to predict their social competence in the second grade. Preschoolers with higher levels of aggression and low child-teacher relationship quality were more likely to experience higher levels of aggression and child-teacher conflict in the second grade. Results also indicated that lower levels of perceived child-teacher conflict coincided with higher levels of child-teacher closeness. Results indicated that teachers who perceived their second grade children with low aggressiveness and disruptive behaviors also perceived them to have lower levels of child-teacher conflict. Additionally, the results indicated a similar relationship between social withdrawal and child-teacher relationship conflict

(Howes, 2000). This study emphasizes the need for early social skills interventions such as the one proposed in this study. Kindergarten interventions can be instrumental in disrupting the long-term effects of poor child-teacher relationships given the relationship between behaviors and child-teacher relational quality.

Regardless of the causality between academic achievement and behaviors, this paragraph highlights the importance of social competence for academic success. The research demonstrates that children with academic and learning impairments are more likely to experience social skills deficits. This research supports the premise of and need for this study, which is that all children can benefit from social skills interventions.

Research on School Related Interventions

There are a large number of prevention and early intervention programs regarding social skills that have been developed for use in the school setting. Schools provide accessibility to children (Hall, Jones & Claxton, 2008) and an ideal social environment in which children interact not only with their same age peers but also older and younger children and adults. Children gain social competence when they engage their peers in social relationships (Howes, 2000). Because of the strong relationship between social skills and academic success in elementary skills, it is easily understood that such programs would be available and researched in the school setting (Raver & Knitzer, 2002).

A number of meta-analytical reviews of school-based social skills interventions have been conducted (Schneider, 1992; Beelmann, Pfingsten, & Loesel, 1994; Gresham, Sugai, & Horner, 2001) that indicate varying degrees of effectiveness for these interventions. For example, Gresham, Sugai, and Horner (2001) reported that the average

effect sizes ranged from .20-.87 with the weakest effects noted for special education students with behavioral disorders and specific learning disabilities. This supported earlier reviews in which Schneider (1992) found average effect sizes ranging from .55-.89. Despite the wide variety of results, the evidence continues to be suggestive that most interventions are effective for teaching pro-social behavior (King, 2001).

One potential reason for the varying degrees of success is that many school-based programs do not utilize sound research methodology and evaluation protocols, which impacts the ability to determine the validity and effectiveness of school-based initiatives (Leff et al., 2001). Another potential reason is that many of the standardized programs do not address specific or individualized needs of students, which may impact results by the presence of outliers. This study will utilize a well-researched and documented intervention and valid and reliable assessment tool to ensure the strength and fidelity of the research. Additionally, this study will utilize a developmentally appropriate intervention, which should meet the needs of all student participants. The specific methodology of this study will be addressed in a subsequent chapter.

The majority of programs currently being used and, subsequently, the majority of research are focused on classroom-based curriculum that is provided by teachers (Brigman et al., 2001). The following section will highlight programs based upon their method of delivery, classroom/teacher-based interventions, small group counseling, and school counseling guidance.

Teacher/Curriculum-Based Interventions

The social skills programs highlighted in this section are curriculum-based programs that teachers provide in a classroom environment. A number of such programs

have been developed along with the majority of research evaluating their effectiveness. Because of the time commitment, they are specifically integrated into the elementary curriculum with many requiring specialized training to integrate the program. These programs differ with regards to the intended population of students for which the program is designed (Leff et al., 2001).

The PATHS Program (Promoting Alternative Thinking Strategies) (Kutsche & Greenberg, 1995) and Second Step (Grossman et al., 1997) are universal prevention programs designed for use with all children in the school (Leff et al., 2001). The PATHS Program (Kutsche & Greenberg, 1995) is a 57-lesson curriculum based program for elementary school children to help children develop problem-solving, emotional regulation and self-control skills. Research outcomes indicate decreased in peer-related aggression and improved interpersonal problem solving skills (Greenberg & Kusche, 1996). A more recent study including data from 6500 students and 378 classrooms indicated more modest effect sizes for aggression and disruptive behaviors (Conduct Problems Prevention Group, 1999). Leff et al. (2001) suggest that contradictory results may be related to differences in post-intervention data collection and that PATHS was used in conjunction with another program in some instances highlighting a need for a replication study. Second Step (Grossman et al., 1997) is a class-wide social skills program for preschool through middle school consisting of 30 classroom lessons that are approximately 35-45 minutes long and taught one to times a week. Research results indicate less physical aggression and more neutral/pro-social behaviors in the lunchroom and playground based on teacher ratings. The authors also reported that treatment effects were consistent over a six-month period.

The First Step to Success Program (Walker et al., 1998) is a school and home-based program designed to assist aggressive Kindergarteners from developing antisocial behavior patterns. It is designed for use with high risk Kindergarteners and involves 1-2 months of classroom intervention followed by 6 weeks of home-based intervention focused on improving parenting skills and school-home communication. Research results indicated that children who participated in the program demonstrated decreases in aggressive and maladaptive behaviors based on two research studies (Golly, Stiller & Walker, 1998; Walker et al., 1998). This program is an example of a selective intervention in that it was specifically designed for use with children who are at high risk for aggressive behaviors (Leff et al., 2001).

The Stop & Think Social Skills Program (Knoff, 2001) is a classroom-based intervention designed to teach pro-social skills based on social learning theory with students in Pre-Kindergarten through Grade 8. King (2001) conducted research with kindergarten students, which resulted in statistically significant improvements for problem and hyperactive behaviors but did not reveal significant improvements for social skills. Hall, Jones, and Claxton (2008) replicated the research using a sequential, multi-cohort design. The results from Cohort 1 indicated increases in both social skills and academic functioning and a decrease in problem behaviors. The results from Cohort 2 indicated increases in social skills and decreases in problem behaviors. A sequential cohort design was used to exclude maturation during the school year as a possible cause of improvements in functioning.

The Social Problem Solving (SPS: Elias & Clabby, 1989) program is a curriculum-based computer facilitated social skills curriculum, which includes models on

self-control and social awareness. At-risk third graders who completed the SPS curriculum improved in their ability to control their emotions and behaviors when compared to their peers who did not participate (Elias, Hoover & Poedublicky, 1997).

The Incredible Years Parent and Child Training Program (Webster-Stratton & Reid, 2003) was originally designed to treat conduct problems with children ages 3-7. Kindergarten children in a culturally diverse, socioeconomically disadvantaged elementary schools participated in a two-year classroom intervention using the Incredible Years program. More than 1,100 children participated in the study that were divided into two intervention groups, children receiving both the parent and classroom intervention and children receiving only the classroom intervention, and one control group. Results indicated that children in both intervention groups (parent and classroom or classroom only) demonstrated significantly fewer externalizing problems and children in the parent and classroom intervention demonstrated greater emotional regulation than children in the classroom intervention-only group or the control group (Reid, Webster-Stratton, & Hammond, 2007). Home observation ratings did not change for any of the children. However, one limitation was the relatively low attendance rating of parents (at least 50% of mothers attended les than half of the sessions despite efforts to reduce barriers to participation) appears to lend support to the importance of finding school interventions.

In general, these findings indicate the effectiveness of teacher/curriculum-based interventions regardless of the current level of social skills functioning. Because they are classroom interventions, large groups of children are afforded the opportunity to receive the intervention. While the universal interventions are effective, there appear to be greater effects for the interventions that specifically target specific groups of children based on

aggressive and disruptive behaviors. However, a gap exists for specific social skills interventions that target children with social skills deficits or that specifically measure the variable of social skills. This study will address a portion of that gap in that it will specifically measure the variable of social skills.

Small Group Interventions

Small group counseling is an ideal way to group students that teachers, parents and school counselors have identified as having similar concerns. Tomori (1995) purports that small group counseling addresses these concerns in a positive and supportive environment that ultimately supports academic success. Typically small groups are either special-concerns groups, such as divorce, grief or substance abuse, or developmental groups, such as decision-making, social skills or self-esteem (Brigman & Early, 1991).

Research indicates that social skills interventions provided in a small group environment can be successful in decreasing disruptive behaviors and negative social interactions (Lane et al., 2005). Small group interventions have been also been used successfully with groups of students who did not benefit from school-wide or curriculum-based interventions (Tomori, 1995; Lane & Menzies, 2002; Lane et al., 2005). The following research includes specific small group counseling interventions that targeted social skills.

Stickel (1990) designed a group based on Lazarus' (1981) BASIC I.D. multimodal approach as a preventative strategy for improving social skills with kindergarten children assigned to one class. Outcome measures were based on the teacher's ongoing observations based on a specific multimodal checklist, which was completed pre- and post-intervention and weekly throughout the intervention. Seven 20-

minute group sessions covering each modality were held. Teacher feedback noted increased cooperation and interaction but overall there was limited quantifiable information. A unique feature of this particle group was that all of the students from the same classroom were able to participate in the small group intervention, which appears to have benefited the entire classroom based on teacher comments (Stickel, 1990).

The Anger Coping Group (Lochman, 1992; Lochman, Dunn, & Klimes-Dougan 1993) is a small group 18-session intervention for use with groups of 4-6 boys ages 8-14. It is a program specifically designed for boys who are already identified as highly aggressive. It has recently been adapted for boys ages 5-7. The results of two research studies (Lochman, Lampron, Gemmer, Harris, & Wycoff, 1989; Lochman & Curry, 1986) indicate improvements in social problem-solving skills, self-esteem and social competence and parent/teacher behavior ratings. A 3-year follow-up study indicated that the participants had lower substance use, more social problem-solving skills and higher self-confidence than control group children.

Third graders identified with social skills deficits participating in a 10-week social skills evidence-based S. S. GRIN (DeRoser, 2007) program improved their reading score on the end-of-grade tests and showed reductions in loneliness and social anxiety (Bostick & Anderson, 2009). Because the results of this initial study were positive, the school counselor continued to provide the intervention based on self-assessments. While the highly structured cognitive behavioral component of this group may not be developmentally appropriate for younger grades, it is an example of how outcome measures can lend support to school counseling interventions.

This research selection highlights the effectiveness of small group counseling interventions as prevention and early intervention programs promoting academic success. This study will utilize a developmentally appropriate small group counseling intervention to promote social skills development in kindergarten children.

School Guidance Counseling and Mentoring

Social skills programs have also been designed for use as part of school guidance programs. They include curriculum-based school counseling programs that are taught by school counselors and mentoring programs. These programs highlight an additional tier that school counseling professionals can use as an intervention method.

