Comparing Child-Centered and Psychoeducational Groups
for Externalizing Behaviors

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For Externalizing Behaviors

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Abstract

A comparison between Child-Centered Group Play Counseling (CCGPC), a psychoeducational group and a non-therapeutic control group resulted in three of four hypotheses being supported. Participants included 79 second and third graders, with one fourth grader, from seven elementary schools. The children had behavioral and social skills difficulties as reported by a teacher rating scale. Using the TRF, DOF and PSPCSAYC as pre-post measures, a two-way repeated measure ANOVA was used to analyze the data. CCGPC showed statistical significance in reducing externalizing behavior as well as increasing social skills. However, when examining the participants' self-perceptions, CCGPC did not show statistical significance in increasing social skills. Also, there was no statistically significant difference in the variables when examining the results between the three groups.

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CHAPTER I

INTRODUCTION

Since schools are required to provide education for all students in the least restrictive environment (AACAP, 2008), teachers have students in their classes with varying abilities from different stages of emotional development. Some children have adjustment difficulties resulting from events in their home setting, which can influence their academic and emotional functioning. There are also children who have mental health disorders, such as Oppositional Defiant Disorder, Attention Deficit/Hyperactivity Disorder, Separation Anxiety, Childhood Depression, and Conduct Disorder, which also can affect how well they function academically and emotionally (Erk, 2008; Nelson, Benner, Lane & Smith, 2004). The difficulty teachers face with children in school is that even when teachers use effective classroom management strategies, some students still exhibit disruptive behaviors.

The children's disruptive actions can affect them on several different levels in the school setting. When the students misbehave, one of the primary areas affected is learning (Erk, 2008). However, it is not just the children with behavioral difficulties that are affected. Other children with different types of struggling also have difficulty learning. These types of dynamics displayed by children can manifest in several different ways as it is related to behaviors in the classroom and in their social relationships.

Some of the disruptive behaviors that can be displayed by the children include arguing, angry outbursts, demanding attention, disobedience, clowning behavior, and

teasing others. When these behaviors reach a point that creates disruptions for the teacher in the classroom the child can be at risk of being removed from the school. An intermediary whom the child can be referred to prior to school suspension or expulsion is the school counselor. School counselors are mental health professionals trained to serve the emotional and behavioral needs of children in order to help them improve academically (American School Counselor Association, 2005). However, existing research available to guide the school counselor in effective interventions that decrease classroom disruptive behaviors has several limitations, particularly not matching interventions to the neurophysiological level of behaviorally disruptive young children (Gaskill & Perry, 2012).

In order to address this limitation, research on developmentally appropriate interventions that match the neurophysiological level of behaviorally disruptive young children is needed (Gaskill & Perry, 2012). Child-Centered Play Therapy is a well-researched intervention (Baggerly, Ray, & Bratton, 2010) that matches the neurophysiological level of behaviorally disruptive young children (Gaskill & Perry, 2012). This present study will attempt to fill the gap in the literature by examining the impact of a Child-Centered Group Play Therapy (CCGPT) (Landreth, 2002) on decreasing disruptive behavior in the elementary school compared to a typical anger management group psycho-education program used in schools (Simmonds, 2003) and a control group.

This study addressed a common dilemma faced by today's elementary school counselors who are held accountable for raising the academic achievement of students with disruptive behavior problems. Specifically, the dilemma for school counselors is

knowing which type of group counseling will produce changes in behavior and social relationships of young children. This study examined this problem by evaluating the effectiveness of two types of group counseling in the elementary school, specifically CCGPT and the typical group psycho-education compared to a control group.

In order to further justify and provide a context for this study, what follows will further explain (a) the need for accountability in elementary school students' academic success, (b) how disruptive student behavior hinders academic success, (c) the responsive service role of the school counselor as defined by the American School Counselor's Association, and (d) how group counseling can benefit students with behavior problems.

Background of the Problem

Elementary School

The education of American youth has faced enormous challenges over the last three decades. A decline in students' test scores in the 1970's caused educators and lawmakers to look at ways to hold schools accountable for student achievement (Education Commission of the States, 2002). The shift to outcomes-based accountability created a change in the education of American youth. Schools now have to make sure that all students achieve at universal benchmarks, which are set by the Department of Education. Curricula and the specific instructional methods are constantly examined in relation to students' learning (Education Commission of the States, 2002). The idea of holding schools accountable for students' academic achievement reached a new peak in 2002 when the No Child Left Behind (NCLB) educational bill initiated mandates that required states to establish annual assessments for students in grades three through eight in reading and math (McGuinn, 2006). Principals and classroom teachers feel the

increased pressure from this requirement. This mandate caused schools to examine every aspect of education, from the curriculum and teacher's management of the classroom to the types of interventions that are used when the students aren't showing adequate academic progress.

Schools are asked to address this accountability measure through a system called Response to Intervention (RtI). RtI is a three-tiered intervention model used throughout the United States to help school personnel provide academic and behavioral interventions in a systematic approach (Brown-Chidsey & Steege, 2010). All students receive Tier 1 support, which includes scientifically based instruction, schoolwide positive behavior rules, developmentally appropriate counseling guidance lessons, and screening assessments for academic and behavior (Brown-Chidsey & Steege). When students are not successful with the schoolwide implementation, members of an intervention team discuss their specific situations. The team is composed of classroom teachers, school counselors, speech and language therapists, social workers, the school nurse, and other resource specialists (Brown-Chidsey & Steege). Approximately 80% of the students are successful with the Tier 1 instruction; however, the other 20% of the children need Tier 2 support, which comes in the form of regularly monitored small group instruction (Brown-Chidsey & Steege). It has been found that nearly 5% of students do not respond to Tier 1 or Tier 2 instruction. Consequently, these students receive intensive instruction, and often a comprehensive evaluation for possible Special Education services (Brown-Chidsey & Steege). At each tier, the intervention team makes every effort to use only "evidence-based" interventions, those that have been shown to be effective in improving academic achievement as evidenced by numerous research studies. Elementary schools

use the intervention team model for decisions regarding movement between tiers as well as appropriate evidence based intervention strategies.

Disruptive Student Behavior in the School

For some children, the intervention team concludes that there is a lack of academic improvement due to disruptive behavior. The behaviors that can be present with these children include arguing, angry outbursts, demanding attention, disobedience, clowning behavior, or teasing others. These types of behaviors can affect the teacher's ability to teach, and as such, most often hinders others from learning. In these situations, the team might recommend specific changes in classroom management or other small group strategies to help the student demonstrate attentive and compliant behaviors that will in turn aid in learning.

Since a major focus in teacher education programs is the teacher's instructional methods and classroom management strategies, it stands to reason why the types of behaviors mentioned would need to be addressed. According to Nelson, Benner, Lane and Smith (2004) the teacher's skills in classroom management, especially related to the control of disruptive student behavior, often affects academic achievement. In 2008, the National Center for Education Evaluation and Regional Assistance (Epstein, Atkins, Cullinan, Kutash, & Weaver, 2008) acknowledged the importance of the classroom teacher's planning and implementation of classroom management strategies that prevent students' disruptive behavior. Epstein et al. stated that even when there is careful preparation and training, there are still students in classes who exhibit significant problem behaviors and create chaotic situations that inhibit adequate learning.

Students with disruptive behavior can include children with a diagnosis of a mental health disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR Edition (DSM-IV-TR)* (American Psychiatric Association, 1994). Childhood behavioral disorders include Oppositional Defiant Disorder, Conduct Disorder, General Anxiety Disorder, Depression, Attention-Deficit/Hyperactivity Disorder, and Reactive Attachment Disorder. The disruptive behaviors most often seen in schools tend to be Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder. The children manifest symptoms related to these disorders in a variety of ways. Some of the ways the behaviors are seen include moving around during in-seat time without permission, calling out in class, threatening peers, initiating fights, losing their temper, and arguing with adults. Other behaviors that can be present with children are noncompliance with rules, easily annoyed by others, and becoming angry or resentful (American Psychiatric Association, 1994). The school's need to control the student tends to exacerbate the maladaptive behavior (Erk, 2008).

Classroom teachers are often not trained to handle students with extreme behaviors as those described above. They rely on professionals, usually school counselors, whose roles are to respond to the emotional and behavioral needs of the students who exhibit such behaviors. Since school counselors have had graduate training in individual and group counseling interventions, they are asked to give Tier 2 and Tier 3 support for behavioral concerns of the children. School counselors provide classroom guidance lessons as a Tier 1 strategy, and individual and small group counseling as Tier 2 and Tier 3 interventions. When students demonstrate disruptive behavior and they show a deficit in grade level academic achievement, the school counselor works with the

classroom teacher to determine if either small group counseling or individual counseling interventions would be beneficial for the child. By working in tandem with the teacher in this manner the school counselor and the school counseling programs provide services to help the disruptive student. The interventions that are offered are responsive services that help the student to demonstrate more appropriate interpersonal and decision-making skills. These skills in turn, may also help them improve academically (American School Counselor Association, 2005).

Classroom Observations of Children's Behavior

Before interventions are implemented, the intervention team members often conduct a classroom observation to determine the specific behaviors exhibited by the disruptive student, and the amount of off-task time spent during classroom instruction. According to Gresham (2001), "observational data are very sensitive to intervention effects and should be included in *all* social skills assessment and intervention activities" (p. 56). The most useful observation is when it occurs in the most natural settings, such as the classroom and the playground (Gresham, 2001). Pepler and Craig (1998) stated that there are drawbacks to utilizing observations. They noted that the observations are labour-intensive, there is an added expense of using standardized instruments, and the necessity for extra personnel. Even with the difficulties in obtaining observations, they added another dimension to assessments (Pepler & Craig, 1998).

When utilizing classroom observations as a method of choosing interventions for specific students there are some questions that need to be addressed. How many observations are necessary to examine the student? Does time of day, subject or type of activity in the classroom make a difference in determining the behavior need? What kind

of recording or standardization instrument is most helpful in completing the observation? Do children “act their best” when an observer is present in the classroom? These questions can be reviewed within the context of the RtI intervention methods, whether the child is having difficulty with on-task behavior, aggressive behavior, or relating to peers. Observation approaches can be beneficial to a treatment team when working to assist children’s disruptive behaviors; however, consideration should also be given to the self-perception that the child has with his or her interaction with others.

Child’s Perception of Social Interaction with Peers

Often a characteristic of children with disruptive behavior is the way they relate to their peers. According to Pepler and Craig (1998), there are four methods for examining the social interactions of children: self-assessments, child assessments of others, teacher or parent assessments of children, and direct observation of children in social interactions. Peer reports seem to be the most valid; however, it takes more time for children to change their beliefs about the social interaction of others following an intervention (Pepler & Craig, 1998). The reports of adults, both parents and teachers, can be inaccurate because they may not see socially inappropriate situations as they occur. Because classroom teachers change from year to year, they provide a fresh look at the socially inappropriate child, but again may miss specific occurrences. Observations that utilize anecdotal notations and behavior checklists can provide an objective assessment, but as children get older, they also become wiser about the fact that someone is watching them (Pepler & Craig, 1998). Self-reports tend to present an overly positive view of a child’s view of social interactions, especially in preschool and kindergarten, but this self-

view tends to decline as the child moves into second and third grade (Mantzicopoulos, 2006).

According to Adlerian counselors, a child's perception of himself or herself within his or her social network is quite important (Kottman, 2011). Children may look at others as more competent, and this self-perception can result in the child's sense of inferiority. According to Kottman these feelings of inferiority led to overcompensation through a superiority complex, or at the other end of the spectrum, a sense of discouragement and despair. The counselor's goal should be to build such a relationship with the child in order to demonstrate that relationships with others can be positive (Kottman, 2011). The school counselor fulfills that role in the school setting by using appropriate counseling skills to reach the personal and emotional needs of children.

School Counseling

The American School Counselor Association (ASCA) has worked closely with the field of education to integrate the role of the school counselor with the responsibilities of educating America's youth in the school. The ASCA National Model (ASCA, 2005) was developed in an attempt to help define the framework for the school counseling programs across the United States. According to the ASCA National Model, school counseling programs should provide responsive services to meet the psychological and emotional needs of every student. The organization recognizes that children and teens have many emotional needs that they bring with them to school every day. The situations that children bring from home can include divorced parents, teen pregnancy, inadequate housing, domestic violence, substance abuse, and hunger. These issues and the intensity of the situation can affect children's ability to focus in class. Additionally, the home

conditions can impede their ability to interact with their teachers and peers in ways that are helpful. Given the nature of some of the aforementioned problems that students face, and the framework provided by the ASCA National Model, school counselors serve as a venue to help children facing such problems.