The Student Success Skills program (SSS) is a classroom and group counseling intervention for teaching academic, social and self-management skills (Brigman, Webb & Campbell, 2007). Students in Grades 5-9 who participated in a counselor-led SSS program scored significantly higher in math achievement and showed behavioral improvement. Additional studies have indicated that the SSS intervention results in positive effects on academic achievement as measured by statewide achievement tests and social competence of students (Brigman & Campbell, 2003; Campbell & Brigman, 2005; Webb, Brigman, & Campbell, 2005)

Ready to Learn (RTL: Brigman, Lane, & Lane, 1994; Villares, Brigman, & Peluso, 2008)) is a curriculum based program that teaches early elementary school students the learning and social skills needed for school success. Multiple research studies have indicated its effectiveness with results indicating that students who participated scored significantly higher on listening comprehension (the prerequisite to reading comprehension) and behaviors related to academic and social skills (Brigman,

Lane, Switzer, Lane & Lawrence, 1999; Brigman & Webb, 2003).

Barron-McKeagney, Woody, & D'Souza (2001) created a mentoring program for Latino middle and high school students. The goal was to increase not only student participation in positive community activities but also parent participation in activities that would improve their parenting abilities. Results indicated that mentored children had more positive gains on social skills than non-mentored children on both the self- and parent ratings of the Social Skills Rating System (SSRS: Gresham & Elliott, 1990) when compared to children in a standardized sample. (Barron-McKeagney, Woody, & D'Souza, 2001).

This research indicates that guidance and mentoring programs can also be effective tools in promoting social skills. While the research may not be as extensive as other types of programs, these types of programs should not be overlooked.

Summary

The wide variety of social skills programs, teacher/curriculum-based, small group counseling and guidance counseling, highlights the multiple tiers that counseling professionals can utilize to implement interventions. The entire body of research also appears to indicate that providing any intervention is better than providing no intervention. This not only underscores the importance of continuing to provide prevention and early intervention social skills programs but also that these programs need to be methodologically sound and evidence-based interventions. An additional consideration is that programs must be developmentally appropriate for the target population. While the programs highlighted in this review may assist with social skills deficits, behavioral and adjustment-related difficulties, and academic functioning, they

were not designed as therapeutic interventions specific to social skills. This study will bridge that gap by providing foundational research specific to the outcome measure of social skills developments. The current study design is evidence-based and developmentally appropriate and will target social skills improvements in kindergarteners, which, in theory, will positively impact academic and emotional functioning.

<div align="center">Play Therapy</div>

The History of Play and Group Play Therapy

The first person to advocate for the study of play in children was Jean-Jacques Rousseau (1762; 1993) while Sigmund Freud was the first to record the actual use of play in therapy in his work with Little Hans (Lebo, 1955). The history of play therapy is rooted in psychoanalytic theory through the works of both Anna Freud and Melanie Klein. The use of psychoanalytic techniques with children was adapted from adult models, and, therefore, the techniques were slow to evolve in their effectiveness as tools for children (Lebo, 1955). It was through the work of Carl Rogers that the roots of non-directive play therapy evolved.

Carl Rogers (1951) is responsible for the emergence of nondirective therapy with adults. At its roots were the principles that individuals have within them means for growth and self-direction. Through unconditional positive regard, empathic understanding and genuineness on the part of the therapist, the client will experience positive therapeutic change. The therapist would make no attempt to change or control the client and would use a nondirective approach allowing the client the freedom to choose the direction and nature of change (Rogers, 1951; Lebo, 1957).

Rogers' non-directive approach was adopted by Virgina Axline (1969), who is credited with developing the nondirective approach to play therapy. Axline (1969) developed eight principles of play therapy to guide therapists in their work with children:

1. The therapist needs to develop a warm relationship with the child and establish rapport as soon as possible.

2. The therapist accepts the child without conditions.

3. The therapist establishes a permissive environment so that the child feels free to express him or herself.

4. The therapist maintains a deep respect for the child's innate abilities for problem-solving and self-direction.

5. The therapist does not control the child's behaviors or verbal expressions and lets the child lead.

6. The therapist recognizes and reflects the feelings of the child to assist the child in gaining behavioral insight.

7. The therapist does not hurry the process.

8. The therapist establishes only those limits that are necessary to anchor the session to reality and return responsibility to the child.

Child-Centered Play Therapy

Axline's principles are the basis of the child-centered play therapy approach of Landreth (2002), which is the theory used in this study. Play therapy is considered one of the most effective therapeutic interventions for young children. To effectively communicate with a kindergarten-aged child at the child's cognitive and social-emotional level, the use of play materials is essential (Landreth, 1993). Play therapy is a safe

relationship between a child and a therapist which provides an opportunity for the child to fully express and explore thoughts, feelings and behaviors through play, which is the "child's natural medium of communication (Landreth, 2002, p. 14)." The play therapist provides the child the opportunity to explore his/her feelings through reflection, and demonstrates confidence in the child's ability to act.

Child-centered play therapy supports the belief that children are growth-oriented with a tendency toward self-actualization (Landreth, 2002). Just as adults are capable of self-knowledge and the ability to come to terms with issues and growth, so it is with the children. They bear an innate ability towards growth and healing. The underlying philosophy of the child-centered approach is the belief in the ability of children to take themselves where they need to go in the treatment process (Landreth, 2002).

The structure of the personality is based on the person, the phenomenological field and the self. The person is everything that makes the child who he/she is: thoughts, feelings, behaviors and physical being. The phenomenological field includes conscious and unconscious experiences. The self is the perception that the child has of him/herself. As the child develops, changes occur in all three. Healthy development is typified by congruence between the child and his/her perceptions of self. All behavior of the child is caused by a need for self-realization (Landreth, 1993). The child's perception of reality must be understood. Incongruencies between the self and ideal self create the child's reality and shape thoughts, feelings and behaviors (Landreth, 1993). It is the misdirected drive for self-realization that causes maladjustment. These drives need to be channeled into more appropriate behaviors (Axline, 1969, p. 58). The child-centered approach

supports the notion that children are people in their own right and, accordingly, children are given the same respect as one would accord an adult client.

Child-Centered Group Play Therapy

Child-centered group play therapy (CCGPT) is, "a psychological and social process in which children, in the natural course of interacting with each other in the playroom, learn not only about other children but also about themselves (Landreth, 2002, p. 38)." It is an intervention resembling group counseling for adolescents and adults wherein small groups of children are taken into the therapeutic playroom and allowed to interact and play with each other under the direction of a play therapist. It is the interaction with other children that helps them learn about themselves and others and developed new skills. It combines the advantages of both child-centered group play therapy and small group counseling (Landreth & Sweeney, 2001).

In group play therapy, children are free to work on their individual problems (Landreth & Sweeney, 2001). "Group play therapy can give children the kinds of experiences that help them learn to function effectively, to explore their behavior, to develop tolerance to stress and anxiety, and to find satisfaction in working and living with others" (p.191). Therapeutic change continues to be a result of the therapeutic relationship but is enhanced because children will change not only as a response to the other children in the group but also the therapeutic environment (Landreth & Sweeney, 2001).

The goals of child-centered group play therapy are to provide and environment in which a child can gain improved coping skills, increased self-acceptance and self-reliance, increased responsibility and choice making, increased independence and

improved self-control (Landreth, 2002; Landreth & Sweeney, 2001). Group play therapy works towards these goals by providing a safe and accepting environment that provides opportunities for vicarious and cathartic learning (White & Flynt, 1999).

Play Therapy Research

The effectiveness of individual play therapy and play therapy modalities as school counseling interventions has been studied in numerous research articles. Meta analysis conducted by Bratton, Ray, Rhine and Jones (2005) determined that play therapy is effective across age, gender, and issue. Of the 93 play therapy studies conducted between the years of 1953 – 2000, 36 were conducted in the school setting. The average number of session conducted in schools was 8.4 sessions. This study is using a ten-session design that is in keeping with current school-related play therapy research design. After play therapy, the average treated child was functioning at 0.80 standard deviations better than children not treated and that humanistic–nondirective play therapy approaches, such as Child-Centered Play Therapy, produced significantly larger treatment effects than non-humanistic–directive approaches (Bratton et al., 2005).

An earlier review of literature conducted by Bratton and Ray (2000) highlighted that the focus of early play therapy research (1950s and 1960s) was on intelligence and school achievement and switched focus to social adjustment and self-concept in the 1970s and early 1980s. More recent research tends to focus on societal issues and specific diagnoses. The topic of social skills has rarely been addressed except in relationship with other variables. Overall, play therapy research has been researched and proven effective for a variety of childhood disorders and issues, including but not limited to anxiety disorders, selective mutism, withdrawn/internalizing behaviors, acting out/externalizing

behaviors, sexual abuse, learning/academic problems, enuresis/encopresis and life adjustment issues (Bratton & Ray, 2000). This literature review will only highlight the play therapy research that has been conducted in the school setting.

Child-Centered Play Therapy Research

The effectiveness of Child-Centered Play Therapy (CCPT) has been demonstrated in multiple research articles across a variety of settings. Based upon a review of archival data of play therapy research conducted since 1990, Ray (2008) highlighted the effectiveness of play therapy for a variety of childhood problems, to include anxiety, self-efficacy, self-concept, internalizing and externalizing problematic behaviors, depression, learning disability and medical treatment compliance.

Research by Kot, Landreth & Giordano (1998) with child witnesses of domestic violence who participated in twelve CCPT sessions scored significantly higher on self-concept than those who did not receive play therapy. Research conducted in schools with elementary school students (Fall, Balvanz, Johnson, & Nelson, 1999; Post (1999) revealed that children who participated in CCPT demonstrated statistically significant greater self-efficacy and self-esteem over their peers who did not participate.

The research conducted by Post (1999) considered the effectiveness of child-centered play therapy on self-esteem, locus of control, and anxiety with at-risk youth in grades four to six. The researchers concluded that the students felt accepted by this particular play therapy approach. The findings indicate that child-centered play therapy may be needed to prevent at-risk children from developing lower self-esteem and from reducing their sense of responsibility for their academic successes and failures.

Utilizing archival data from a previous study on group play therapy as a comparison group, Rennie (2000) examined the effectiveness of individual CCPT on self-concept. Results indicated that individual play therapy was more effective than group play therapy based on teacher ratings of self-concept for kindergarteners with adjustment problems. The study also lends support that play therapy can be an effective intervention for children at-risk for behavioral problems and negative self-concept (Rennie, 2000).

Garza and Bratton (2005) studied the impact of CCPT on behaviors with Hispanic, Spanish-speaking elementary school students in Grades K – 5 who had been referred for school counseling due to behavioral problems. They utilized a comparison group that provided curriculum-based small group counseling. The results indicated that the children who received the CCPT displayed significantly fewer internalizing and externalizing behavior problems on the based solely on parent ratings. There were no observable differences based on teacher ratings.

Group Play Therapy Research

Irwin (1972) established that group play therapy meets the linguistic, social and emotional needs of young children. Group play therapy has been used with children who have been sexually abused (Perez, 1987), child witnesses of domestic violence (Kot, Landreth, & Giordano, 1998; Tyndall-Lind, 1999), homeless children (Baggerly & Borkowski, 2004), aggressive acting out children and social skills deficits.

Research conducted by Gaulden (1975) examined the effectiveness of developmental play group counseling and play group counseling with second graders in a Title I school who were identified as having behavior problems. Developmental play group counseling combined the use of discussion triads with unstructured play. Play

group counseling used an unstructured approach with toys and other play materials. Children who participated in play group counseling significantly reduced their classroom behavioral problems by one or more standard deviations and maintained their behavioral improvement at the eight week post-intervention follow-up. The author determined that play group counseling was more effective than the developmental play group counseling, whose results were similar to those in the control group. He posited the verbal component of the developmental play group intervention might not have been developmentally suited for the age range (Gaulden, 1975).

Gould (1980) studied the effectiveness of non-directive group play therapy on behavioral problems and self-concept with kindergarteners identified as having adjustment problems. The results were compared with data from an earlier study the used a psycho-education discussion group format. Both groups of children who received an intervention demonstrated positive change compared to the control group with the children in the non-directive group play therapy exhibiting the most change. The author indicated that children in both of the intervention groups benefited because they had the opportunity to learn and practice social skills, which resulted in a positive increase to their self-concept.

Using Moustakas' relational model (1973), Perez (1987) researched the effectiveness of both individual and group play therapy for children ages 4 – 9 who had been sexually abused. The self-concept and self-mastery scores for the children receiving either individual of group play therapy improved significantly over children in the control group, whose post-test score decreased. The author observed that participation in group play therapy was advantageous as the group allowed children to identify with others

decreasing their sense of isolation and providing a pseudo-family in which therapeutic

healing could take place (Perez, 1987).

Hoffman and Rogers (1991) researched the effectiveness of group play therapy

with children who had been earthquake victims. The results indicated decreased levels of

anxiety, increased self-control and improved understanding of the trauma associated with

the earthquake.

Kestly (2001) created a sandplay group for fifth grade boys who were referred

due to their disruptive classroom behaviors and fighting at recess. The participants in her

sandplay friendship groups decreased the overall number of office referrals, a change that

maintained for several months after the completion of the group. Teachers also noted that

the students were calmer upon returning to class after the sandplay group session.

This body of research demonstrates the effectiveness of group play therapy for

children experiencing difficulties ranging from abuse and trauma to adjustment and

behavioral difficulties. The benefits of the group model for providing opportunities to

learn and practice new skills in a safe environment were also noted. This study will

provide students with the opportunity for vicarious and direct learning of social skills

from their fellow participant/group member.

Child-Centered Group Play Therapy Research

As early as 1970, researchers recognized the need to validate the effectiveness of

child-centered group play therapy (House, 1970). This study was focused on discerning

the effects of child-centered group play therapy on the self-concept of second grade

students who were identified as "under chosen". Small groups of six children participated

in twenty 30-minute sessions over period of 10 weeks and were measured against

children participating in comparison group, which consisted of a specialized reading program with the same regimen as the experimental group and the control group, which received no treatment. The results indicated that the self-concept of experimental group increased significantly while the self-concept of control group decreased (but not significantly). The author posits that child-centered play therapy groups provided an atmosphere in which children learned to express themselves in positive ways which supports the child-centered philosophy that children will mature if given the opportunity to do so (House, 1970).

Trostle (1988) was interested in the effects of child-centered group play therapy and sex differences on self-control in young bilingual Puerto Rican children who had lived in United States less than six months. A comparison/control group was used with children who participated in unstructured free play. The results demonstrated that the children in the experimental group showed significant improvement compared to the control group on self-control and higher-level play behaviors, such as make-believe and reality play.

Tyndall-Lind (1999) conducted research to compare individual and sibling group play therapy with child witnesses of domestic violence. The results indicated that both interventions resulted in decreases in externalizing and internalizing behaviors and improvements in self-concept.

Shen (2002) conducted research on the effectiveness of group play therapy with Chinese children in Taiwan, who were earthquake survivors. School and disaster relief counselors who had limited time and resources utilized short-term group play therapy because of its relative convenience for use. Following the group play therapy treatment,

the children in the experimental group self-reported decreased levels of anxiety at

significant levels. Participants also self-reported decreased levels of depressive

symptoms but not at statistically significant levels with the exception of suicidal ideation,

which was significantly reduced. The author notes that some of the children involved in

the study were discouraged from participating by their parents because it was considered

as "play" and detracted from schoolwork.

The basic tenets of CCPT were adapted for group play/activity therapy with

learning disabled adolescents in grades four and five who were identified with behavioral

problems (Packman & Bratton, 2003). The results indicated that children who

participated in the group demonstrated fewer problem behaviors.

Child-centered group play therapy has been used with a homeless child (Baggerly

& Borkowski, 2004). A homeless student was paired with a female classmate for ten

weekly sessions of CCGPT. The lead researcher observed that play themes evolved from

nurturing and dependency themes in the first four sessions to themes of mastery and

positive power nearing the end of the intervention. Post-intervention data was unable to

be collected from the mother but she did report verbal satisfaction and improvements in

behaviors. Teachers also rated improvements in social skills and observed fewer incidents

of dependency, lying and stealing upon completion of the group play therapy sessions.

Baggerly and Parker (2005) researched the effectiveness of group play therapy

with African American boys based on the belief that this intervention would honor an

Afrocentric worldview and build self-confidence. The authors determined the

successfulness of the group therapy process through qualitative analysis of verbal data

culled from the group play therapy sessions and that the play therapy groups were instrumental in facilitating self-confidence.

Danger and Landreth (2005) studied the effectiveness of child-centered group play therapy as an intervention for pre-kindergarten and kindergarten children with identified speech impairments. The 11 children in experimental group were divided into dyads (one group of three) and received 25 30-minute group play therapy sessions in addition to their weekly speech therapy. Research findings indicated that children in the experimental group improved their receptive and expressive language skills. The impact of CCPT on anxiety had mixed results. Individual reviews of scores indicated some children who rated significant scores for anxiety at the pre-test, decreased in levels to non-significance upon completion of the study.

These studies not only demonstrate the effectiveness of the child-centered group play therapy model with a variety of issues but also their utility as a school-counseling intervention. The results indicate the significant positive impact in functioning, which ultimately could possibly improve students' academic functioning. This study will examine the impact of this model with regards to social skills. Given its proven effectiveness with a range of issues, it is highly plausible that a ten session intervention will produce significant positive results for social skills enhancement.

Research Related to Other School-Related Play Therapy Interventions

Kinder therapy is a model in which teachers are trained in play therapy and subsequently engage in play therapy sessions with a student. Draper et al. (2001) utilized Kinder Training with teachers and students in kindergarten and first grade. Upon completion of the intervention, overall teacher ratings on the Social Skills Rating System

(SSRS: Gresham & Elliott, 1990) indicated improvements with scores falling within the average range. Prior to the intervention, teachers rated their students as below average for social skills. This particular study did not use a control group so the only data available were the pre-and post-test data of the experimental group (Draper et al., 2001). This study is unique in that it utilized the SSRS as an assessment tool, which is the same instrument that will be used in this study.

Kindergarten and prekindergarten students who participated in filial therapy with high school mentors experienced a significant reduction in internalizing behaviors (e.g. withdrawal, depression, anxiety) and fewer externalizing behaviors though not significant (Jones, Rhine & Bratton, 2002). Positive trends in decreasing problematic behaviors in the younger students were also indicated. A similar model was used with fifth grade students providing filial therapy with kindergarten students identified as having adjustment difficulties (Robinson, Landreth, & Packman, 2007) but did not include measures to identify changes in behaviors of the kindergarteners.

Pair counseling is similar to group play therapy providing a structured, developmental play therapy intervention with the goal of helping children manage basic relationship functions and use age appropriate social skills (Selman & Schultz, 1990, Karcher, 2002). It is used with older children ages 8 – 14 and helps them practice social skills in a two-person relationship that can aid them in more complex social relationships. It was initially developed for youth in residential treatment settings who were identified with more severe clinical disorders such as depression and conduct disorder (Lyman & Selman, 1985; Selman & Cohn, 1990). Karcher (1999, cited in Karcher, 2002) manualized pair counseling into a 20-session intervention that could be used in schools as

a counseling intervention. Research indicates that pair counseling is effective with remedying social skills deficits reducing the levels of internalizing and externalizing behaviors for children ages 8 – 12 (Karcher & Lewis, 1992)

This body of research highlights the effectiveness of play therapy for withdrawn/internalizing behaviors, acting out/externalizing behaviors, sexual abuse, homelessness, trauma, learning/academic problems, self-concept and life adjustment issues. Some research highlighted social skills improvements as a result of the play therapy intervention although it has not been targeted as a specific stand-alone variable. This study will bridge that gap by specifically assessing the impact of CCGPT on social skills. Based on the importance of early elementary school experiences, a counseling intervention that specifically addresses the social skills development of kindergarten children will add to not only the play therapy literature but also the social skills and school counseling literature.

<div align="center">Summary</div>

This chapter provided an in-depth examination of the current literature relating to social skills and play therapy interventions conducted in the school setting. Models of social development relative to children in Kindergarten were presented along with social skills research specific to academic achievement and emotional functioning. The section on social skills research ended with an examination of prevention and early intervention programs. This section underscores the need for developmentally appropriate interventions to address social skills deficits as a means for improving academic and emotional functioning. The literature highlights that while all children can benefit from

social skills interventions, there exist particular groups of children who need such interventions for positive school adaptation.

The second half of the chapter was focused on play therapy. An explanation of the theoretical foundation of play therapy followed by a thorough review of the play therapy and group play therapy research specific to schools was provided. Play therapy, specifically child-centered group play therapy, has demonstrated its effectiveness across a variety of settings and issues. Therefore, it appears credible that child-centered group play therapy could be effective counseling intervention for social skills development in kindergarteners, Chapter Three will outline the methodology to be used in conducting such research.

CHAPTER 3: METHODOLOGY

This study assessed the effectiveness of child-centered group play therapy as an intervention for kindergarten children with regards to social skills development. In particular it addressed whether child-centered group play therapy has an impact on increasing social skills of kindergarten children when compared to the control group who did not receive child-centered play therapy. This chapter will describe the research methodology in sections devoted to the participants, procedures, instrumentation, and data analysis associated with the study.