Responsive services that are provided by the school counselors vary. They can conduct individual, small group counseling, and crisis counseling. They can also serve parents and other professionals in a consultation role. Additionally, their position can mean that they are in the position of making referrals to appropriate agencies or community services, and as a peer facilitator within the school environment (ASCA, 2005).

Even though school counselor roles have been deemed important and necessary in schools, there are some disturbing outcomes regarding the availability of school counselors. In 2009, ASCA published each state's student-to-school counselor ratio (U.S. Dept. of Education, 2009). The results that were revealed were quite alarming. Even though the ASCA student-to-counselor recommendation is 250-to-1 (ASCA, 2005), the national average in 2009 was 457-to-1, with California having rates as high as 814-to-1 (U.S. Dept. of Education, 2009). With each counselor being responsible for so many students, individual counseling becomes unfeasible. Given these numbers, school counselors have to consider moving to a small group model. By making this type of clinical decision for providing services to the school students, it allows for a more effective tool in meeting the emotional and academic needs of today's youth.

Group Counseling

Since the model of providing services to children has changed given the student-teacher ratios, the benefit of such groups has to be considered. The school counselor's use of group counseling with only a few students at a time is encouraged in the elementary school. The reason is because it is a developmentally appropriate and efficient way for the school counselor to actually observe the students interact with their peers (Dollarhide & Saginak, 2012). From a developmental standpoint, children at the elementary school level have a natural desire to interact with others. It is through this interaction that children explore their values and make decisions about the choices they make within the safety of the counseling office (Dollarhide & Saginak, 2012).

In addition to the groups being an efficient manner to observe social interactions, groups are also a reasonable mode for a counselor to provide services to a large number of children at one time. Since elementary schools rarely have more than one school counselor, and often the elementary school counselor has the responsibility for more than one school, group counseling is also beneficial from that perspective. As a result, small group counseling becomes an effective method of offering therapy to groups of children who exhibit behavior concerns. Group counseling also allows the school counselor the opportunity to actually see students interact with their peers in the controlled environment of the counselor's office.

Small group counseling in the elementary school can be conducted in a structured (psychoeducational) approach or an unstructured approach, sometimes called process groups (Dollarhide & Saginak, 2012). In structured groups, the school counselor directs the activities by presenting a lesson that is designed to help the students change a specific

behavior. Some possible activities for psychoeducational group counseling are role-playing, art activities, or games (Dollarhide & Saginak, 2012).   In the unstructured groups, the learning occurs through the group interaction and spontaneous behavior during the group sessions (Dollarhide & Saginak, 2012). This study compared these two types of group experiences in mostly second and third graders using a teacher rating of the students' behavior, classroom observations and an individual assessment of the child's perception of peer acceptance.

The unstructured small groups in this study are based on the Child-Centered Play Therapy (CCPT) theoretical approach, which states that play therapy is a developmental process where children can express themselves in a safe environment with a trained professional who helps them become stronger (Landreth, 2002). Play therapy provides opportunities for children to discharge energy, prepare for the real world and relieve frustration. In the school environment, the school counselor does not conduct "therapy"; therefore, the term used in this study is defined as Child-Centered Group Play Counseling (CCGPC).

In CCGPC, there is a relationship developed between the counselor and each group member, as well as a relationship between each of the group participants (Landreth & Sweeney, 1999). In these groups the counselor does not accept the responsibility for directing group activities, but allows the group members to accept that responsibility (Landreth & Sweeney, 1999). The counselor sets the climate for each session with basic therapeutic conditions of empathy, acceptance, warmth, and positive regard (Landreth & Sweeney, 1999). Counselors also provide structure by starting and ending the group in the same way at each session, and by setting limits that provide safety for each of the

participants. Counselors who practice CCGPC believe that the spontaneous interaction of the group members in a safe controlled environment contributes to the participant's ability to learn positive behavior.

Unlike the non-directive counselor role in CCGPC, the counselor in structured psychoeducational groups takes an authoritarian role (Geroski & Kraus, 2010). Counselors show they are the experts by planning the activities they feel the participants need in order to learn the appropriate skill that will improve their behavior. At the first group session, the counselor discusses limits and asks the group members for input (Geroski & Kraus, 2010). The counselor takes responsibility for several aspects of the group and the information that gets processed during the group. The counselors in structured psychoeducational groups are involved in planning the group session, and introducing activities the children will be involved in during the group. They also facilitate the experience, as well as process with the children at the conclusion of the group what was learned (Geroski & Kraus, 2010). Some common topics for structured psychoeducational groups in the schools are friendship, conflict resolution, study skills, and anger control.

There are several research studies that have demonstrated positive results for psychoeducational groups in the school settings (DeRosier, 2004; Larkin & Thyer, 1999; Nelson & Dykeman, 1996; Schechtman & Ifargan, 2009; and Steen & Kaffenberger, 2007; Web & Myrick, 2003). The research data using an unstructured group model are limited to only one study that showed significance for improving disruptive classroom behavior (Brantley, 1996). This particular study had small groups that included more than two elementary students. Several studies examined CCPT groups but used only two

children in the groups (Baggerly, 2004; Baggerly & Parker, 2005; McGuire, 2000). To date there is little research that compares the psychoeducational-structured group model to the unstructured child-centered model with elementary students who exhibit disruptive behavior problems.

The psychoeducational small group studies included those that focus on students with aggression, students who experience attention concerns, and students who have deficits in social skills. DeRosier (2004), developed a psychoeducational small group intervention, called Social Skills Group Intervention (S.S.GRIN), to address those third grade students who were socially anxious, peer-rejected, and victimized by bullying. The eight weekly sessions, which were 50-60 minutes in length, indicated that aggressive children showed the most treatment gains. Aggressive children who participated in the S.SGRIN groups had bullying behavior and antisocial behaviors decrease over the course of the school year, but the children who did not participate in the groups and had these same behavior difficulties had an increase in behaviors (DeRosier, 2004).

Webb and Myrick (2003) studied small group intervention related to Attention Deficit/Hyperactivity (ADHD) symptoms in children. School counselors provided a 6-week group counseling intervention based on the Rational Emotive Behavior Therapy (REBT) model to help students learn about the effects of ADHD on their behavior and academic performance. At the completion of the intervention, the school counselors completed a survey, and 94% reported an increased confidence in consulting with teachers, while 93% felt that the students changed their views of themselves as students (Webb & Myrick, 2003).

In yet another study, Nelson and Dykeman (1996) examined elementary students who exhibited disruptive behavior, which is also termed externalizing behavior. These students participated in a small group intervention that focused on teaching cognitive behavioral skills. The treatment group saw significant changes in behavior, but those in the control group had no change in behavior. In another study, Schechtman and Ifargan (2009) compared two types of psychoeducational groups and their effect on children's externalizing behaviors. The researchers compared classroom guidance and small group counseling groups and analyzed their effect on aggressive behavior, externalizing behavior, and positive classroom relationships. Both of the treatment groups showed improvements with students who exhibited aggressive behavior (Schechtman & Ifargan, 2009).

Besides the effect of the psychoeducational small groups on behavior, some studies examined the effect of psychoeducational small groups on self-esteem and academic learning. Larkin and Thyer (1999) studied a structured psychoeducational small group counseling model with behaviorally disruptive elementary school children. In reports given by teachers and teacher's aides the students made significant improvement in self-esteem, and perceived self-control (Larkin & Thyer, 1999). More recently, Steen and Kaffenberger (2007) conducted a structured small group design in a suburban elementary school. They concluded that group counseling interventions were effective in addressing student learning behaviors in the classroom. The study also examined the grades for the participants in their language arts classes. At least 60% of the children improved their grades by at least one letter grade while the other grades remained the same (Steen & Kaffenberger, 2007).

Unlike the numerous studies that have used psychoeducational groups, the research with unstructured CCPT groups is limited. Of the studies that have been conducted, most of the studies used only two children in each group. In two such studies (Baggerly, 2004; Baggerly & Parker, 2005), the impact of a CCPT group model was studied. One study consisted of children in a homeless shelter's onsite elementary school. The group's size was limited to two children due to the size of the playroom and the intense needs of the children. In this study Baggerly used the small group model and measured mood and self-esteem using the Children's Depression Inventory (CDI). After participating in the small group, the results showed a large effect on Negative Mood, and a moderate effect on Negative Self-Esteem. Baggerly also used the Revised Children's Manifest Anxiety Scale (R-CMAS) and found after the groups that there was a moderate decrease in the participants' Physiological Anxiety.

The study by Baggerly and Parker (2005) examined the effect of a CCPT group model with African American boys in an elementary school. As in the previous study, only two children were in the group. This qualitative study indicated that the group sessions improved the boys' African worldview and facilitated their self-confidence. The variables in each of the previous studies suggested that there was an effect on disruptive behavior, even though this was not the purpose of the study. A separate study, also using only two children in a CCPT group, found no significant improvement in behavior problems in children who were experiencing adjustment difficulties (McGuire, 2000). Brantley and Brantley (1996) compared two small group models, structured and unstructured, with a control group. The unstructured groups did not follow the Child-Centered play therapy guidelines. These small groups had more than two children in a

group and met for eight weeks. This research examined the disruptive behavior of fourth through sixth graders from at-risk, inner-city schools. The structured groups followed a typical psychoeducational curriculum, while the unstructured groups did not. They found that the structured groups had a slightly higher rate of behavior change (73% versus 64%) than the unstructured groups.

Statement of the Problem

In light of the No Child Left Behind (NCLB) mandate, elementary schools have increased pressure to demonstrate academic proficiency in reading and math; however, disruptive students in the classroom can interfere with other students' abilities to obtain the necessary skills for showing proficiency in these areas of learning. Often, these children can create a chaotic environment that inhibits learning for all students. In many schools children who have disruptive behaviors need mental health services in order to remain in the classroom. The school counselor in many states has an education background as well as counselor training. Oftentimes, it is the professional school counselor who is asked to provide these counseling services to children with disruptive behavior problems, but many schools only have one counselor for every 400+ students (U.S. Dept. of Education, 2009). These staggering differences in numbers make it impossible for the counselor to provide adequate care to each student. As such, group counseling can be a type of therapy that the school counselor can engage in, and that is encouraged by administrators.

Group counseling can provide an environment for student growth where the school counselor builds therapeutic relationships with students. Students can grow interpersonally as they interact with their peers in these group settings. Furthermore,

groups can be conducted in keeping with two models: structured psychoeducational groups and unstructured child-centered groups. There has been some research regarding the strengths of structured group counseling as it relates to decreasing disruptive classroom behavior (Brantley & Brantley, 1996; DeRosier, 2004; Larkin & Thyer, 1999; Nelson & Dykeman, 1996; Schechtman & Ifargan, 2009; Web & Myrick, 2003). Nonetheless, additional studies are needed to provide efficacy for child-centered group counseling, specifically CCGPC, in the schools. As schools are asking school counselors to participate in more responsive services, it is imperative that researchers examine the interventions of group counseling.

Purpose of the Study

The purpose of this study was to compare CCGPC with psychoeducational group counseling when used by school counselors as an intervention for decreasing disruptive student behavior (specifically externalizing behaviors) and increasing social skills in the elementary school setting. The study used a control group, as well as two different types of group counseling approaches: unstructured child-centered group play counseling (CCGPC) and structured psychoeducational group counseling. It is hoped that this research will help demonstrate the need for school counselors' use of CCGPC in the school environment. The following review of literature will examine past research with disruptive students in the elementary school, and studies where school counselors have used small group interventions in order to respond to these students.

Review of the Literature

The Elementary School

Elementary schools in the United States provide education for children from 5-12 years old, or kindergarten through 5th grade. In most schools, students are grouped in one classroom for the entire day with one teacher per classroom. Class sizes vary from 20-30 students depending on the school district. Classroom teachers have the responsibility for teaching all academic subjects throughout a 7-hour day. School principals provide the administration of the building, including the hiring and evaluation of all staff, decision-making responsibilities for parents, community involvement, academic and school-wide planning, and major disciplinary responsibilities for students. Support professionals within the elementary school most often include a school nurse, school counselor, school psychologist, and school social worker. Even though these professionals are available for student and teacher support, it is the role and responsibility of the classroom teacher to educate students in the basic skills of reading, writing, and arithmetic.