Participants

Participants were male and female students enrolled in kindergarten at a public elementary school (grades K – 5) school in a city of approximately 28,000 in North Carolina. Participants were drawn from all enrolled kindergarteners (approximately 100 students) within the school whose parents provided permission to participate in the study. Prior to the start of the study, an a priori power analysis using the G*Power 3.1 application (Faul, Erdfelder, Lang & Buchner, 2007) indicated that a sample size of 45 participants would be necessary to achieve power of .95 with alpha equal to .05 and a moderate effect size (Cohen's $d = .5$). The ideal total sample size planned for the research was $n = 48$, in which the children would be randomly assigned and then divided into either the experimental or control groups. Upon the return of all parent consent forms, 49 children were provided permission to complete in the study.

Procedures

Application for approval by the Institutional Review Board for Research with Human Subjects at the University of North Carolina at Charlotte was completed and approved prior to recruitment of participants and data collection. Approval from the principal of Elizabeth Koontz Elementary School and Rowan-Salisbury Public Schools to conduct the research study had already been obtained during the planning phases of the research. After permission was received by the IRB, the primary researcher met with the kindergarten teachers to explain the research and answer questions.

Pre-Intervention Data Collection

All kindergarten students in the school were invited to participate in the study. Envelopes, which contained a packet of forms including a letter explaining the study, an informed consent form for parents, a demographic survey and the parent questionnaire of the Social Skills Rating System (SSRS: Gresham & Elliott, 1990) were sent home to every kindergarten students in their weekly school folders. A signed parent consent form was required for student participation (See Appendix A). In total, 49 signed parent consent forms, along with the pre-test SSRS and parent demographic surveys, were returned to the school, which accounted for 53% of the total kindergarten population To protect the identity of all participants, a participant code was used to identify those students with permission to participate in the study. The code was used to preserve anonymity and was needed to link the pre- and post-intervention data. Because the number of parent consent forms returned was almost equal to the sample required, all children whose parents provided consent were included in the research ($n = 49$).

Upon receipt of the parent packets, the teacher questionnaires of the Social Skills Rating System (SSRS: Gresham & Elliott, 1990) were administered for the pre-test. Each kindergarten teacher received an envelope with the requisite number of pre-labeled questionnaires for each student within their class who had parental permission to participate. Once the teacher surveys were returned for each respective child, the children were randomly assigned into the experimental and control groups. Because both an even number of children were required and 13 small groups could be accommodated with the school schedule, a random number generator was used to select 26 children for the experimental group. The remaining children (n = 23) were assigned to the control group. Children in the experimental group were paired according to classroom assignment and scores. For example, the children randomly assigned to the experimental group in Classroom A were grouped together so that a child with a lower overall Social Skills score on the teacher questionnaire of the SSRS (Gresham & Elliott, 1990) was paired with a child with a higher overall score. Pairing children with dissimilar social skills levels provided the greatest opportunity for vicarious learning and modeling within the group sessions (White & Flynt, 1999).

Intervention: Child-Centered Group Play Therapy

The primary investigator conducted ten play therapy sessions using child-centered group play therapy (CCGPT: Landreth, 2002) with each pairing of children. A typical play therapy group consists of two-three children but due to size constraints of the play therapy room, this study created pairings of two children for each group. Thirteen play therapy groups were formed. The groups met twice a week for five weeks in a specially outfitted play therapy room that the school utilizes for play therapy. Each session lasted

30 minutes with the investigator escorting the children to and from their classrooms. Sessions were rescheduled to accommodate absences, fieldtrips, testing, etc so that each child completed all ten sessions. However, two of the children could only complete eight sessions, due to extended absences greater than one week.

The play therapy room utilized play materials from three categories, which afforded the exploration of a variety of play behaviors and associated feelings. Examples of toys from each category were:

1. Creative – easel for coloring and chalkboard (construction paper, newsprint, markers, pencils, etc), glue, popsicle sticks, pipe cleaners, scissors, dry erase board with dry erase markers, musical instruments (xylophone, maracas, bells); container with sand

2. Real life – dollhouse with figures, cash register, play food; kitchen utensils and serving ware, phones, dolls, animal figures, blocks

3. Aggressive-Release – Nerf sword, handcuffs, toy gun/knife, snake/dinosaur/shark figures, small army men

Because of the non-directive nature of CCGPT, group members were allowed to play freely with the toys with limits given only to protect the safety and welfare of the child/ren, materials, and therapist. At the beginning of each session, the primary investigator/therapist told the children, "In this playroom you may play with all of these toys in most any way you would like," and then the therapist sat in a chair. Children were allowed to play freely and the primary investigator refrained from asking questions or directing play, which is typical of CCGPT. The therapist personalized statements about the child/ren's play or reflected their feelings using their first name to ensure that the

child/ren knew to which of them the therapist was speaking. For example, "Joe, you are enjoying playing in the sand. And, Sam, you are watching Joe." The therapist used the following child-centered play therapy skills when interacting with the groups:

1. Tracking – saying out loud what the child is doing

2. Responding to feeling – noting out loud the expressed and unexpressed feelings of the child and/or child's play

3. Returning responsibility – allows the child to be in charge and make choices, e.g. a question would be responded to with, "That is something you can decide."

4. Responding to effort/esteem building – reflecting out loud the effort the child is showing in their activity

The therapist created a permissive environment so that children could play freely and enforced limits only when safety was a factor. The therapist used the ACT model (Landreth, 2002) of limit setting, which is a three-step process. The first step involves acknowledging the purpose of child's behavior and/or associated feeling. The second step is communicating the limit and is focused solely on the behavior of the child. The third step is targeting an alternative behavior for the child to choose over the limited behavior. For example, "Jimmy, you are frustrated but the car is not for throwing at the wall but you may slide across the floor."

As stated earlier, care was given to personalize each statement. The therapist also tried to maintain vigilance so that both children were equally attended to. When children engaged the therapist, she addressed the child using the most appropriate play therapy response. As is typical, the therapist told the children when there was 5-minutes left in

the session so they would know that the session was nearing completion. At the end of the session, the therapist told the children the playtime was over and then escorted them back to class. During the time between sessions, the therapist returned to the playroom restoring it to pre-session order prior to the start of the next session.

All play therapy sessions were videotaped and case notes were completed. The use of videotapes and case notes were used to ensure intervention fidelity or that the intervention was conducted as planned. The videotapes were used during weekly supervision between the therapist and the dissertation advisor. Additionally, the documentation was used to provide interpretive data to support the results, which will be discussed in later chapters.

Post-Intervention Data Collection

Upon completion of the ten sessions of group play therapy, the post-test surveys were distributed to the parents and teachers of both the experimental and control groups. The same methods of data collection used for the pre-intervention data were used for the post-intervention data. All 49 teacher questionnaires (100%) of the SSRS (Gresham & Elliott, 1990) were completed and returned while only 43 parent questionnaires (87%) were completed and returned. Of the six questionnaires that were not returned, four were students in the experimental group (one relocated out of state prior to end of school year, one relocated into an emergency shelter, two were non-responsive to follow-up) and two were in the control group (both non-responsive to follow-up). While the majority of parent forms were returned quickly to the school, the primary investigator did follow-up with phone calls and used teacher assistance to collect as many forms as possible. In some instances, duplicates of forms were resent and returned after follow-up

communication by both the primary investigator and teacher. The ESL teacher also assisted with the parents whose primary language was Spanish by arranging meetings for them to come to the school to complete the SSRS (Gresham & Elliott, 1990).

Control Group Intervention

Upon the receipt of the data, the children in the control group participated in five play therapy sessions of 45 minutes each. These groups included groups of three children that sometimes crossed classroom boundaries. While the groups were held in the same playroom, the therapist took a more directive approach with the children, which included directed activities such as sharing, storytelling and performing either a puppet show and/or musical act. No follow-up data was collected upon the completion of the control group

Instruments

A number of different instruments were used to collect data and evaluate the effectiveness and intervention fidelity of the research. A demographic survey, which solicited information about the participant's age, gender, ethnicity, and early childhood education experience (Appendix B), was used. Both the Teacher and Parent Questionnaires of the Social Skills Rating System (SSRS) were utilized to measure social skills, respectively. A play session summary form was used to record each group play therapy session (See Appendix C).

Parent Demographic Survey

Parents were asked to provide general demographic information regarding their child in the form of the survey provided as Appendix B. The primary investigator created this form for use in this study. The survey questions asked the participant's age, gender,

and ethnicity. In addition, parents were asked to report the number of children in the family and the early childhood experiences of the child with regards to day care, pre-kindergarten programs, etc. The purpose of this information was to provide additional descriptive information regarding the demographics of the children participating in the study. This data will be summarized and shared in later chapters as it provides useful information for school counselors to assist with developing programs or identifying children who might benefit from social skills interventions.

Social Skills Rating System

The Social Skills Rating System (SSRS), developed by Gresham and Elliott (1990), is a norm-referenced, standardized instrument that was designed to assess social skills in school-age children from Preschool through High School. The SSRS includes three scales: Social Skills, Problem Behaviors, and Academic Competence. For this research study, the scores from only the Social Skills scale and its associated subscales from the Elementary School version of the SSRS (Gresham & Elliott) were used. The surveys are self-administered and require the rater to rate relative frequency based on "How Often" a behavior occurs (0 for Never, 1 for Sometimes, 2 for Very Often).

The Teacher and Parent Questionnaires of the SSRS (Gresham & Elliott, 1990) are self-administered multi-item surveys. Summing the raw scores from three subscales produces the Social Skills score of the teacher questionnaire: Cooperation (items 8, 9, 15, 16, 20, 21, 26, 27, 28, 29), Assertion (items 2, 3, 6, 7, 10, 14, 17, 19, 23, 24), and Self-Control (items 1, 4, 5, 11, 12, 13, 18, 22, 25, 30). The Cooperation subscale measures behaviors such as helpfulness and compliance. The Assertion subscale measures initiating and responding behaviors. The Self-Control subscale measures behaviors

related to both conflict and non-conflict situations. Summing the raw scores from four subscales produces the Social Skills score of the parent questionnaire: Cooperation (items 1, 2, 11, 15, 16, 19, 21, 27, 28, 33), Assertion (items 4, 10, 12, 13, 23, 24, 30, 34, 35, 38), Self-Control (3, 6, 9, 14, 17, 22, 25, 26, 32, 36) and Responsibility (items 5, 7, 8, 9, 18, 20, 29, 31, 37, 38). The subscale measurements for Cooperation, Assertion, and Self-Control on the parent questionnaire are the same types of behaviors as the teacher questionnaire. The Responsibility subscale measures behaviors that demonstrate the ability to communicate with adults and regard property and work.

The reliability of the SSRS is estimated by determining an internal consistency coefficient or coefficient alpha to ensure that all of the items on the scale are homogeneous, i.e. measuring the same construct. Gresham and Elliott (1990) reported coefficient alpha scores for the teacher questionnaire of .94 and the parent questionnaire of .87, which indicates a relatively high degree of scale homogeneity. The coefficient alpha scores of the subscales are lower, ranging from .86 to .92 for the teacher questionnaire and .65 to .80 for the parent version. The lower scores of the parent questionnaire indicate a moderate degree of homogeneity and can be best explained that fewer items (between six and ten) are being measured in each of the subscales. More research has been conducted using the teacher questionnaire resulting in similar internal consistency ratings (King, 2001; Miller, Lane, & Wehby, 2005; Hall, Jones, & Claxton, 2008).

The validity of the SSRS (Gresham & Elliott, 1990) is based on moderate-to-high correlations with other similar rating skills such as the Child-Behavior Checklist (CBCL:

Achenbach & Edelbrock, 1983), the Social Behavior Assessment (SBA: Stephens, 1978),

and the Harter Teacher Rating Scale (TRS: Harter, 1985).

The majority of child-centered play therapy research has been conducted using

the CBCL or the Filial Problem Checklist (Horner, 1974), which have been normed on

populations of children with identifiable and diagnosable behavioral problems. The SSRS

Social Skills scale and associated subscales are consistent with the goals of child-centered

group play therapy.

Session Documentation

The use of session case notes and videotapes were used for each group play

therapy session. Case notes were completed for each group play therapy session utilizing

the play session summary form included as Appendix C. The purpose of this form was to

preserve observations, impressions and trends of a more qualitative nature and prove

instrumental in interpreting data for the future chapters in this study.

Additionally, sessions were also videotaped. The use of videotapes was used to

ensure the fidelity of the intervention. As part of weekly supervision, segments were

selected by the primary investigator to share with the advisor/dissertation chairperson and

reviewed utilizing the form provided as Appendix D. The advisor reviewed the tapes to

ensure that the child-centered play therapy groups were conducted in the manner

prescribed and that the theoretical foundation of the intervention was maintained.

During the review of tapes, it became clear that the sessions demonstrated value

as a teaching tool. Permission was sought and obtained by ten of the participants'

parents/guardians to use the tapes for educational purposes to highlight the utility of the

intervention and to educate counseling professionals. Upon the completion of the research study, the case notes and remaining videotapes of were destroyed.

Data Analysis

For the purposes of statistical analysis, all data was entered and analyzed by the researcher using statistical software. An analysis of covariance (ANCOVA) was used to determine the significance of differences of various dependent variables on both the parent and teacher ratings for the experimental and control groups. These results are provided in Chapter Four. To ensure the fidelity of the intervention, case notes/observations were recorded for the individual sessions and are discussed for their qualitative value in Chapter Five

Summary

Chapter Three described the study devoting sections to the participants, procedures, instrumentation, and data analysis. The research questions address the impact of child-centered group play therapy on the social skills of kindergarten children. Quantitative methods were used to compare the data between the experimental and control groups. An analysis of covariance (ANCOVA) was used to determine the significance of differences of the dependent variables between the experimental and control groups, the results of which will be discussed in detail in Chapter Four. The interpretative data retrieved in the course of the study via the case notes and video observations are presented in Chapter Five.

CHAPTER 4: RESULTS

Introduction

This study assessed the effectiveness of child-centered group play therapy as an intervention for kindergarten children with regards to social skills development. In particular it addressed whether child-centered group play therapy has an impact on increasing social skills of kindergarten children when compared to the control group who did not receive child-centered play therapy. This chapter presents the findings of the study. The first section provides a description of the sample population. The second section presents reliabilities of measures and analyses of the data. Results of the statistical analyses that were used to investigate the following two research hypotheses which are presented in the final section:

1. Kindergarten children who receive child-centered group play therapy will be rated higher by teachers for social skills (assertion, cooperation and self-control) than children who do not participate.

2. Kindergarten children who receive child-centered group play therapy will be rated higher by parents for social skills (assertion, cooperation, self-control and responsibility) than children who do not participate.

Description of Participants

A total of 92 kindergarten students were invited to participate in the research study. Envelopes containing a letter explaining the study, an informed consent form for

parents, a demographic survey and the parent questionnaire of the Social Skills Rating

System (SSRS: Gresham & Elliott, 1990) were sent home to every student in their

weekly folders. Of these 92 packets, 49 (53%) were returned with signed parent consent

forms and completed surveys and questionnaires.

Of the 49 participants, 55% (*n* = 27) were male, while 45% (*n* = 22) were female.

Specific birthdates were not provided but 47 of the children were aged five to six. The

African American students accounted for 47% of students (*n* = 23) and the next highest

percentage was 27% Caucasian (*n* =13). The overall majority of student participants were

non-Caucasian which reflects the ethnic and racial diversity of the school population. The

majority of participants resided in families with two or more children. Eighteen children

(37%) lived with one other sibling/child but the next highest category was only children

at 20% (*n* = 18). Forty-five percent of the participants attended a formal Pre-Kindergarten

children, such as Bright Beginnings or Head Start. Frequencies and percentages for each

of the demographic characteristics of the sample are summarized in Table 1.

Table 1: *Demographic Characteristics of Participants*

Characteristic		Frequency	Percentage
Gender	Male	27	55.1
	Female	22	44.9
Age (years)	5	21	42.9
	6	26	55.1
	7	2	4.1

Table 1 (cont'd)

Race/Ethnicity	African American	23	46.9
	Caucasian	13	26.5
	Hispanic/Latino	6	12.2
	Multi- Racial	3	6.1
	Asian American	2	4.1
	Other	2	4.1
Total Children Household	1	10	20.4
	2	18	36.7
	3	8	16.3
	4	5	10.2
	5	6	12.2
	6	2	4.1
Early Childhood Education	Pre-K Program	22	44.9
	Relative	11	22.4
	Other Pre-school	6	12.2
	Daycare Center	5	10.2
	Other	5	10.2

SSRS Means and Standard Deviations

The pretest and posttest means and standard deviations for the experimental and control groups of both the teachers' and parents rating of children on the SSRS Social

Skills scale and subscales are reported in Tables 2 and 3. On the SSRS, higher scores

indicated higher the perceived level of social skills as indicated by the rater.

According to Gresham & Elliott (1990), the average behavioral level for social

skills as rated by teachers for girls ranges from 33-52 and for boys ranges from 25-49.

According to Table 2, the students in both the experimental and control groups fall within

the average behavioral level for both the pre-and posttest scores. An examination of the

subscale scores confirms that all of the scores again fall within the average behavioral

level. Additionally the control group had higher scores than the experimental group for

the social skills scale and the assertion and self-control subscale. The experimental group

had a higher score on the cooperation subscale for the pretest and this remained true on

the posttest. All of the scores increased for all scales and subscales for both the control

and experimental groups upon the posttest rating.

Table 2: *Means and standard deviations of the teacher ratings on the social skills scale and subscales of cooperation, assertion and self-control of the SSRS-T*

SSRS Scales		Pretest		Posttest	
		M	*SD*	*M*	*SD*
Social Skills	Experimental	35.77	11.20	45.12	11.36
	Control	38.74	11.80	47.73	10.49
Cooperation Subscale	Experimental	13.58	4.8	15.46	16.26
	Control	13.48	4.91	14.73	4.00

Table 2 (cont'd)

Assertion Subscale	Experimental	10.42	4.24	14.34	3.68
	Control	11.35	4.27	15.17	3.51
Self-Control Subscale	Experimental	11.77	4.31	13.91	4.52
	Control	13.91	4.52	16.31	3.70

With regards to the parent ratings, the average behavioral level for social skills for girls ranges from 44-64 and for boys ranges from 40-58. According to Table 3, the students in both the experimental and control groups fall within the average level for both the pre-and posttest scores as rated by parents. An examination of the subscale scores confirms that all of the scores again fall within the average behavioral level. Additionally the experimental group had higher scores than the control group for the both the social skills scale and all subscales. All of the scores increased from the pretest to the posttest with the exception of the Assertion subscale for the control group in which parents rated as lower upon the pretest.

Table 3: *Means and Standard Deviations of the Parent Ratings on the Social Skills Scale and Subscales of Cooperation, Assertion, Self-Control, and Responsibility of the SSRS-P*

SSRS Scales		Pretest		Posttest	
		M	*SD*	*M*	*SD*
Social Skills	Experimental	51.38	13.97	54.23	10.77
	Control	49.10	9.10	51.71	8.39

Table 3 (cont'd)

Cooperation Subscale	Experimental	11.92	3.80	11.91	3.04
	Control	11.22	3.5	11.29	2.85
Assertion Subscale	Experimental	14.85	3.55	15.55	3.08
	Control	14.52	3.27	15.43	2.62
Self-Control Subscscale	Experimental	12.42	3.91	13.55	3.04
	Control	11.39	3.50	12.09	4.02
Responsibility Subscale	Experimental	12.19	4.48	13.23	3.46
	Control	11.96	2.41	12.91	2.00

Analysis of Covariance

Survey results were analyzed by an analysis of covariance (ANCOVA). ANCOVA is used to test the significance of group differences when several dependent variables are involved. ANCOVA determines whether mean differences among groups on a combination of dependent variables are likely to have occurred by chance thereby reducing the probability of a Type II error. Typically, ANCOVA is applied to experimental situations in which independent variables are manipulated and subjects are randomly assigned to groups helping to control for preexisting differences between groups. An ANCOVA uses the pre-test score (a dependent variable) as a covariate to help control any differences between the groups. (Tabachnik & Fidell, 2007).

Three assumptions should be considered in using ANCOVA. The first assumption is that the independent variable is not associated with the covariate. To ensure this assumption was met, group assignment was not based on the values of the covariate but instead the participants were randomly assigned to the experimental and control groups. A second assumption in the use of ANCOVA is that the correlation between the covariate and the dependent variable is the same for both the experimental and control groups, i.e. homogeneity of regression. This was tested before the ANCOVA was run and was found to be tenable for all scales. A third assumption for use of ANCOVA is that the within group relationship between the covariate and dependent variable is linear relationship. This means that the independent variable will follow a normal distribution and the relationship with the dependent variables will be linear. (Tabachnik & Fidell, 2007). All three assumptions of the ANCOVA appear to have been met. Additionally, the homogeneity of variance using Levene's Test of each rating was verified to ensure that the error variance of the dependent variable was equal across all groups.