Of these three basic skills, reading and math have been the focus of the No Child Left Behind (NCLB) mandate, which requires statewide assessments in reading and mathematics for grades 3-8 (McGuinn, 2006). NCLB, which passed in 2001, was the reauthorization of the Elementary and Secondary Education Act (ESEA) of 1965 (Brown-Chidsey & Steege, 2010). The goal of NCLB is for all children to achieve proficiency in reading and math by 2014 (Kress, Zechmann & Schmitten, 2011). The measure of accountability is left to states, even though the federal expectation of

proficiency and accountability is made clear. States are challenged to develop statewide assessments in reading and math, in order to examine the progress of students in each school. The criteria for proficiency are determined on a state-by-state basis, where schools are graded as to the standard of Adequate Yearly Progress (AYP). Schools that do not show AYP for two consecutive years are identified as needing improvement, and after four consecutive years corrective measures are required (Kress et al, 2011). Some types of "corrective action can include replacing relevant school staff, implementing a new curriculum, decreasing management authority in the school, appointing outside experts to advise the school, extending the school year or school day, or restructuring the school" (Kress et al, 2011, p. 216). School funding is contingent upon this AYP report, which shows outcomes of instruction and all school programs. Programs that are implemented to aid with improvement need to show scientifically based research that improves academic achievement, and is known as evidenced treatment (EVT). The term "evidence-based" effectiveness is monitored by the yearly statewide assessments (Brown-Chidsey & Steege, 2010).

Under a guideline called Response to Intervention (RtI), evidence-based effectiveness has forced the schools to examine every component of student learning, which includes student behavior. The RtI model is an intervention plan, or sometimes a method of continual assessment, that ensures students' success for academic and behavioral interventions in schools across the United States (Brown-Chidsey & Steege, 2010). It is the responsibility of the teachers, principals, and curriculum coordinators "to know how to identify and verify the evidence base for appropriate instructional materials and methods" (Brown-Chidsey & Steege, 2010, p. 85). As students have difficulty in the

classroom with academics or behavior, the RtI intervention team, composed of teachers, school counselors, school psychologists, and administrators, recommend specific interventions for students within a three-tier-level approach that resemble a triangle.

According to Brown-Chidsey and Steege, (2010), Tier 1, which is at the bottom of the triangle, provided intervention and support for all students in the school. Schools develop universal screening procedures to identify which students did not meeting grade level goals. Schools use normative data that compared students' scores with other student scores in the same grade, either locally or nationally (Brown-Chidsey & Steege). After cut-off points had been set, teachers could see which students were at-risk in certain subjects. Eighty percent of students appeared to be successful at the Tier 1 level. For the remaining 20% of students who were not successful with Tier 1 interventions, Tier 2 interventions were provided (Brown-Chidsey & Steege; Pavri, 2009).

According to Pavri (2009), the Tier 2 interventions were implemented so that the students were able to have success at Tier 1. Interventions may focus entirely on evidence-based instructional methods, or they might include interventions that meet social-emotional behavioral difficulties (Pavri; Brown-Chidsey & Steege, 2010). Tier 2 instructional interventions include instructions for small groups of four to six students at a time, and can also include instructions for groups that may have only two students with one teacher (Brown-Chidsey & Steege). Tier 2 behavioral interventions include interventions that are "easy to administer in small groups, and are not too time and personnel intensive" (Pavri, p. 4). Schools rely upon school counselors, school psychologists, and behavior specialists to help in providing interventions for at-risk

behavior. Some of the interventions at this level include behavior charts, small group counseling and individual mentor support (Gresham, 2005).

One method used by the RtI team to assess the students' social emotional needs within this tiered approach, specifically at Tier 2, is by using a functional behavior assessment (FBA). Gresham (2005) defined FBA as "a collection of methods for collecting information regarding antecedents, behaviors, and consequences to determine the function ('cause' or purpose) of behavior" (p. 334). Gresham (2005) simplified the question of the effectiveness of an intervention by addressing this behavioral functioning question in two ways. The first was to examine the quantity and quality of the changes in behavior through teacher or parent ratings on a nationally normed behavior rating scale. Second, were direct observations of the student with non-referred peers, which aided in examining the target behavior problem (Gresham, 2005). When the student's behavior did not change after applying the prescribed interventions, then it became necessary to do more specific assessments for Tier 3 interventions.

Tier 3 intervention, which is at the top of the triangle, is available for the remaining 5% of the students who need substantially stronger interventions for success (Brown-Chidsey & Steege, 2010; Pavri, 2009). Tier 3 assessments include two types, which are both under the umbrella of diagnostic assessments. These two assessments are diagnostic assessments, which include progress data, and specialized assessments that help the team determine if the student needs special education services (Brown-Chidsey & Steege, 2010). When the Tier 3 diagnostic assessment shows a need for behavioral interventions, the school often collaborates with mental health, juvenile justice, and social service agencies (Pavri, 2009).

Researchers regularly search for the most evidence-based strategies in both academic and behavioral dimensions. The various types of interventions used in each of the tiers vary from school to school as researchers search for the most evidence-based strategies in both academic and behavioral dimensions. The RtI intervention teams are constantly searching for strategies that have been shown to be effective through research, and if the intervention meets the needs of the student. Effective problem solving involves an assessment of the student's specific needs, identifying those needs, and developing strategies as a team to improve the student's academic achievement and his behavior in the classroom (Brown-Chidsey & Steege, 2010).

Disruptive Behavior in the Classroom

Specifically, as it relates to children with disruptive behavior disorders, the teacher can face particular difficulties in the classroom setting. Children with disruptive behavior disorders tend to show symptoms most often in two settings - home and school. When the behaviors are evident in the school it can create stress for the teacher and the child. Because of the school's need to control the student's disruptions, the steps the school takes can sometimes tend to exacerbate the maladaptive behavior (Erk, 2008). Both at home and in school, when attempts are made to address children's inappropriate behaviors, discipline appears to be negative in nature. Moreover, when strong negative measures are implemented, it only serves to cause more of the same type of disruptive behavior (Erk, 2008). The school personnel, especially classroom teachers, search for ways to respond with appropriate interventions while still trying to manage to educate the rest of the remaining students.

Pearce (2009) conducted a two-year study in the rural western United States to look at a systematic approach teachers could use for the extreme emotional difficulties of children in the classroom. The study followed nine students, Kindergarten through 5th graders with emotional and behavioral difficulties, over a two-year period to evaluate the implementation of an RtI model in providing interventions. The students' behaviors were described as aggressive, having tantrums, non-compliance, low frustration tolerance, crying, perfectionism, anger, theft, running away from the classroom, ritualistic, impulsive, hyperactive, and moody (Pearce, 2009). Using the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR Edition (DSM-IV-TR)* (American Psychiatric Association, 1994), the mental health diagnoses for the nine students in the study included Oppositional Defiant Disorder, Depression, possible Reactive Attachment Disorder, Bipolar Disorder, Learning Disorder, Asperger's Disorder, and Attention-Deficit/Hyperactivity Disorder (Pearce, 2009). In Pearce's (2009) study, the schools implemented three tiers of interventions to meet the needs of all of the students in the school.

Tier 1 interventions included classroom and building level strategies that promoted positive behavior within the entire school that emphasized the six character traits of trustworthiness, respect, responsibility, fairness, caring, and citizenship (Pearce, 2009). Classroom teachers used a management and discipline technique with a color-coded system for inappropriate behavior and positive classroom consequences for appropriate behavior (Pearce, 2009). The variable in this study was the number of maladaptive episodes in the classroom that resulted in office referrals. An intervention team met weekly, and often included parents, to develop and implement Tier 2 and/or

Tier 3 interventions as part of an individual plan for each student. These interventions included social skills training, cognitive behavioral interventions, differentiated instructional approaches, individual and group counseling with the school counselor, and parental involvement (Pearce, 2009).

The kindergarten and first graders benefited the least from social skills training or cognitive behavioral interventions even though they learned to seek help when they faced challenges within the school (Pearce, 2009). The researcher concluded that the reason for the lack of results was due to the student's age and cognitive level of development. After the social skills and cognitive behavior interventions training, the disruptive behavior for students in grades 3-5 diminished with seven of the nine students. The behavior of two of the students did not show significant improvement, and they were eventually placed in special education services on the basis of aggression toward staff and other students (Pearce, 2009). The Pearce study is an example of teachers implementing and following the RtI guidelines using the three tiers of behavior interventions. While this study showed some promising results, more research is needed with a broader sample to examine if the strategies are indeed effective in decreasing disruptive behavior.

The Pearce (2009) study also found that the maladaptive behaviors that the children displayed caused disruptions with other students, as well as disruptions in teacher's instructions. Some educators believe that disruptive behaviors actually influence academic achievement. A study by Nelson, Benner, Lane and Smith (2004) examined 155 students in kindergarten through 12th grade who had emotional and behavior disorders (E/BD) to see if they had large achievement deficits in all content

areas as compared to those in a control group. Nelson et al. (2004) examined which types of problem behaviors had the greatest affect on academic achievement. The results showed that externalizing behaviors, such as attention seeking, aggression, delinquency, were most closely related to academic achievement in all content areas (Nelson et al., 2004). The researchers concluded that early intervention for students who exhibit externalizing behaviors could prevent academic deficits later. The individual who is called upon to assist in addressing the externalizing behaviors is the school counselor. This professional works with the child by focusing on disruptive classroom behavior as it relates to academic achievement.

Classroom Observations

One way to assess the specific type of externalizing behavior is through classroom observations. School counselors, school psychologists and behavior specialists are sometimes asked to visit a classroom to observe a student's behavior. Child observations in several different settings help educators know about the "child's learning style, attention span, mood and affect, expression of emotions, and interactions with parents, teachers, and peers" (Orton, 1997, p. 152). Gresham (2001) believed that observational data need to be included as one means of assessment in order to plan and review intervention strategies. Landau and Swerdlik (2005) stated that direct observation procedures follow best practice guidelines endorsed under the National Association of School Psychologists (NASP).

Anecdotal observations are one method of observing children in the school setting. This allows the observer to make notes of observations with no predetermined behaviors in mind (Volpe, McConaughy & Hintze, 2009). Systematic direct observations

instead focus on specifically defined behaviors and follow standardized procedures (Volpe & McConaughy, 2005). School wide Tier 1 programs might utilize a systematic direct observation in the classroom in order to assess a specific teaching method or with disruptive behavior occurring in transition points of the day (Landau & Swerdlik, 2005). Tier II interventions that focus on small group instruction or small group work on behavior skills could benefit from systematic direct observations also (Landau & Swerdlik, 2005; Volpe & McConaughy, 2005). Landau and Swerdlik emphasized the need for using observation data that was collected during Tier I and Tier II assessments for the discussion of effective interventions at Tier III. Direct systematic observations can also be used to assess if the treatment at Tier I or Tier II was completed as intended (Landau & Swerdlik, 2005).

Because it can be established that there is value in using systematic direct observations in the school setting, the next step is to evaluate the specifics of the observation itself. First, it is necessary to have a specified time for the observation. Several observations of the same student will give a stronger validity, but the time and expense can make the process unreasonable (Volpe, DiPerna, Hintze & Shapiro, 2005). Volpe et al. recommended that "multiple observations should be performed within each setting" (p. 470), and at each assessment the observer collects data on one or more peers. As observers are in the classroom often for various activities, the students will not see this as a questionable experience, where they "act their best" but instead a more normal part of the classroom (Volpe et al., 2005). It can be concluded that direct observation of students in the classroom can give another layer of knowledge about the disruptive

child's targeted behavior. These data can be added to the data from teachers, parents, peers and child self-reports.

Self-Perceived Peer Acceptance

Self-reports can be added to the data for appropriate intervention strategies in the school setting. One type of self-report could be one that asks the child questions related to his social interaction with others. When children are asked to self report there is an assumption that the child has knowledge different from those who are observing a child (Pepler & Craig, 1998). In the case of reporting on bullying behavior or any type of antisocial behavior, the child may have witnessed an act that an observer did not see. Pepler and Craig cautioned that children are not always accurate in their self-reports. For example, children are reluctant to admit that they have problems with other children. Aggressive children in particular tend to be more positive in reporting on their own behavior (Pepler & Craig, 1998).