Results

The results of this study are presented in the order the hypotheses were tested. Analyses of covariance were performed on all hypotheses and a level of significance of .01 was established as the criterion for either retaining or rejecting the hypotheses. The research question for the study was the following: *What is the impact of child-centered group play therapy on social skills for kindergarten children?* In reference to this question, two hypotheses were formulated:

1. Kindergarten children who receive child-centered group play therapy will be rated higher by teachers for social skills (assertion, cooperation and self-control) than children who do not participate.

2. Kindergarten children who receive child-centered group play therapy will be rated higher by parents for social skills (assertion, cooperation, self-control and responsibility) than children who do not participate.

Hypothesis 1: Teacher Ratings

The first hypothesis is that the experimental group will attain significantly higher mean scores on the Social Skills scale and subscales of the SSRS-T post-test than will the control group. In Table 4 is presented the analysis of covariance data, showing that there is not a significant difference between the experimental and control groups' post-test mean scores. For purposes of clarification, the main effect is the intervention (i.e. group play therapy) and the covariate is the pre-test score of each particular scale. None of the F ratio scores for the intervention indicate a significant increase in the experimental groups' mean total scores. Therefore, Hypothesis 1 was not retained.

Table 4: *Source Tables for the ANCOVA for the Teacher Ratings of the Social Skills Scale and Subscales of Cooperation, Assertion and Self-Control of the SSRS-T*

SSRS Scales	Source	Sum of Squares	Df	Mean Square	F Ratio	Significance of F
Social Skills	Main Effect	164.08	1	164.08	2.35	.13
	Covariate	6348.00	1	6348.00	90.84	.00
	Error	3214.66	46	69.88		
Cooperation Subscale	Main Effect	8.90	1	8.90	.712	.40

Table 4 (cont'd)

Cooperation Subscale	Covariate	338.36	1	338.36	27.09	.00
	Error	574.54	46	12.49		
Assertion Subscale	Main Effect	2.17	1	2.17	.22	.64
	Covariate	162.33	1	162.33	16.71	.00
	Error	116.86	46	9.71		
Self-Control Subscale	Main Effect	.001	1	.001	.000	.993
	Covariate	194.23	1	194.23	18.23	.00
	Error	490.16	46	10.66		

Hypothesis 2: Parent Ratings

The second hypothesis is that the experimental group will attain significantly higher mean scores on the Social Skills scale and subscales of the SSRS-P post-test than will the control group. Table 5 presents the analysis of covariance data, showing that there is not a significant difference between the experimental and control groups' post-test mean scores. For purposes of clarification, the main effect is the intervention (i.e. group play therapy) and the covariate is the pre test score of each particular scale. None of the F ratio scores for the intervention indicate a significant increase in the experimental groups' mean total scores. Therefore, Hypothesis 2 was not retained.

Table 5: *Source Tables for the ANCOVA for the Parent Ratings of the Social Skills Scale and Subscales of Cooperation, Assertion, Self-Control, and Responsibility of the SSRS-P*

SSRS Scales	Source	Sum of Squares	Df	Mean Square	F Ratio	Significance of F
Social Skills	Main Effect	22.01	1	22.01	.40	.53
	Covariate	1642.57	1	1642.57	29.87	.00
	Error	2199.58	40	54.99		
Cooperation Subscale	Main Effect	.08	1	.08	.014	.91
	Covariate	138.22	1	138.22	25.38	.00
	Error	217.88	40	5.48		
Assertion Subscale	Main Effect	.36	1	.36	.06	.81
	Covariate	79.82	1	79.82	12.43	.001
	Error	256.78	40	6.42		
Self-Control Subscale	Main Effect	6.94	1	6.94	1.11	.30
	Covariate	266.80	1	266.80	42.61	.00
	Error	250.47	40	6.26		
Responsibility Subscale	Main Effect	.37	1	.37	.08	.78
	Covariate	150.05	1	150.05	33.05	.00
	Error	181.63	40	4.54		

Summary

This chapter presented the results of the study. The first section presented a description of the sample of 49 participants. The second section gave preliminary analyses of the data in terms of mean scores and standard deviations. The third section of the chapter presented the statistical analysis comparing the experimental and control groups. The results of univariate tests were provided. The study hypotheses were evaluated in light of these results, and the research question answered. The ANCOVA found no statistical differences among groups on either of the independent variables. Therefore neither of the two hypotheses was supported by the data. Chapter Five will provide a discussion of the study results and an examination of other tests and qualitative data.

CHAPTER 5: SUMMARY

This study assessed the effectiveness of child-centered group play therapy as an intervention for kindergarten children with regards to social skills development. Specifically, it addressed whether child-centered group play therapy has an impact on social skills of kindergarten children when compared to the control group who did not receive child-centered group play therapy. This chapter discusses the results of the study. The chapter is divided into several sections, including an overview of the study, the conclusions and implications of the study, the limitations, recommendations for further research and concluding remarks, which highlights the contributions of this study.

Overview of the Study

The purpose of this study was to assess the effectiveness of using child-centered group play therapy on social skills development. Prior research has demonstrated that the transition to kindergarten provides a new opportunity for children to learn and demonstrate social skills (Snyder, 2001; Tremblay, Mass, Pagani, & Vitaro, 1996) with the need to develop satisfactory, age-appropriate social skills to ensure a successful transition and integration into elementary school. For many children it is their first large group experience providing a new opportunities for peer group play and a challenge in social competence (Corapci, 2004). Therefore, the importance of this area of study, which focuses on the development of social skills of children who have just entered school, cannot be overstated.

The literature review provided in Chapter Two indicated that there has been

limited use of the SSRS in the play therapy literature and the topic of social skills has not been researched independently of other variables. Additionally, the other research used specific criteria to screen participants based on the presence of a specific disorder, performing below average on the survey instrument, whereas this study did not use exclusionary criteria. Therefore, it is difficult to ascertain exact comparisons to prior literature. This study was designed to address these gaps in the literature.

This study did not demonstrate the same levels of improvements when compared to the prior social skills research focusing on school-wide and or classroom interventions. Most of the non-play therapy interventions that showed positive gains in social skills were programs that lasted a large portion of the school year (Kutsche & Greenberg, 1995; Grossman et al., 1997) or were designed specifically for at-risk children (Elias & Clabby, 1989; Walker et al., 1998; Webster-Stratton & Reid, 2003; Reid, Webster-Stratton & Hammond, 2007) with the greatest gains being evidenced by those programs that targeted specific groups of children based on aggressive and disruptive behaviors. However, this study was designed as an evidence-based, developmentally appropriate intervention to target social skills improvements for all kindergarteners. The premise was that all children can benefit from social skills improvement which, in theory, will positively impact academic and emotional functioning. Additionally, promoting social skills for all children highlights the vicarious learning that occurs when skills that are learned or mastered in the group play therapy session are generalized to the classroom or home.

The meta-analytic review conducted by Bratton, Ray, Rhine, and Jones (2005) indicated that the average number of sessions conducted in schools was 8.4 sessions with the average child participant functioning at .80 standard deviations better than a non-

treated child. According to the results provided in Table 2, none of the experimental group children scored higher than the average reported in the earlier research. However, the experimental group did evidence a greater than .80 standard deviation improvement in the teacher's total score of the social skills scale and the assertion subscale while none of the control group children evidenced that level of a gain. There were no improvements of such degree based on the parent ratings of either group.

Prior research has emphasized the important role that child-centered play therapy groups (House, 1970) and non-directive play therapy groups (Gould, 1980) have in providing children opportunities to learn and practice pro-social skills. This research was able to provide just such opportunities. Teachers and parents commented that their students enjoyed the experience and observed improvements in behaviors for some of the groups. This is also supported by the positive trends in both teachers' ratings of total social skills and all subscales and the parents' ratings of total social skills and on assertion and self control subscales. However, the changes were not strong enough to achieve significance at the .05 level.

<div align="center">Conclusions and Implications</div>

This section will discuss the results of the data analyses conducted in Chapter Four as related to the two research questions and their respective implications.

Teacher Ratings

As can be seen in Table 2, teachers reported that the students who received child-centered group play therapy demonstrated increases on mean scores of the total score of the social skills scale and the subscales (cooperation, assertion and self-control) of the Social Skills Rating System – Teacher (SSRS-T: Gresham & Elliott, 1990). However, the

increases were not significant (see Table 4) and the hypothesis that kindergarten children who receive child-centered group play therapy will be rated higher by teachers for social skills than children who do not was rejected. One explanation for the lack of significant increases in all areas may be attributed to the improvements that were also demonstrated by the control group. Because all of the pairings were based on classroom assignment, the control group improvements could be a result of the benefits that the classroom system as a whole experienced from the experimental groups' improvements. Experimental group participants could be seen using play therapy skills in the classroom. For example, models of limit setting and tracking were observed by some teachers.

Earlier research by Draper et al. (2001) reported similar classroom system improvements based on kinder training research. The kinder training research conducted by Draper et al. (2001) is the only other play therapy study to have used the SSRS as the study instrument. Their results indicated that children who participated in the kinder training who were rated as below average on social skills improved post-intervention but that research did not include a control group for comparison of results. Therefore, the results are based on the significant improvements in behaviors achieved by the kinder training intervention and are supported by similar positive trends in this research. Additionally, this current study, which uses classroom-centric groups, lends support to the use of play therapy interventions that will benefit the classroom system.

Parent Ratings

As can be seen in Table 3, the students who received child-centered group play therapy also demonstrated increases on mean scores as reported by parents on the total score of the social skills scale and subscales (assertion, self-control, and responsibility) of

the SSRS with the exception of the cooperation subscale which noted a slight decrease. Parents rated improvements in behavior for the control group children for the social skills scale and all subscales. Table 5 indicates that none of the increases in scores for the experimental group were significant and the hypothesis that kindergarten children who received child-centered group play therapy would show increases in social skills compared to children who did not receive child-centered group play therapy was rejected.

Overall, parents rated the children lower on the cooperation subscale than teachers and indicated no improvement on the post-test. Because parents probably did not remember their original ratings of their child, the most probable explanation is that the parents' perception of their child's cooperation did not change. Overall, based on this research alone, there is no evidence to conclude that child-centered group play therapy has any impact on parents' perceptions of their children's cooperative behaviors.

This study did not examine the differences in teachers' and parents' perceptions of the students but these differences were noticeable. Parents rated the students higher than teachers on the total score of the social skills scale and the subscales of assertion and self-control and, as earlier referenced, lower on cooperation. There is not enough information from this study to explain the different perceptions of the teachers and parents but it is warranted for future study and will be addressed in a later section of the chapter regarding future research.

<div align="center">Limitations of the Study</div>

This section will focus on limitations in this study that could explain the results. Specifically, the use of the SSRS, the model used, the teacher ratings and lack of exclusionary criteria will be discussed.

The SSRS as an Instrument

  The SSRS was specifically chosen for this study because of its emphasis on social skills and because the subscales align conceptually with the goals of child-centered group play therapy. The SSRS records responses on a Likert scale with three choices for determining the frequency of occurrence for the various behaviors: 0 = Never, 1 = Sometimes, 2 = Very Often. The explanation for selection of the response is very simple. For example, if it never happens, the response is 0, if it sometimes happens, the response is 1 and if it happens very often the answer is 2. It is possible that the fewer rating choices afforded by the SSRS was not broad enough to differentiate behaviors and/or improvements in behaviors between the pre-and post tests. .

  A review of the literature indicates that majority of play therapy research has used the Child Behavior Checklist (CBCL: Achenbach & Edelbrock, 1983) or the Filial Problem Checklist (Horner, 1974) as the survey instrument, all of which record responses on a Likert scale similar to the SSRS. However, the criteria explanations for choices are more detailed with the Filial Problem Checklist also affording a "Not Applicable" choice for raters. Additionally, there are over 100 questions/items for both of these instruments. The SSRS has 57 items for the teacher rating and 55 items for the parent rating. Both the clearer definition of answers and the increased number of items, and the greater range of response items could contribute to their use and applicability in research in ascertaining the valid and reliable results. Therefore, while the SSRS is both a valid and reliable instrument, it may not have been the best choice of instrument for this study.

The Five Week – Ten Session Model

  An accelerated model of the group play therapy intervention was used to

determine if this was applicable for use as a school counseling intervention that would afford more children the opportunity for services during a school year. As the review of group play therapy research from Chapter Two indicates, the majority of prior group play therapy studies have employed a model providing weekly sessions over a minimum ten week period (Tyndall-Lind, 1999; Baggerly & Parker, 2005) in which the skills used may have more time to develop and generalize. This model used 30-minute play sessions twice a week while earlier research has typically used a more traditional 45-minute session. This research was unique in its accelerated design as the intent was to provide a more viable option for school setting. Landreth (2002) addresses the use of accelerated models and adaptations from which this design was adapted.

Typically, in play therapy, counselors do see progress based over the course of sessions regardless of how often the sessions occur (i.e. ten sessions that occur twice weekly, weekly or biweekly) (Bratton et al., 2005). However, the timing of the post-test results may have been too soon after the intervention to allow the skills to generalize to the classroom and/or home settings. It could be that more time is needed for skills to generalize and an additional post-intervention rating may have been needed to more accurately address this issue. This might also address any concerns about the use of the SSRS as the survey instrument because it does have high reliability and would theoretically be the ideal instrument for use in child-centered play therapy research because of the similarities in conceptual framework.

Teacher Bias and the Timing of the Study

The completion of the pre-test teacher ratings of the SSRS were completed prior to the random assignment into play groups. Therefore, bias was not an issue on the pre-

test. This was a concern for the post-test and while it was addressed as a limitation in the research design, it was assumed that teachers would rate their children without bias on the post-test. However, teachers were still aware of which children were receiving the intervention and did have an understanding that the study was about social skills interventions. During the course of the interventions, some of the teacher's comments to the researcher indicated that a particular student was not in need of any social skills intervention or that a particular child really needed counseling. In these cases, teachers might have been biased in their ratings on either the pre- or post-test scores.

The study was conducted starting at the end of the third quarter and during the fourth quarter of the school year. While an attempt was made to prevent an increased workload for the teachers and while teachers where aware of the schedule from the onset, the timing of post-test ratings coincided with their end-of-year assessments. Because they had just completed the end-of-year assessments they may have given more thought to behaviors on the post-test than pre-test. Another possible explanation is the opposite of the first, in that teachers may have been more rushed due to the demands of school requirements and been more hurried to complete the post-test ratings. This is discussed further in the recommendations for future research.

Lack of Exclusionary Criteria

This study was designed as a preventative and/or early social skills intervention for all children and did not include exclusionary criteria for participation. The intervention was designed to include all children based on the presumption that all children can benefit from social skills interventions regardless of their baseline functioning. Prior research has focused on children with significant behavioral problems

learning disabilities or some other criteria (e.g. homelessness, domestic violence) which may exclude children that could benefit from interventions (Trostle, 1988; Danger & Landreth, 2005) However, in retrospect, the inclusive design of this study may have contributed to the lack of significance in the final results.

It is possible that based on childhood development and classroom norms, participants had achieved what was considered developmentally appropriate for their age and grade. As discussed in Chapter Four and according to the SSRS, the children were rated within the average behavioral range although it was clear during the play sessions that social skills levels varied. By including only those students with below average or low average ratings and excluding participants in the mid-average and above average range, the significance of the intervention may have been more apparent. As previously addressed, five weeks may not be a long enough period of time to see developmental change in children who were rated average although it might be possible to see a change with children with identified problems and should be considered in future studies.

<center>Recommendations for Future Research</center>

This section expands to include recommendations and areas of future research to be considered based on the findings of this study. While the findings of this study were not significant, the positive trends in scores coupled with observations of change and development by the children and prior research results is enough to conclude that child-centered group play therapy continues to be a viable social skills intervention that should be considered in future research. In conjunction with prior research in kinder training (White & Flynt, 1999; Draper et al., 2001), there are positive indications that child-centered group therapy could be used as a tool to improve the classroom system. The

following recommendations are based on the outcomes of this research.

Further research is needed where child-centered group play therapy groups begin during the first few months of the school year to assist with appropriate socialization and assimilation during kindergarten. Providing children early on in the school year with improved social skills would increase their ability to succeed academically, emotionally and socially. In addition, examining the impact of child-centered group play therapy on academic achievement could also be examined.

Replicating this study with some adjustments to the model and the instrument would be prudent as this study had many unique qualities when compared to prior group play therapy research. A ten session model over ten weeks in school should be considered in lieu of the accelerated model. By also using exclusionary criteria with only those students identified with social skills deficit based on teacher ratings, school counselors can ensure that those students with the greatest need are selected. Maintaining classroom-centric groups should be the goal. Additionally, the use of another instrument either in lieu of or in conjunction with the SSRS should be considered. While more labor intensive, using both the CBCL and the SSRS to compare the ratings might prove instructive in ascertaining the viability of the SSRS for play therapy research. Future research should also address the feasibility of offering the intervention in such a way that teachers do not know which of their students are receiving the experimental intervention. This would also address a limitation of this study. Additionally, the timing of the intervention should be addressed to ensure that groups are done earlier in the school year. Ideally, starting the groups approximately one month after the start of the school year affords teachers an opportunity to assess children who can benefit from a social skills

intervention with additional groups being formed as the school year progresses so that they end before the final month of the school year.

Based on the differences shown in this research of the teachers' and parents' perceptions of the participants, further research is warranted to determine the underlying causes of these differences. It could be that the parents have different standards of what they consider normal or acceptable behaviors and, subsequently, perceive their children in a different manner from their teachers. Another possible explanation is that teachers may view children's behavior from the context of developmental norms and or within the larger classroom system which may be a different from parents' views. Finally, it could also be that individual children behave differently in different environments based on the standards required by either the home or school environment. Specifically looking at the differences in scores between the parents and teachers with regard to social skills would make a significant contribution to the literature. Additionally, analysis of data could also include demographic data similar to that which was collected at this the start of this study (Appendix B), could be used to determine if other factors might play a role in perceptual differences.

Finally, a follow-up study based on the qualitative data garnered from the play therapy sessions could examine emerging patterns and themes within the sessions. In this research, some pairings of students displayed interactions in their relationships, which could be described as cooperative or conflictual while other children appeared to interact without any involvement with each other. Changes in their interactions were also noticed during the course of the intervention. Reviewing this data in conjunction with the quantitative data from the SSRS might provide insights into children's behaviors and the

power of child-centered play therapy groups.

Concluding Remarks

While grounded in prior research, this study is important in a number of ways. An examination of prior literature revealed a paucity of research utilizing sound research methodology and evaluation protocols. This study utilized a well-researched intervention (child-centered group play therapy) by adapting its use to an accelerated model in the hopes of providing a viable school counseling intervention. While employing this method was plausible it highlighted concerns about the time it takes for behaviors to generalize from the playroom into other settings. This provides a valuable contribution to the body of play therapy research when considering adaptations to play therapy models. Furthermore, this research highlights the continued need to address assessment methods and interventions for children who perform within the average range of rating instruments but who could still benefit from interventions.   Another contribution this research makes is in its use of the Social Skills Rating System (Gresham & Elliott, 1990) as a possible survey instrument. This research clarifies considerations that future researchers should use to more clearly evaluate its effectiveness relative to other instruments that have been traditionally employed for play therapy research. The primary reason for selecting this instrument was that this assessment has been normed on typically developing children which aligns with the focus of this research, providing an effective social skills intervention for all children. Because school counselors work with the entire school population, it is important to find interventions that will provide benefits for all children. This research addressed that need although it is clear that more work needs to be done. To discount the value of the SSRS as a rating instrument for future play therapy

research would be premature.

While not considered in this study, the results indicated differences between parents' and teachers' perceptions that have not previously been addressed in the school play therapy literature. The results highlight an important gap that exists between parent-teacher perceptions and the impact they could have on social, emotional and academic functioning.

Most importantly, though, his study makes a contribution to the literature in that it provides ideas about needed alterations to be considered for future child-centered group play therapy in the school setting by presenting suggestions to improve the quality of future research. It served to further build the body of research by addressing existing gaps in the literature and clarified future research by narrowing these gaps.

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APPENDIX A: PARENT INFORMED CONSENT FORM

University of North Carolina at Charlotte

Informed Consent Form

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, benefits and risks of the study and how it will be conducted.

Title of Study: The impact of child-centered group play therapy on social skills development of kindergarten children.

Principal Investigator: Theresa M. Kascsak-Miller, as a requirement for earning a doctoral degree as a student in the counseling department, under the supervision of Dr. Phyllis Post, Professor of Counselor Education.

Purpose of the Study: You are being asked to allow your child to take part in a research study that will require your child to participate in school-based group play therapy services. The purpose of the study is to assess the impact of school counseling interventions on social skills. Experts in child development suggest that developing social skills in children helps them to do better developmentally and academically. Your child's participation is completely voluntary 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.