Mantzicopoulos (2006) studied the difference in the way children view their social acceptance between the ages of pre-school and second grade. His longitudinal study followed 87 children from preschool through second grade to assess their cognitive, physical and peer competence using the Pictorial Scale of Perceived Competence and Social Acceptance instrument (Harter & Pike, 1984). Even though the assessment examines four subscales, this review of literature will focus on the Peer Acceptance subscale results. Mantzicopoulos found that the children's self-evaluations of peer competence decreased with age. Preschoolers reported the highest self-perceptions and second-graders reported the lowest self-perceptions of peer acceptance. The study compared the child's self-perceptions with those ratings by teachers using the Social

Skills Rating System (Gresham & Elliott, 1990) and found a small but statistically significant correlation at kindergarten between teacher ratings of risk for peer relations and children’s beliefs about peer acceptance. Mantzicopoulos surmised that this was only a chance correlation considering the number of correlations tested for significance. The participants in the study were in a Head Start program during their preschool years, but transferred to a more economically diverse public school setting during their elementary grades.

This study supported Pepler and Craig’s (1998) belief that bias might occur when children are completing a self-perception of peer relationships assessment. Evaluators should review the cognitive and language developmental ability of the children to see if they can accurately evaluate themselves and then interpret, process and respond to the questions when asked (Pepler & Craig, 1998).   Cognitive development is based upon Piaget’s theory (Santrock, 2009). In this theory, children progress from the pre-operational stage of development, usually occurring between 2 and 7 years of age, to the concrete operational period at 7 to 11 years of age. It isn’t until the concrete operational period that children can reason logically about concrete events, but they still are unable to think in abstract terms (Santrock, 2009; Orton, 1997). Concrete operations aid in language development, because usually at about 7 years of age children can begin to analyze words that are outside their realm of personal experience (Orton, 1997, p. 57).

Moral development also contributes to children’s perceptions of themselves socially. Kohlberg extended Piaget’s cognitive development to propose six universal stages of moral development (Santrock, 2009). At the first level, children obey because adults tell them to obey or they will be punished (Santrock, 2009). As they progress

through that level, children begin to pursue their own interest and allow others to do the same (Santrock, 2009). According to Santrock, Kohlberg believed that before the age of 9, children remain at this first level. So, the level of moral development may also be a contributor to children's self-perceptions.

Cognitive and language development combine with a child's emotional development to help her or him problem solve about peer interactions. Orton (1997) stated, "children who are good communicators and who are friendly and outgoing are usually popular with their peers" (p. 62). However, aggressive behavior in children could lead to rejection (Orton, 1997). Children move through the elementary school years trying to find their place with their peers (Orton, 1997). Teachers and school counselors see the effect of this struggle in the school setting.

School Counseling

School counselors can be helpful in screening and providing treatment for students with behavioral difficulties in elementary school. They serve as educational leaders in the school, and members of the tiered intervention team previously mentioned. As part of that team they provide expertise in school-wide interventions as well as small group and individual strategies. The ASCA National Model (2005) acknowledges that the chief mission of the school counselor is to support the academic achievement for all students. Thus school-wide pressure for academic achievement gives the school counselor a variety of roles and responsibilities depending on the school climate, the principal, and the state's guidelines. The ASCA National Model recommends that the counselor participate in four major interdependent systems: Foundation, Management System, Accountability, and Delivery System. Responsive Services, the school

counselor's response to the individual needs of students, is addressed under the umbrella of Delivery Systems (ASCA). The services in this system include individual and group counseling, consultation, referral to outside sources, and peer mediation. The school counselor uses these responsive services to help in Tier 2 and Tier 3 interventions. ASCA emphasizes that the main purpose of these services is to maximize each student's ability to learn.

A well-structured guidance curriculum and group counseling plan for those who need additional support gives the school counselor the opportunity to focus on specific ways to help students learn. Because it is the school counselor's role to provide services for all students in a school building, ASCA (2005) states that the majority of the elementary school counselor's time should be allocated to teaching classroom guidance lessons – a preventative approach to guide students in the areas of career development, academic achievement, and personal/social development. Specifically, Gybers and Henderson (as cited in ASCA, 2005) recommend that elementary school counselors spend approximately 80% of their time on direct services to students. These direct services consist of Guidance Curriculum at 35-45%, and Responsive Services at 30-40%. More students can be seen in the time allotted when the school counselor teaches classroom guidance lessons and sees students for group counseling. Small group counseling is one service that can be provided to those students who exhibit emotional or mental health needs.

Group counseling allows the school counselor to address specific emotional behaviors that a growing number of students in elementary school are displaying. The school counselor can address the emotional behaviors that are common to a small group

of students in group settings. Elementary schools that have more and more students with symptoms of emotional disturbance (ED), as defined by the Individuals with Disabilities Act (IDEA), may be served in this type of setting.

According to the U.S. Department of Education (as cited by the National Dissemination Center for Children with Disabilities, 2010), in the 2003-2004 school year there were more than 484,000 students who received special education and related services for ED symptoms. Some of the ED symptoms include short attention span, impulsiveness, aggression or self-injurious behavior, withdrawal from others, inappropriate crying or temper tantrums, and academically performing below grade level. Special Education services for children with ED symptoms might include an Individual Education Plan (IEP) for goals related to the behavior and/or goals to address the academic needs. Because school counselors are charged with the task of referring students with mental health needs to community resources, it is worth noting that many children would not receive mental health interventions if it were not for the school counselor. These children would not receive such services either because of the lack of community services or the family's inability to pay for services. According to the National Health and Nutrition Examination Survey (NHNES) (as cited in the National Institute of Mental Health press release, December 14, 2009), only 55% of those children who met criteria for a mental disorder had actually consulted with a mental health professional outside the school. Since students and parents already have formed a trusting alliance with the school counselor, it seems natural that the school counselor should be available to provide small group and individual counseling during the school day to assist in addressing some of the students' problem behaviors.

This trusting alliance can be the initial step in building a relationship between the school counselor and the child. The American Psychological Association (APA) Division of Psychotherapy and the Division of Clinical Psychology sponsored a task force to study the counselor relationship (Norcross, 2011). One of the conclusions from the resulting meta-analysis of over 20 research studies showed that regardless of the psychotherapy approach, the counselor relationship with the client accounts for why clients improve or fail to improve. One characteristic of the counselor relationship is empathy. In another meta-analytic review of 57 studies, empathy, as expressed by the counselor, predicted treatment outcome regardless of the theoretical orientation (Elliott, Bohart, Watson, Greenberg, 2011).

Even though both individual and group counseling are possible responsive service interventions, there are many benefits to the use of group counseling. One benefit of group counseling that was mentioned previously is time efficiency--the advantage of seeing several students at the same time (Dollarhide & Saginak, 2012). Another benefit is that the group is a natural medium for learning and support. Students seem to learn from each other in a relaxed and fun atmosphere, and the group experience can be like a real-life setting where students work out problems with each other (Dollarhide & Saginak, 2012; Perusse & Goodnough, 2009). Since school counselors are not expected to do therapy, ASCA states that “group counseling needs to be provided on a short-term basis to help students identify problems, causes, alternatives, and possible consequences so they can take appropriate action” (2005, p. 42).

There are several types of group counseling that the school counselor can use to help students with their problems. Erford (2010) listed two types of groups that can be

used in a school: task groups and psychoeducational groups. Task groups are groups that are developed for a specific task, such as planning committees, clubs, or fundraising (Erford, 2010). School counselors most often use the psychoeducational type of group. In keeping with ASCA's requirement that group counseling should be short term, the school counselor can provide psychoeducational groups for a limited number of sessions. The primary goal of the groups is to impart knowledge or training to students (Erford, 2010). The groups are directive in nature and discuss specific topics to help a group of students in a specific skill (Erford, 2010). Another type of small group that can be used in schools is non-directive in nature, and often called process groups (Dollarhide & Saginak, 2012). These can be based on the Client-Centered theoretical model. This current study examined two types of small groups: Psychoeducational directive groups, and Child-Centered non-directive groups.

Psychoeducational Group Counseling in the Schools

In the elementary school, counselors conduct psychoeducational groups through classroom guidance, as well as through small groups with four to six students. Classroom guidance groups are held in the students' classrooms and are designed to follow the curriculum of the National Standards for School Counselors (ASCA, 2004). The guidance curriculum is a systematic approach that is "preventative and proactive, developmental in design, coordinated by school counselors and delivered, as appropriate, by school counselors and other educators" (ASCA, 2005, p. 40). As a Tier 1 level intervention, all students in the class participate in classroom guidance groups, which focus on cognitive, behavioral, or affective growth and development (Geroski & Kraus, 2010). However, there are some students who need extra practice and skill training in

some of the curriculum areas. The school counselor can use small groups as a way to meet the additional needs of these students.

The school counselor can use the psychoeducational type of group to provide an opportunity for the students to share specific issues or problems with each other (Geroski & Kraus, 2010). Small groups are designed to meet the needs of four to six students with similar concerns allowing for more personal sharing among the students, and providing an opportunity for students to see the perspective of others in the safe environment of the counselor's office (Dollarhide & Saginak, 2012; Geroski & Kraus, 2010). Participants in small groups are screened prior to group formation to assure that the composition of the group is appropriate but still diverse in membership (Geroski & Kraus, 2010). According to Sweeney and Homeyer (1999), children benefit from the interaction with other children just as adults benefit from the group counseling experience.

In addition to the benefit of group interaction, group counseling allows children to learn the skills of cooperation and compliance (Sweeney & Homeyer, 1999). These skills are important for daily interactions in the school environment. In the small group atmosphere, children can practice skills first with only a few of their peers, and then apply what they have learned to their real-life situations with other children. Psychoeducational groups can focus on student problems, such as friendship, anger management, study skills, and self-esteem issues. In the studies to follow, disruptive behavior was defined as acting out behavior and aggression towards others. DeRosier (2004) studied a school-based small group model (S.S.GRIN) that addressed social skills in third grade students. Webb and Myrick (2003) studied a 6-week group counseling intervention for Attention Deficit/Hyperactivity Disorder (ADHD) where school

counselors led the groups. Nelson and Dykeman (1996) examined a cognitive-behavioral small group model to see if there would be a decrease in disruptive classroom behavior. A comparison of classroom guidance and small group counseling was studied by Schechtman and Ifargan (2009) to see if internalizing behavior and externalizing behavior would decrease and positive classroom relationships would increase. Larkin and Thyer (1999) evaluated cognitive-behavioral group counseling in two elementary schools (kindergarten through grade five) to see the effect of the model on disruptive behavior. These quantitative studies using psychoeducational group models have shown some significant results in decreasing disruptive behavior. In turn, these group models demonstrated that children were able to improve in their interpersonal relationships with other children. However, little research has studied the effect of unstructured child-centered groups (Baggerly, 2004; Baggerly & Parker, 2005; Brantley & Brantley, 1996; McGuire, 2000). Only Brantley and Brantley (1996), who used unstructured but not CCPT groups, examined disruptive behavior in an elementary school with more than two students in a group.

Student disruptive behavior can be exhibited by aggressive behavior, inattention, hyperactive behavior, acting out, lack of self-control, or inappropriate social skills with authority or peers. In 1996, Nelson and Dykeman studied a small group model in the elementary school to see its effectiveness in decreasing disruptive behavior, specifically externalizing behavior. There were 24 participants in the study (12 in the CBT group model and 12 in the control group). The children consisted of second, fifth and sixth graders, from two low socio-economic schools in the Pacific Northwest. Certified school counselors conducted the eight weekly small group sessions using a psychoeducational

model that taught interpersonal skills (Nelson & Dykeman, 1996). Teacher rating scales that were administered pre- and post-intervention showed that only the experimental group students' scores improved (Nelson & Dykeman, 1996).

Shechtman and Ifargan (2009) conducted another study that examined disruptive behavior of children in schools in Israel. This study examined students' aggressive behavior by comparing two types of group experiences: psychoeducational classroom intervention, and group counseling in a small group. The researchers also included a control group that received no treatment. They found a significant decrease in adjustment symptoms, student aggression, and class aggression for students in both types of group experiences (Shechtman & Ifargan, 2009). There was no change for students who were in the control group. The researchers did not find any adverse reaction to segregating the aggressive students into the small group intervention. In fact, as compared to those without any treatment, the small groups of aggressive students had the same positive results in relation to their aggressive behavior as those who were with others in the classroom (Shechtman & Ifargan, 2009). Shechtman and Ifargan concluded that even though the aggressive children were not segregated out for treatment, the dynamics of the classroom had a positive impact on their behavior, and that any intervention is better than no intervention.

Larkin and Thyer (1999) focused exclusively on a small group cognitive behavioral intervention with aggressive children by conducting a study using an immediate-treatment (IT) and delayed-treatment (DT) control group design. Both IT and the DT groups were equivalent on demographic and pre-test outcomes, with a few differences related to teacher and teacher aide ratings of student behavior (Larkin &

Thyer, 1999). The design of the researchers used assessments of both groups at the beginning of treatment, following the IT group intervention, and following the DT control group intervention (Larkin & Thyer, 1999). Results found that IT groups' self esteem, perceived self-control, and teacher and teacher aide grades of classroom behavior improved significantly immediately following treatment, and continued to improve when assessed at the completion of the DT control group intervention (Larkin & Thyer, 1999). The DT control group showed no significant improvement on any of the outcomes at the second assessment, before their treatment was conducted. However, results were similar to the IT groups when data was examined at the conclusion of DT's group treatment (Larkin & Thyer, 1999). These conclusions add credibility to the fact that a structured cognitive behavioral group counseling model used in the elementary school can show positive changes with disruptive classroom behavior.

Another type of disruption that students present in classrooms is inattention, hyperactivity and impulsivity, often diagnosed as Attention Deficit/Hyperactivity Disorder or ADHD (American Psychiatric Association, 1994). Webb and Myrick (2003) studied a six-session group-counseling model with ADHD students based on Rational Emotive Behavior Therapy (REBT). School counselors taught specific skills related to goals in academics, personal, social, and career development (Webb & Myrick, 2003). At the completion of the six group sessions, researchers did not see significant changes in the student self-rating scores, but after six more weeks of practice and feedback activities provided by the classroom teacher, the scores improved significantly (Webb & Myrick, 2003). The researchers concluded that the added six weeks of practice and feedback with

the teacher played a significant role in the students' improvement in the classroom (Webb & Myrick, 2003).

In addition to using groups to address aggressive disruptive behavior, many school counselors also search for small group interventions that will improve social skills. Bostick and Anderson (2009) examined a cognitive behavioral group counseling intervention with third graders who had peer problems and/or high social anxiety. Social Skills Group Intervention (S. S. GRIN) (DeRosier, 2004, 2005) was implemented using a follow-up assessment with teachers and parents, and a more intensive intervention for identified students in a small-group format (Bostick & Anderson, 2009). The students who were originally studied experienced peer dislike, bullying or social anxiety (DeRosier, 2004). They were selected by a sociometric measurement administered to them in the classroom. Those students with significant peer issues were randomly assigned to the S.S.GRIN group or to a control group that received no treatment (DeRosier, 2004).

Treatment groups were composed of six students, who met for 8 consecutive weeks for 50-60 minutes (DeRosier, 2004). The group lessons were highly structured focusing on children's peer relationships and social behavior skill training. After the eight-week intervention, the students who participated in an S.S.GRIN group showed greater peer likeness than those in the control group, and also showed an increase in self-esteem, greater social self-efficacy, and lower social anxiety (DeRosier, 2004). In a follow up after one year, there were significant differences between the treatment group and no-treatment control group for both peer-rated behavior and self-reported measures of social and emotional functioning (DeRosier, 2005). Those who were initially

identified with aggressive behaviors received some of the strongest gains in the follow up study. The researchers believed that this was due to the fact that S.S.GRIN provided the children with more opportunities to practice and model prosocial behaviors, and that over time, their negative feelings about themselves diminished (DeRosier, 2005).

As Bostick and Anderson (2009) discovered, not only do small group interventions help with students' social skills and classroom behavior, these interventions also help students show academic improvement (Steen & Kaffenberger, 2007). Steen and Kaffenberger (2007) used small groups to address classroom behavior and academic needs by including session topics of anger management, changing families, friendship, social skills and grief. The learning behaviors of the students improved following the small counseling group intervention according to students' self reports, and parent and teacher feedback (Steen & Kaffenberger, 2007). Researchers concluded that the school counselor's use of group counseling can be an effective intervention for assisting students in achieving academic success (Steen & Kaffenberger, 2007).

Each of the aforementioned research studies suggested that children had significant improvement in classroom behavior when elementary school counselors used the intervention of a structured small group counseling method (Bostick & Anderson, 2009; DeRosier, 2004, 2005; Larkin & Thyer, 1999; Shechtman & Ifargan, 2009; Webb & Myrick, 2003). Steen and Kaffenberger's (2007) study showed a positive correlation between classroom behavior and academic achievement. Brantley and Brantley (1996) compared structured and unstructured groups with inner city youth, and concluded that the structured model showed a slightly higher decrease in acting-out behavior. These researchers concluded that inner city youth might benefit from more structure in-group

settings (Brantley & Brantley, 1996). In addition to using psychoeducational group counseling, the school counselor can also use another group counseling approach in the elementary school called child-centered group play counseling (CCGPC).

Play Therapy

Before examining the use of child-centered groups, it is beneficial to reflect on the therapeutic use of play in counseling children in the schools. For many years, educators and psychologists have both recognized the importance of play. Maria Montessori thought of play as the work of children (Sciarra, 2004). Many school counselors see the benefit of play in teaching guidance lessons and working with children individually and in groups. Shen (2006) conducted a study in which she examined the percentage of school counselors in Texas who use play therapy techniques in individual counseling or group counseling. The results demonstrated that 81% of the 252 school counselors who were surveyed used play therapy for individual counseling, and 47% used play therapy for group counseling (Shen, 2006).

Sigmund Freud initiated play therapy in the early 1900's (Landreth, 2002). Freud's treatment examined the play of a child, Little Hans. However, Freud had no counseling sessions with Little Hans, only exclusive counseling sessions with Hans' father. It was through the work of Hermine Hug-Hellmuth, Anna Freud, and Melanie Klein that the technique of play as a modality for the treatment of children was used. They compared the analysis of the child's play to make assumptions regarding preconscious and unconscious interpretations, much the same as free association in psychoanalytic talk therapy (Landreth, 2002).

These psychoanalytic pioneers realized the need for play when counseling children. However, according to Garry Landreth (2002), Carl Rogers' person-centered counseling approach provided the foundation for child-centered play therapy (CCPT). Virginia Axline, a student of Rogers, believed that it was the relationship between the counselor and the child that provided the healing power (Axline, 1974). She used the nondirective, child-centered principles of Carl Rogers to help the child grow and develop (Landreth, 2002).

Axline (1974) gave eight basic principles that are a guide for counseling children. Child-centered play counselors use these principles as a framework for both individual and group counseling. The principles are listed in a simplified format for the purpose of this project:

1. The therapist must develop a warm, friendly relationship with the child.
2. The therapist accepts the child exactly as he or she is.
3. The therapist establishes a feeling of permissiveness in the relationship, so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to her or him.
5. The therapist maintains a deep respect for the child's ability to solve his or her own problems if given an opportunity to do so.
6. The therapist does not attempt to direct. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his or her responsibility in the relationship. (Axline, 1974, pp. 73-74).

These same eight principles set the philosophy when counselors use the Child-Centered theoretical model for group counseling.

Child-Centered Group Play Counseling

Axline (1974) was one of the first therapists to use CCPT in group counseling. She described an annotated case example of a child-centered group play counseling experience with five boys who had behavior problems and lived in a foster home (Axline,1974). She noted that children in this type of a group sometimes have the courage to do things that they might normally be hesitant to do. Sometimes there was a pressure in the group dynamics that caused one of the children to do something that another child had done (Axline, 1974). Axline stated that often children in a group take pleasure in the company of a child when they normally would be at odds with that child. She also cited examples of the boys stating that they can do things in the counseling room that they could not do outside the counseling room, illustrating the permissive relationship within the safe environment of the counseling room.

Even though the counseling relationship is permissive, it is necessary for the counselor to set structure by stating the number of group sessions at the beginning of treatment (Axline, 1974). For example, Axline recommended five-week schedules for group counseling that can be renewed if the counseling seems incomplete. Davis and Fry (2010) implemented this type of group in a school setting with four children meeting for eight sessions. At each session, one of the children was in charge of deciding what the

activity would be. This small addition to the structure of the group session added a cooperation component encouraging work on the improvement of social skills.

Another example of structure in the group is setting limits when there is a need for safety in the environment. Landreth and Sweeney (1999) emphasized limit setting by stating that more than one child in the playroom magnified the need for limits. Actually, children do not feel safe when they are in a totally permissive relationship (Landreth & Sweeney, 1999). Limits are set only when they are needed, according to Landreth and Sweeney. Examples of limits are when children's behavior is dangerous to another child or themselves, when they disrupt the structure of the session, destruction of the room or toys, or inappropriate play of affection (Landreth & Sweeney, 1999).

There are four studies that examined CCGPC with elementary school children (Baggerly, 2004; Baggerly & Parker, 2005; Doubrava, 2005; McGuire, 2000). However, one study completed the intervention in a mental health agency instead of in a school (Doubrava, 2005). Even though the group intervention is the same, each study has unique characteristics and various lengths of treatment. McGuire (2000) studied the effect of the group model on disruptive classroom behavior. None of the studies used students with aggressive behavior. Additionally, the studies used the term child-centered group play therapy, but because of the negative reaction in the schools to the term "therapy," this study refers to the intervention as CCGPC. The specific characteristics of each study still demonstrated a need for more research in examining CCGPC with disruptive children in the elementary school.

One study that used child-centered play counseling in an elementary school examined self-confidence and the African American worldview (Baggerly & Parker,

2005). Baggerly and Parker referred to this intervention as a group intervention even though the participants included only two children. The researchers referenced Sweeney and Homeyer (1999) indicating that group play therapy can have two participants. This qualitative study of two African American boys consisted of nine to eleven child-centered group sessions (Baggerly & Parker, 2005). The sessions were held either once or twice a week at the boys' school. The overall goals of the child-centered group counseling intervention were 1) to help students learn self-control, responsibility, expression of feelings, respect and acceptance of self and others; 2) to improve behavior, social skills, and self-esteem; and 3) to decrease depression and anxiety (Landreth, 2002; Sweeney & Homeyer, 1999). The specific goal for this study was to honor the African worldview and build self-confidence (Baggerly & Parker, 2005). Comments from the boys during the play sessions reported positive results regarding a strong African American identity and a positive self-concept (Baggerly & Parker, 2005).

Besides being culturally sensitive, child-centered group play counseling can help children with adjustment difficulties. If a child has adjustment difficulties it can hinder the child's behavior. CCGPC showed success with 14 kindergarten students who were experiencing adjustment difficulties (McGuire, 2000). McGuire evaluated the 12-week group-counseling model as to its effectiveness for improving self-concept, reducing behavior problems, increasing emotional and behavioral adjustment to school, and increasing self-control. This study did not show statistically significant change in any of the variables. Even so, McGuire observed positive trends in children's behavior, self-control, and self-concept. It is noted that the limitations were due to the small sample size and the fact that the participants were from only one environment (McGuire, 2000).

Adjustment difficulties can often manifest as symptoms of a mental disorder in some children. Doubrava's (2005) study of a CCPT group model examined children with at least one Axis I mental disorder, as defined by the DSM-IV-TR. Ten group sessions were held in a community mental health agency studying nineteen children, ages 7-10, with the purpose of examining the effectiveness of CCPT on emotional intelligence, reduction in problem behaviors, and reduction in parenting stress (Doubrava, 2005). A small sample size contributed to the lack of statistically significant differences in the three areas that were measured; however, the researcher did include positive feedback from the group and favorable comments by the group leader (Doubrava, 2005).

One adjustment difficulty that certain children experience is when the economic conditions of the family necessitate living in homeless shelters. Baggerly (2004) studied a CCPT group model with children who lived in a homeless shelter and attended school at the site. Over a two-year period, there were only 25 of the original 42 children who completed 9 to 12 sessions because of the natural movement of this population. The mean age of the participants was 8, with age ranging from 5 to 11 years old. For the children who participated in the study Baggerly found that there was significant improvement in self-concept, measured by the Joseph Pre-School and Primary Self Concept Screening Test (JPSPSCS). The study also found significant improvement in depression symptoms, which was measured by Children's Depression Inventory (CDI), and significant improvement in the Total Anxiety scale, which was measured by Revised Children's Manifest Anxiety Scale (RCMAS) (Baggerly, 2004).

Summary

The review of literature seems to suggest the necessity for more research on small group interventions by school counselors in the elementary school setting. It has been noted that disruptive classroom behavior creates problems for students in many different areas of functioning. These behaviors can prove to be quite problematic in the area of the child's academic achievement. Where there are problems academically, the long-term effects can be widespread, stretching into many other areas of the child's development and future. Since students need to increase their proficiency scores in reading and math, it will be necessary for disruptive behaviors to be addressed in the school settings. Research suggests that the school counselor may be the best person to assist in carrying out this responsibility. If the school counselor can use an effective small group-counseling model to reduce problematic classroom behavior, it might also result in an increase in the overall class end-of-the-year assessment scores in reading and math.

Research Questions and Hypotheses

Research Questions:

1. Is there a statistically and/or clinically significant difference in externalizing problem behaviors as measured by the difference between the pre-test and post-test scores on the TRF (Attention, Aggression, Rule Breaking subscales, or the composite scale of Externalizing Behavior) of elementary school students who participate in CCGPC when compared to students who receive a typical group psychoeducational program and a control group?

2. Is there a statistically and/or clinically significant difference in externalizing problem behaviors as measured by the difference between the pre-test and post-test

scores on the DOF (Attention Problem, Intrusive or Oppositional subscales) of elementary school students who participate in CCGPC when compared to students who receive a typical group psychoeducational program and a control group?

3. Is there a statistically and/or clinically significant difference in social skills as measured by the difference between the pre-test and post-test scores on the Peer Acceptance subscale of the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter, 1983) in elementary school students who participate in CCGPC when compared to students who receive a typical group psychoeducational program and a control group?

4. Is there a statically and/or clinically significant difference in social skills as measured by the difference between the pre-test and post-test scores Social Problems subscale of the TRF in elementary school students who participate in CCGPC when compared to students who receive a typical group psychoeducational program and a control group?

Hypotheses:

H1: The difference between teacher reports on pre- and post-test scores assessing externalizing behavior will show CCGPC to be as effective as the psychoeducational group program when compared to a non-therapeutic control group.

H2: The difference between pre- and post-test scores using classroom observations to assess externalizing behavior will show CCGPC to be as effective as the psychoeducational group program when compared to a non-therapeutic control group.

H3: The difference between child's self-reports on pre- and post-test scores assessing social skills will show CCGPC to be as effective as the psychoeducational group program

when compared to a non-therapeutic control group.

H4: The difference between teacher reports on pre- and post-test scores assessing social skills will show CCGPC to be as effective as the psychoeducational group program when compared to a non-therapeutic control group.

CHAPTER II

METHODOLOGY

Although various types of psychoeducational models have been shown to be effective in decreasing problem behaviors in elementary school students, very little research has examined how child-centered group play counseling (CCGPC) might decrease these behaviors. This study examined the effect of small group counseling on the externalizing behavior and social skills of elementary students. Most were in second and third grade, but one fourth grader was included. Three levels of the independent variable, small group counseling, were examined: CCGPC, a psychoeducational model and a non-therapeutic control group. This repeated measure (within subjects) design examined all participants before the intervention and after the intervention. In this chapter, the critical terms are defined; the population and sampling are discussed; the human subject, data procedures, and research methods are explained; and the data collection analysis procedures are described including specifics of the assessment instruments that were used in the study.

Definition of Terms

Achenbach System of Empirically Based Assessment (ASEBA) includes a set of forms to assess behavior of children. These forms are Child Behavior Checklist for Ages 6 to 18 (CBCL/6-18), Youth Self-Report (YSR), Teacher's Report Form (TRF) and Direct Observation Form (DOF).

Aggressive behavior characteristics included as a subscale in the Teacher Report Form (TRF) (Achenbach & Rescorla, 2001) are explosive temper, threatens others, disobedient, gets in fights, defiant, and mean to others.

American School Counselor's Association (ASCA) is the professional association of school counselors in the United States.

ASCA National Model is published by the American School Counselor's Association as a framework for school counseling programs across the United States. It is to be used by school counselors to help them design, implement, coordinate, manage and evaluate their programs in an effort to aid students' academic success (ASCA, 2005).

Attention Problems is a sub-scale on the Teacher Report Form (TRF) (Achenbach & Rescorla, 2001).

Child-Centered Group Play Counseling (CCGPC) is a small group counseling model where the child leads the play session. It is based on the Client-Centered theoretical framework developed by Carl Rogers (1951).

Developmental Delay (DD) refers to students under 10 years of age who need special resource help according to their Individualized Education Plan (Personal Communication, Lanie Fasulo, Director of Special Services, Olathe School District, April 5, 2011).

Direct Observation Form (DOF) (McConaughy & Achenbach, 2009) is a standardized rating observation assessment of children ages 6-11 in school settings. Observers can be teachers' aides, university students as well as school professionals.

Emotionally Disturbed (ED) refers to students who have been identified to need special education services because of behavioral problems, and have specific behavior

goals on their Individual Education Plan (IEP). According to the Kansas Special Education Process Handbook (Kansas Department of Education, 2009),

> the child exhibits one of more of the following conditions over a long period of time and to such a significant degree that it affects the child's education: 1) inability to learn that cannot be explained by intellectual, sensory or health factors; 2) inability to build and/or maintain satisfactory interpersonal relationships with peers or teachers; 3) inappropriate types of behavior or feelings under normal conditions; 4) a general mood of unhappiness or depression; 5) a tendency to develop physical symptoms or fears associated with personal or school problems (p. 11).

Externalizing Problems refers to the disruptive child behavior that is most evident in the classroom. This is a composite score on the TRF that includes Rule-Breaking Behavior and Aggressive Behavior subscales (Achenbach & Rescorla, 2001).

Group counseling is an intervention where several participants participate in a counseling session at the same time. The counselor uses the dynamics of the group experience as a strategy for meeting treatment goals. In a school setting, the school counselor uses group counseling as a Tier 2 intervention to help students who have difficulties in personal and emotional issues, academic struggles, or post-secondary career pursuits. (ASCA, 2005; Geroski & Kraus, 2010).

Individualized Education Plan (IEP) refers to a specific educational contractual agreement between the student, his/her parents and the school if the student is eligible for special education services (Brown-Chidsey & Steege, 2010). This plan specifies the amount of time in each day that the student will receive special education services and the yearly goals and plan for meeting these goals.

Intervention is the term for a strategy used on a specific student to help the student become successful in the classroom. Classroom teachers, resource teachers,

school counselors or other persons in the building can implement interventions with students.

Intervention teams meet regularly to discuss specific child behavior problems. These teams are composed of classroom teachers, resource teachers, school psychologists, administrators, and school counselors (Brown-Chidsey & Steege, 2010).

Lifeskills classes are available for students who receive more than 2 hours of Resource services a day according to the student's Individual Education Plan (Personal Communication, Lanie Fasulo, Director of Special Services, Olathe School District, April 5, 2011).

No Child Left Behind (NCLB) is the name of the Elementary and Secondary Education Act (ESEA) reauthorization passed in 2001 (Brown-Chidsey & Steege, 2010). The NCLB act states stringent requirements for states emphasizing evidence-based practices.

Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983) is an assessment used with children ages 4-7. The Peer Acceptance subscale scale examines perceived social acceptance through the use of pictures.

Play therapy is a method of counseling children that is based on the premise that play is the language of children (Axline, 1974). Play therapists use toys and play in therapeutic approaches much as an adult therapist uses "talk therapy."

Psychoeducational groups are a specific type of small group where the school counselor uses the teaching of specific skills to focus on developing the participants' cognitive, affective and behavioral deficits. The counselor plans structured lessons for

each session to meet the treatment goals (Corey & Corey, 2006; Geroski & Kraus, 2010). Sometimes the sessions include play and art media; however, unlike Child-Centered Play Therapy, the counselor directs the group session.

Response to Intervention (RtI) is a "systematic and data-based method of identifying, defining, and resolving students' academic and/or behavior difficulties" (Brown-Chidsey & Steege, 2010, p. 3). This approached is a direct result of the school's effort to implement the requirements of the NCLB act of 2001.

Responsive Services are "activities that meet students', parents' and teachers' immediate need for referral, consultation or information" (ASCA, 2005, p. 152). The ASCA National Model includes responsive services as one aspect of the Delivery System role for school counselors.

School counselors, previously referred to as guidance counselors**,** are mental health/education professionals who work in elementary, middle, or high school settings (Sheel & Gonzalez, 2007). They address the academic and social needs of all students with the help of parents, teachers, other staff and the community (Legum & Hoare, 2004).

Teacher Report Form (TRF) (Achenbach & Rescorla, 2001) is the behavior rating that teachers use in this research study. It is one of the forms included in the Achenbach System of Empirically Based Assessment (ASEBA). This will be referred to as TRF in this study.

Population & Sampling

In accordance with Baggerly's (2010) evidence-based criteria for play therapy researchers, a power analysis was conducted using G*Power 3.1.5.1 (Faul, Erdfelder, Lang & Buchner, 2009) to determine an adequate sample size. Specifically, an A priori

was computed for an ANOVA: repeated measures, within-between interaction of three groups and three measurements for a small effect size of .25. The power analysis results indicated a total sample size of 15 was needed when using the seven scales measuring the dependent variable Externalizing Behavior, and the sample size of 30 was needed when using the two subscales measuring the dependent variable Social Skills. The 79 participants were selected from seven elementary schools in suburban and rural school districts in the Midwest. The school counselors in six of the schools completed university graduate coursework in play therapy, and had experience in using Child-Centered Play Therapy (CCPT). Another CCGPC group facilitator was a retired school counselor and a Registered Play Therapist Supervisor. She facilitated the CCGPC small group sessions in the seventh school. The school counselors met with classroom teachers to produce the names of second, third, and fourth grade students who exhibited the following behavior problems: arguing, angry outbursts, demanding attention, disobedience, or teasing others. In order to participate in the study, the students had to meet the following criteria: (1) Exhibit at least one of the above behavior problems; (2) Have no current IEP which indicated the need for "ED" placement; and (3) Have no current IEP which indicated the need for "Lifeskills" placement or for more than 2 hours of Special Education Resource Services a day, but could have an IEP designation of Developmental Delay (DD). After parent permission was obtained (Appendix A), the classroom teachers for each of the student participants completed a TRF assessment (Achenbach & Rescorla, 2001) as a pretest. The pre-test score was also a part of the selection process. The students who scored at 60 or above on the TRF subscales of Social Problems, Attention Problems, Rule Breaking Behavior, Aggression, or the

composite score of Externalizing Behavior were asked to participate in the study. The score to obtain to be in the At-Risk category is 65 and a score above 70 is in the Clinically Significant category. There were six students who did not meet the cut off score, but were included as participants in two of the schools to have a complete group structure. This allowed the groups to have a minimum of three students in a group. The children were asked to indicate their willingness to participate by signing an "Assent to Participate" form (Appendix B).

Human Subjects Procedures

Prior to conducting this study, approval was obtained from Regent University's Human Subjects Review Committee (HSRC). Additionally, the IRB from a Midwest university was submitted and approved allowing graduate students to participate in the study. Finally, this study used participants, teachers, and school counselors from four school districts and one private Parochial school in the Midwest. Therefore, the researcher obtained permission from the Research Committee in these schools or districts.

Data Collection Procedures

This study used two dependent variables: 1) Decrease in externalizing behavior problems in the school setting, and 2) Increase in social skills with other students. The independent variable was small group counseling with three levels: psychoeducational group, CCGPC group, and a non-therapeutic control group.

Selection of School Sites. Eight elementary schools in the Midwest were originally selected to participate in this study. Four of the schools were in the same suburban school district, one was a parochial school, and the others were in rural

communities. The schools were selected as a convenience sample with the following considerations: (a) There needed to be a school counselor who was trained in Child-Centered play therapy through a university class; (b) The school principal and administration gave approval to participate in the research study; (c) School counselors needed to be willing to attend training sessions, help in the participant selection process, conduct the groups in their school, and be the liaison to the primary investigator (PI) for weekly checks. There was consideration given for schools that showed a diverse population regarding ethnicity of the students and socio-economic issues.

During the selection process, one of the suburban school district schools was unable to have the required number of students that qualified with a score of 60 on one of the TRF subscales. The demographics of the remaining schools are listed in Table 1.

Table 1.

School demographics

	School Population	Caucasian	Latina(o)/ Hispanic	African American	Free/ Reduced Lunch
School 1 Suburban	600	72%	12%	6.5%	4.5%
School 2 Suburban	400	50%	38%	6%	68%
School 3 Suburban	250	33%	59%	2%	85%
School 4 Parochial	650	93%	1%	3%	No data
School 5 Rural Grades K-2	430	93%	3%	1.5%	38%

(continued)

Table 1. *School demographics* (continued)

	School Population	Caucasian	Latina(o)/ Hispanic	African American	Free/ Reduced Lunch
School 6 Rural Science/Math Magnet	350	89%	3%	21%	59%
School 7 Rural	340	95%	2%	1.5%	20%

Pre-assessment Procedure and Selection. In the summer and fall of 2012, after obtaining approval from all Human Subject Committees, the PI met with principals and school counselors in each school to finalize plans for the research study. School counselors and classroom teachers referred possible participants who were students in second, third or fourth grade in each school who they determined had externalizing behavior problems and poor social skills. The classroom teachers completed the initial TRF assessments on the referred students. The researcher examined four clinical subscale scores: Aggressive Behavior, Rule Breaking Behavior, Attention Problems, and Social Problems. Aggressive Behavior and Rule Breaking Behavior were also combined to form a Composite Externalizing Behavior score. Students were asked to participate if their score on any of the subscales was at 60 or above (At-Risk score of 65-70 and Clinically Significant at 70 or above). Some of the students who were referred by the teachers did not score at the 60-point range on the above noted subscales. As a result the teachers and counselors referred other students. The PI finalized the selection with 73 qualifying participants from the seven schools. Six more students who were initially selected by teachers were added, but did not qualify with scores in range noted above.

This allowed each of the schools to have three groups with at least three participants in each group.

The school counselors distributed consent/assent forms to each of the students who qualified, based on the TRF's completed by the teachers, including the six who did not qualify. The screened students' parents or guardians, had to give consent by signing the consent forms (Appendix A) in order for the child to participate in the study. Additionally, after the consent forms were returned, the school counselor met with each child and explained that they were being asked to participate in the study. Students signed an assent form to indicate their willingness to participate in the study (Appendix B).

After the parents and children signed the consents, school counselor interns, who were enrolled in a CACREP approved Master of Arts in Counseling program, conducted two assessments. One of the assessments was the Direct Observation Form (DOF) (McConaughy & Achenbach, 2009), a standardized observation of the participants in the classroom. The second assessment that the graduate interns administered was the social skills assessment, Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983).

Once pre-test assessments were completed, students were randomly assigned to one of the three groups - a CCGPC small group, a psychoeducational small group, or a control group. Two schools had 12 students who qualified with four students in each group. In three schools there were 11 students who qualified with four students each being place in the CCGPC small group and the psychoeducational small group, and three students in the non-therapeutic control group. In one school, there were only nine

students who qualified. Consequently, two other students who did not have qualifying scores were placed in the groups. This allowed the CCGPC and psychoeducational groups to each have four students. The last school had only seven students who had qualifying scores on the TRF. These students were randomly placed in the three groups (three in CCGPC, two in the psychoeducational group, and two in the control group). Four other students who did not have qualifying scores were placed in the groups, one in the CCGPC group, two in the psychoeducational group, and one in the control group. This allowed the CCGPC group and the psychoeducational group to have four students in each, and the control group to have three students. One of the students who initially qualified and had been randomly placed in the control group was never able to attend the group sessions due to some behavioral problems during group time. This particular student subsequently withdrew from the school. A replacement student was added to this group at session four to complete the group. This student qualified on the pre-test TRF scores, but only attended five of the eight group sessions.

The seven school counselors who facilitated the CCGPC groups in each school had been trained in CCPT through graduate level course(s) in play therapy. Five of the seven counselors had the credential of Registered Play Therapists and one was a Registered Play Therapist Supervisor. In five schools, the school counselor conducted all three groups. In one school, a graduate intern conducted the psychoeducational group and the control group. In another school, a retired school counselor who was a Registered Play Therapist Supervisor conducted the CCGPC group, the school counselor conducted the psychoeducational group and the school social worker conducted the control group. All three small group experiences met concurrently for 30-minute

sessions. Five of the schools completed all eight sessions prior to the post-tests, administered before Winter Break. The other two schools completed the last two sessions after Winter Break.

Small Group Design. Each of the seven elementary schools had one CCGPC group, one psychoeducational group, and one non-therapeutic control group. The CCGPC groups consisted of four students with no more than one grade level difference. The students in the CCGPC group met in a play room/school counseling office for their small group sessions. Each school counselor had a similar size group room (approximately 12 X 15 feet) with the same toys. The toys that were used included nurturing toys, aggressive toys, real life toys, and creative or expressive toys, and five games (Appendix C). The PI, a Registered Play Therapist Supervisor and former school counselor, held a mandatory training prior to the beginning of the school year, and met with each group facilitator weekly for fidelity checks throughout the study. Confidentiality was maintained by each of the group facilitators. Classroom teachers did not know which of the students participated in which type of group.

In the CCGPC groups the counselor allowed children to lead the play, but structure was established at the first meeting. When students arrived, the counselor asked them to sit in chairs around a table in the room or on the floor. Each week one child was in charge of the activity that the group would do. This process was determined during the first session, as each child drew a number between 1 and 4. The child who drew the number "1" was in charge during session 1, the number "2" during session 2, etc. After week 4, the order repeated itself through the remaining 5 to 8 weeks. During the group activities the counselor reflected back to students with empathic statements, such as

"Sam, you decided to play Trouble today. It looks like you are excited to include the others in the game." When conflicts occurred, the counselor's role was to keep the students safe and reflect what was being expressed during the conflict, such as "Sarah and Stacy, it looks like you both want the doll. I wonder if you can figure out a way to solve your problem." The counselor did not lead the activities or state the rules of the game. Limits were set as necessary to allow for a safe environment. Some examples of necessary limits were 1) possible injury to a child, 2) possible harm to the counselor, or 3) possible harm to the room or the toys. Specific ways to set limits and conduct the sessions are listed in Appendix D.

Prior to the conclusion of each session, the counselor gave a 5-minute warning, and told the students when their group session was over. Since the school counselor may have to quickly move to other responsibilities, these CCGPC students were asked to put the toys away before returning to their classrooms. A timer was set for 3 minutes to aid in the pick up procedure. Before returning to their classroom, students again gathered around the table or on the floor to discuss briefly what they had done that day. The students completed a self-assessment after sessions one, four and eight (Appendix G).

In order to assure the fidelity of the group process, the PI met weekly with each of the school counselors who conducted the CCGPC groups. Immediately after the completion of each group session, the school counselor reviewed the interaction among the children by completing the Fidelity Checklist (Appendix H). This checklist was adapted from one used by the University of North Texas Center for Play Therapy (Ray, 2009, p. 25). This provided an opportunity for the school counselor to write a thoughtful

review of the interactions and the specific activities completed during the session, and list any questions to ask the PI during the weekly meeting.

Multicultural issues were discussed during the training and weekly supervision of the school counselors who conducted the groups. One topic included how to conceptualize cultural aspects of play and ways to allow the natural interaction between all children, realizing that Child-Centered group play therapy allows children to be themselves in a relaxed and accepting atmosphere, as stated by Glover (1999, p. 279). Also, school counselors were encouraged to select toys that would reflect the culture of the children in their groups (Glover, 1999, p. 290). For example, specific dress-up clothes were chosen that represent the type of clothes worn in the community surrounding the school. The play food was selected to represent foods that the children would be familiar.

The psychoeducational small groups were conducted following the protocol of Simmonds (2003). However, the curriculum was condensed from twelve sessions to eight. The group topics included recognizing anger, who's at fault, what's beneath the anger, controlling the anger, communication strategies, I-messages, the consequences of bullying, and celebrating peace (See Appendix E). The groups were held in a room similar in size to the CCGPC group room, except this room did not include access to any toys or games other than those used for the activity for the particular session. The psychoeducational groups met for the same amount of time, 30-minutes. The structure was such that the students gathered around a table for an introductory warm-up activity and the closing activity that included the self-assessment during weeks one, four and eight (Appendix G). The first warm-up activity focused on getting acquainted, which

included guidelines for group behavior. The closing activity summarized the topic and discussions, ending with a homework assignment for the week. The homework assignment was discussed during the warm-up activity the following week. At the end of sessions one, four and eight, the students completed the self-assessment before returning to their classrooms. Immediately following each group session, the facilitator completed the Psychoeducational checklist (Appendix I) in an effort to reflect on the interactions among the group members. Any specific questions for the PI were noted on the form and discussed in weekly meetings with the PI.

School counselors facilitated the psychoeducational groups in all the elementary schools except one. At this school, there was a graduate student intern who facilitated the psychoeducational group and the control group. The graduate intern was completing her last semester of internship at the elementary school and was under the supervision of the school counselor at that school. She was not a graduate student at the same university as the PI, but she attended the training with the school counselors on the specifics of both the psychoeducational curriculum and the non-therapeutic activities used in the control group sessions. This graduate intern also met for weekly fidelity checks with the PI, as well as weekly supervision with her site supervisor.

The students who were randomly selected to participate in the control group were also removed from the classroom to participate in activities; however, these small group sessions were non-therapeutic. The control group met for 30-minutes weekly for eight weeks and listened to a story that was read by the facilitator. Following the story, the students drew a picture of an animal from the story (See Appendix F). At the end of session one, four, and eight, these students also completed the self-reflection questions.

Facilitators completed the weekly fidelity checks for the control group also. (Appendix I).

Implementation. Following the selection and random grouping of the participants, graduate students conducted pre-test assessments using the DOF and the Pictorial Scale of Perceived Competence and Social Acceptance (Harter & Pike, 1983). The three groups in each school met for 30-minutes weekly for eight weeks. After the eight-week group sessions were completed, teachers assessed all participants as a post measure using the TRF. Graduate students completed the DOF post measure observing each child in their classroom for 10 minutes and completing the checklist included in that assessment. Graduate students also administered the individual Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983). Participating students completed a self-assessment following sessions one, four and eight.

Instrumentation. In order to measure the variables in this study, the researcher obtained evaluations from the teachers, an observer in the classroom and the children themselves. In each case, similar research was examined for the most effective measurement. The Teacher Report Form (TRF) (Achenbach & Rescorla, 2001) that is part of the Assessment System of Empirically Based Assessment (ASEBA) was selected for the teachers' report. The Direct Observation Form (DOF) (McConaughy & Achenbach, 2009), also an assessment of ASEBA, was selected for the classroom observations that were conducted by graduate students. Also administered by graduate students, individual assessments were conducted using the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC) (Harter & Pike, 1983).

Thomas M. Achenbach first developed the Assessment System of Empirically Based Assessment (ASEBA) in the 1960's, and the school-age assessment, Child Behavior Checklist for ages 6-18 in 2001 (Achenbach, 2009). The Teacher Report Form (TRF) allows teachers and other school staff to assess what specific problem behaviors a child is exhibiting. The TRF is composed of 118 specific behaviors that the teacher rates on a 3-point Likert scale (Not True, Somewhat or Sometimes True, or Very True or Often True). It also allows the rater to add any other problems that the student has that were not specifically listed. There are ten other questions at the beginning of the assessment that allow the teacher to state the amount of time spent with the student, academic performance in each subject, the student's work behavior, any achievement or cognitive test scores, and specific concerns that the teacher has about the student. The TRF subscales used to assess pre and post data for Hypothesis 1 were Attention, Rule Breaking and Aggression, as well as the composite score of Externalizing Behavior. The TRF subscale Social Problems was used to assess pre and post data for Hypothesis 4. In examining 28 evidence-based psychosocial treatments for children who exhibit disruptive behavior, Eyberg, Nelson and Boggs (2008) found that the TRF and the Connors Teacher Rating Scale were the most common teacher measure used.

The reliability of the TRF includes an analysis of inter-interviewer reliability and test-retest reliability (Achenbach & Rescorla, 2001). Internal consistency asks the question of how consistent the assessment is in measuring each specific behavioral category. The internal consistency on the ASEBA is configured by "split-half reliability" test (Achenbach & Rescorla, 2001). For the composite subscale of Attention, the alpha was .95, with Inattention at .93 and Hyperactivity-Impulsivity at .93 (Achenbach &

Rescorla, 2001). The Externalizing Behavior subscale had an alpha of .95, and the Social Problems had an alpha of .82 (Achenbach & Rescorla, 2001). As such, the TRF has high internal consistency in all subscales for this study.

The test-retest reliability looks at the consistency of the teacher's ratings of the same child twice over several weeks. The test-retest reliability for the TRF used ratings by teachers at mean intervals of 8 to 16 days (Achenbach & Rescorla, 2001). Reliability was very high for all subscales in this study. The test-retest *r* for overall Attention Problems was .95, with Inattention's *r* at .96 and Hyperactivity-Impulsivity's *r* at .92 (Achenbach & Rescorla, 2001, p. 102). Externalizing Problems had an *r* of .89, and Social Problems had an *r* of .95 (Achenbach & Rescorla, 2001, p. 102).

Content validity of the TRF has been strongly supported by research and feedback for four decades. The TRF has also been compared to other instruments that measure children's behavior for diagnostic purposes. When compared to the Conners Scales, the Pearson correlations of .88 and .89 between the TRF Attention Problems subscale and the ADH Problems scale on the Conners (Achenbach & Rescorla, 2001, 131). All other correlations of the TRF with the Conners scales were very high, ranging from .71 to .85 (Achenbach & Rescorla, 2001, p. 131). Correlations between the TRF and the Behavioral Assessment Scale for Children (BASC) ranged from .73 to .87 on the subscales used in this study.

Observing children in natural settings is regarded as an effective measurement tool (Hintz & Matthews, 2004; Pepler & Craig, 1998). The Direct Observation Form (DOF) (McConaughy & Achenbach, 2009) is a standardized method of observing the behaviors of the child in the classroom environment. First, the observer conducts a 10-

minute observation of the child's on-task and off-task behavior including a minute-by-minute narrative description of these behaviors. Then, the observer scores the child on 89 problem items by a 0-3 rating scale. The DOF subscales used to assess data for Hypothesis 2 were Attention Problems, Intrusive and Oppositional. The recent addition to the ASEBA system includes the Direct Observation Form (DOF) (McConaughy & Achenbach, 2009). Even though little research has been conducted using the DOF, Volpe, McConaughy and Hintz (2009) cited generalizability data for its use with children who exhibit disruptive behavior problems. The authors (Volpe, McConaughy and Hintz, 2009) reported high reliability, $\geq$.80, for those behaviors that are readily observable, specifically the subscales of Intrusive and Oppositional.

The DOF has internal consistency alphas for classroom observations between .49 and .87 over the nine problem scales (McConaughy & Achenbach, 2009, p. 95). The mean alpha = .73 for the empirically based scales (McConaughy & Achenbach, 2009, p. 96). The inter-rater reliabilities for the empirically based scales were .71 to .88 for the problem scales, and .97 for the On-task/Off-task measure (McConaughy & Achenbach, 2009, p. 92). Over an average interval of 12.4 days, the test-retest reliabilities were .43 to .77 for seven problem scales and .42 for the On-task/Off-task measure (McConaughy & Achenbach, 2009, p. 94).

In order to evaluate the content validity for the DOF, McConaughy and Achenbach (2009) used the behaviors listed in the CBCL and TRF, but reduced them to 88 items in the latest 2009 version. The content validity is supported by four decades of research using the CBCL and TRF, showing that 63% of the DOF behavior items

discriminated significantly between the clinically referred children and the control children (McConaughy & Achenbach, 2009, p. 97).

An observer in the classroom may view a child's relationships with others differently than the way the child actually perceives the relationship. Self-reports are cited as an additional way to measure peer relationships (Pepler & Craig, 1998). The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC) (Harter & Pike, 1983) is a social skills assessment that is individually administered to children to assess the child's perception of social acceptance. The examiner uses 24 picture plates with two pictures on each plate to ask the child questions regarding his competence related to cognitive, physical and social attributes. The child's answers are scored on a 4-point scale. This instrument has four subscales; however, this study used only the Peer Acceptance subscale.

The internal consistent alpha showed values ranging from .74 to .83 within the Peer Acceptance subscale (Harter & Pike, 1984). The children's scores used in the standardization of the instrument chose "3" or "4" skewing the range to the upper end of the scale. However, the scores showed a high alpha due to the consistency of the scores (Harter & Pike, 1984).

In order to examine discriminant validity on the Peer Acceptance subscale, the researchers hypothesized that children who had recently moved would have a lower peer acceptance score than those children who had been in the school for a minimum of one year (Harter & Pike, 1984). This did in fact prove accurate as the "new" children had a significantly lower mean (mean = 2.9) on the peer acceptance questions than the mean of the other students (mean = 3.3) (Harter & Pike, 1984).

Statistical Analysis. The independent variable, small group intervention, included three levels: CCGPC groups and psychoeducational groups, compared with a non-therapeutic treatment control group. A two-way analysis of variance (ANOVA) examined if the repeated measure within-subject design was statistically significant, and to see if there were significant mean differences among the three categories of the independent variable: CCGPC groups, psychoeducational groups, and the control groups. The covariance, the initial difference in pre-test scores rated by the classroom teachers, was not necessary since all initial scores needed to qualify with at least a score of 60 on the TRF subscales of Attention, Aggression, Rule Breaking, or Social Problems. The mean scores for each type of group were compared using pre- and post-test assessment times.

The dependent variables that were examined are improvement in social skills (examined by the Social Problems subscale on TRF and the Peer Acceptance subscale of the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children), and decrease in externalizing behavior (examined by the Attention subscale of the TRF, and the Externalizing composite scale on TRF, which includes the subscales of Aggressive Behavior and Rule-Breaking Behavior). ASEBA Web Forms Direct was used as a website for teachers to complete the TRF assessments. Teachers received an email with a link for each student's assessment. After completion, the scored profiles were available for review by the PI. Scores were transferred to an Excel spreadsheet and imputed into the Software Program for Social Sciences (SPSS). The handwritten copies of the DOF and the PSPCSAYC assessments were analyzed. These scores were also recorded on the Excel spreadsheet and later placed in the SPSS statistical analysis. The

students' three self-assessments were used as a more qualitative tool. Another qualitative measure was reflected in the comments from the school counselors during the weekly fidelity check meetings with the PI. Based on the data, the corresponding hypotheses were either accepted or rejected.

Since all groups were pulled from class each week, there was a possibility for the Hawthorne Effect. This concern is based on the belief that improvement will occur simply because the participants receive special treatment and they know they are participating in a research study. In an updated historical review of the Hawthorne Effect, Izawa, French and Hedge (2011) discussed the results of the classic studies at the Hawthorne Works of Western Electric Company in Cicero, Illinois, from 1924 to 1927. Basically, the study wished to show that "additional artificial illumination would increase worker productivity" (Izawa, French & Hedge, 2011, p. 528). However, at the conclusion of three different experiments on worker productivity at the plant, the results showed that lighting had no effect on worker productivity (Izawa, French & Hedge, 2011). Instead, the control group's worker productivity increased as much as those who were receiving variations in illumination (Izawa, French & Hedge, 2011). This assumption over the years, as reviewed by Adair (1984) has been attributed to three variables: special attention, awareness of participation in an experiment, and novelty. The current study does seem to provide all three.

Method of Data Protection. In order to protect confidentiality and prevent treatment provider bias, teachers completed the TRF forms online using the Web Forms Direct software (ASEBA). The PI analyzed the data from the password protected online link, and each participant was assigned numbers according to their treatment group and

their site. There were two alphabetical letters (corresponding to the name of the school) and a two-digit number for each participant. The data was scored, numbered and placed in appropriate computer folders. Folders were saved to an external hard drive, which was stored in a locked file cabinet in the office of the PI at MidAmerica Nazarene University. Only the PI and a research assistant had access to the materials. Graduate students completed their observations and individual social skills assessments and used locked briefcases to move the data from the school site to the university site where they were immediately placed in the locked file cabinet to be scored and saved to the external hard drive.   Either the PI or the research assistant scored these assessments.

CHAPTER III

RESULTS

This study used a pre-test and a post-test to examine the effectiveness of a Child-Centered small group model when compared to a typical psychoeducational small group model and a non-therapeutic control small group. The small group participants were primarily second and third graders, along with one fourth grader, in seven schools who qualified with a sufficient number of students exhibiting disruptive behavior in the classroom, as well as showing the possibility of poor social interactions with others. A mixed-model design using both within-group differences and between groups differences was examined. This chapter will present the demographics, the statistical analyses, address whether the hypotheses were met, and an overview of the results.

Preliminary Analysis

All seven of the elementary schools had three small groups. There were 79 participants from each of the schools who were randomly assigned to one of the three groups. The demographic make-up of the participants were as follows: 49 males (62%), 30 females (38%), 40 second graders (51%), 38 third graders (49%), 1 fourth grader (.01%), 52 Caucasian/White/European American (66%), 14 Latino (a)/Hispanic/Hispanic American (18%), 8 African American/Black (10%), and 5 multiracial (.06%).

The groups began in the fall, after the selection of the students and randomization of the groups. Each school was supposed to complete eight weekly sessions of the group intervention prior to Winter Break; however, two of the schools were unable to complete

the eight weeks due to scheduling conflicts and a snow day. One school had five sessions of CCGPC groups, and six sessions of the psychoeducational group and the control group. Another school had all three groups to complete six sessions. Post assessments were completed at all seven schools during the week prior to Winter Break even if the schools had not completed the eight sessions.

Statistical Analysis of the Data

Of the 79 participants, 73 children qualified by having a score of 60 or higher on one or more of the TRF subscales: Social Problems, Attention, Aggression, or Rule Breaking. At one of the schools a student who had been randomly assigned to the control group was not able to attend the small group because of behavioral outbursts in the classroom. This same child later changed schools, which resulted in the child not being a participant in the study. It took several weeks to realize that the student would need to withdraw from the study. When it was determined that the child would not be participating, another student was added for the fourth session. This allowed the group to have three students instead of two. The participant who was added had a qualifying score of at least 60 on one of the TRF subscales. At the same school, there was a fourth grader who was selected to participate in the study. Except for this fourth grader, the participants at the school were all third graders. Therefore, the participants were still no more than one grade level difference. All the students were randomly assigned to groups. The fourth grader ended up in the CCGPC group. Since the PSPCSAYC has not been standardized for children in fourth grade, the fourth grade student's score was not included in the data set addressing Hypothesis 3. Also at this school, one teacher did not

complete the TRF post-assessments. The data for this student was removed from the analysis addressing Hypothesis 1 and 4.

In another school there were two participants who moved after the sixth session, and consequently, did not complete the last two sessions. One of the students was in the control group and the other student was in the psychoeducational group. As a result, there were three students in the control group and the psychoeducational groups. Teachers still completed TRF post-assessments for these two students. However, because the post-test observations and the individual assessments (PSPCSAYC) were completed at the end of the final week of group, the graduate students were unable to complete the observations and individual assessments. The data for these two students was not used to address Hypothesis 2 and 3, but because TRF scores were used to address Hypothesis 1 and 4, the post-test score data was used to address those hypotheses.

At another school, a student who participated in the CCGPC group intervention was absent when the graduate student conducted the post-test observations. Another student at that school who participated in the psychoeducational group sessions was absent during the individual post-assessment (PSPCSAYC). Both students were removed from the data sets used to address Hypothesis 2 and 3 respectively.

A student at another school voluntarily dropped out of the study, and was not included in any of the data sets. This student had been randomly assigned to the psychoeducational group. Furthermore, a teacher at this school did not complete the TRF post-assessment on two of the students until after Winter Break. One of the students had participated in the CCGPC group and the other student had participated in the

psychoeducational group. The data for both students was included in addressing Hypothesis 1 and 4.

Even though there were 79 students who participated in the small group study, data included 71 participants for Hypothesis 1, 70 participants for Hypothesis 2 and 4, and 69 participants for Hypothesis 3. The data was examined for outliers, normality, and homoscedasticity. With the exception of the post-test data listed above, there were no missing data. The covariate of pre-test scores was not a factor since students had to score at least 60 to qualify. According to Mertler and Vannatta (2010), "analysis of variance is robust to violations of the normality assumption" (p. 74). Since this sample size was not large, the researcher did check for