Study Procedures: As a parent of a potential participant, you will be asked to complete a brief demographic information survey and the parent version of the Social Skills Rating System (SSRS), which are attached to this Informed Consent. The SSRS should take approximately 20-25 minutes to complete. You will be asked to rate your child on "How Often" a behavior occurs (0 for Never, 1 for Sometimes, 2 for Very Often). Teachers will complete a different version of the SSRS.

A maximum number of 48 students will be selected to participate. If your child is selected as a study participant, he/she will be asked to participate in group play therapy sessions. All sessions will take place during regular school hours at a time determined by the teacher. The first group of children will participate in the group play sessions with another child. The 10 group play therapy sessions will occur twice a week for 5 weeks. Sessions will be video-recorded to provide additional data about the social interactions. All videotapes will be erased after the completion of the study. At the completion of the group play therapy sessions, the SSRS will be re-administered to parents and teachers

Foreseeable Risks: The potential risks involved in this study are minimal. Because the children will receive play therapy services with another child, we cannot guarantee confidentiality. The only other potential risk is possible emotional distress because of interacting with another child in

the playroom; however, the play therapist is trained to create an emotionally safe environment for the children

Benefits to the Subjects or Others: We expect the project to benefit your child by allowing him or her an opportunity to learn social skills such as self-control, socially acceptable behaviors, and empathy, which can then be transferred to the classroom.

Procedures for Maintaining Confidentiality of Research Records: Your child's name will be removed from all identifying materials related to this research and replaced with a random code number. Consent forms will be stored in a location separate from coded materials. All research records including video-recordings will be kept in a locked cabinet in the researcher's office, and accessible only to the researchers. Research records will be kept for a period of 3 years following the conclusion of this study. At that time, all records will be properly destroyed. Videotapes will be destroyed at the completion of the study. The confidentiality of your child's individual information will be maintained in any professional publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact *Theresa Kascsak*-Miller at telephone number (704) 650-0766 or tmmiller@uncc.edu; or *Dr. Phyllis Post,* at telephone number (704) 687-8961.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNCC Institutional Review Board (IRB). You can contact the UNCC office by calling (704) 687-2291.

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:
- Ms. Theresa Kascsak-Miller, Dr. Phyllis Post, or your child's school counselor has answered any questions you may have about the study. You have been informed of 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.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your child's participation in this study.
- You have been told you will receive a copy of this form.

_____
Printed Name of Parent or Guardian

_____   _____
Signature of Parent or Guardian   Date

_____   _____
Signature of Principal Investigator   Date

APPENDIX B: PARENT DEMOGRAPHIC SURVEY

PARENT DEMOGRAPHIC SURVEY   Code _____

Please answer the following questions as they apply to your child whose name appears on the previous page of this packet.

1. My child is a: (Check one)   ____MALE   ____FEMALE

2. My child is _____ years old.

3. Which of the following best identifies your child's ethnicity? (Check one)

____AFRICAN AMERICAN____ASIAN/PACIFIC ISLANDER

____CAUCASIAN   ____HISPANIC/LATINO

____MULTI-RACIAL   ____OTHER

4. There are (Check one)

____TWO   ____THREE   ____FOUR   ____FIVE   ____MORE THAN FIVE

    children in our family.

5. In the year before my child started Kindergarten, he/she:

_____Attended a Pre-Kindergarten program _____Stayed home with a relative

_____Attended a day care center   _____Attended a home day care

_____Attended a half-day and/or part-time pre-school program

_____Other (please specify)_____

APPENDIX C: SESSION CASE NOTES FORM

Group Session Summary
(Adapted form used by used by the Center for Play Therapy)

Child code nbr/group/class_____ Date: _____ Session: _____

Subjective:

HAPPY: relieved, content, satisfied, pleased, delighted
CONFIDENT: proud, strong, powerful, determined, free
CURIOUS: interested, focused

SAD: disappointed,hopeless,pessimistic,discouraged, lonely
ANGRY: impatient, annoyed, frustrated, mad, mean, jealous
AFRAID: vulnerable, helpless, distrustful, anxious, fearful,
scared, terrified
HESITANT: timid, confused, nervous, embarrassed, ashamed
FLAT: restricted, contained, ambiguous

HAPPY: relieved, content, satisfied, pleased, delighted
CONFIDENT: proud, strong, powerful, determined, free
CURIOUS: interested, focused

SAD:disappointed,hopelesspessimistic,discouraged,lonely
ANGRY: impatient,annoyed,frustrated,mad,mean,ealous
AFRAID:vulnerable,helpless,distrustful,anxious,fearful,
scared, terrified
HESITANT:timid,confusednervous,embarrassed,ashamed
FLAT: restricted, contained, ambiguous

Toys played with: Together:

sandbox	sandbox	sandbox
broom	broom broom	
puppets	puppets	puppets
kitchen/cooking/food	kitchen/cooking/food	kitchen/cooking/food
easel/paint	easel/paint	easel/paint
bop bag	bop bag	bop bag
dress up	dress up	dress up
crafts/clay/markers/finger paints/glue/scissors	crafts/clay/markers/finger paints/glue/scissors	crafts/clay/markers/finger
paints/glue/scissors		
doll house/doll family	doll house/doll family	doll house/doll family
bottle/pacifier/baby	bottle/pacifier/baby	bottle/pacifier/baby
cash register/money	cash register/money	cash register/money
telephone/camera	telephone/camera	telephone/camera
medical kit/band aids	medical kit/band aids	medical kit/band aids
musical	musical	musical
bowling/balls	bowling/balls	bowling/balls
animals (domestic/wild)	animals (domestic/wild)	animals (domestic/wild)
guns/handcuffs/rope	guns/handcuffs/rope	guns/handcuffs/rope
blocks	blocks blocks	
vehicles	vehicles	vehicles

Limits set:
Protect child (health/safety)   Protect child (health/safety)
Protect therapist/promote therapist acceptance   Protect therapist/promote therapist acceptance
Protect room/toys   Protect room/toys
Structuring   Structuring
Reality testing   Reality testing
Socially unacceptable behavior   Socially unacceptable behavior

Participation level:
Introspective productive unmotivated superficial withdrawn

Introspective productive unmotivated superficial withdrawn

Play themes:
Exploratory   Exploratory
Relationship (connecting/approval seeking/manipulative   Relationship (connecting/approval
/competitive/collaborative)   seeking/manipulative/competitive/collaborative)
Power/control   Power/control
Helpless/inadequate   Helpless/inadequate
Aggression/revenge   Aggression/revenge
Safety/security   Safety/security
Mastery   Mastery
Nurturing (self care/reparative)   Nurturing (self care/reparative)
Death/loss/grieving   Death/loss/grieving
Sexualized   Sexualized

Other:

Dependent   1 2 3 4 5 6 7 8 9 10 Independent   Dependent   1 2 3 4 5 6 7 8 9 10 Independent

External LOC 1 2 3 4 5 6 7 8 9 10 Internal LOC   External LOC 1 2 3 4 5 6 7 8 9 10 Internal LOC

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

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

Verbal   1 2 3 4 5 6 7 8 9 10 Non-verbal   Verbal   1 2 3 4 5 6 7 8 9 10 Non-verbal

Involved/active   1 2 3 4 5 6 7 8 9 10   Uninterested/withdrawn

                              Involved/active   1 2 3 4 5 6 7 8 9 10   Uninterested/withdrawn

Impulsive/easily distracted   1 2 3 4 5 6 7 8 9 10 Purposeful/focused

                              Impulsive/easily distracted   1 2 3 4 5 6 7 8 9 10 Purposeful/focused

APPENDIX D: SKILLS CHECKLIST

Group Play Therapy Skill Checklist/Feedback Form
(Adapted form used by used by the Center for Play Therapy)

Date/Session # _____ / _____

Therapist: _____ Supervisor: _____

Session _____ Child Code Nbrs. _____

Basic Play Therapy Skills	Range	Comments

Needs Work – Average - Excellent

1. Tracking 1…….2……3……4……5 _____

2. Reflecting content 1…….2……3……4……5 _____

3. Reflecting feelings 1…….2……3……4……5 _____

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

5. Facilitated spontaneity 1…….2……3……4……5 _____
   and creativity

Advanced Play Therapy Skills

6. Facilitated self-esteem 1…….2……3……4……5 _____
   and confidence

7. Conveyed understanding 1…….2……3……4……5 _____
   Identified themes

8. Limit setting 1…….2……3……4……5 _____

Group Play Therapy Skills

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

10. Appropriate focus on the relationship needs between 2 or more children
    a. Facilitated interaction between children 1…….2……3……4……5 _____

    b. Facilitated cooperation/problem solving 1…….2……3……4……5 _____
       between children

    c. Facilitated connection between children 1…….2……3……4……5 _____

Therapist Non-Verbal Language

11. Comfortable/open/interested 1…….2……3……4……5 _____

12. Facial expression and voice 1…….2……3……4……5 _____
    tone matches child's affect

13. Voice tone congruent 1…….2……3……4……5 _____
    with response

14. Tolerant of noise/messiness 1…….2……3……4……5 _____

Competence

15. Student recognizes the boundaries 1…….2……3……4……5 _____
    Of her/his particular competencies and
    the limitations of her/his training and
    expertise in play therapy

16. The student takes responsibility for 1…….2……3……4……5 _____
    compensating for her/his deficiencies

17. The student takes responsibility for 1…….2……3……4……5 _____
    assuring client welfare when
    encountering the boundaries of her/his expertise.

18. The student provides only those services   1…….2……3……4……5 _____
    and applies only those techniques for which
    she/he is qualified by education, training and experience.

19. The student demonstrates basic cognitive,   1…….2……3……4……5 _____
    affective, sensory, and motor capacities to
    respond therapeutically to clients

Maturity

20. The student demonstrates appropriate   1…….2……3……4……5 _____
    self-control (such as anger control, impulse
    control) in interpersonal relationships with
    faculty, peers, and clients.

21. The student demonstrates honesty, fairness, 1…….2……3……4……5 _____
    and respect for others

22. The student demonstrates an awareness of   1…….2……3……4……5 _____
    his/her own belief systems, values, needs
    and limitations and the effect of these on his/her work.

23. The student demonstrates the ability to receive, 1…….2……3……4……5 _____
    integrate and utilize feedback from peers,
    teachers, and supervisors.

24. The student exhibits appropriate levels of   1…….2……3……4……5 _____
    self-assurance, confidence, and trust in own ability

Strengths:

Areas for growth:

Theoretical consistency: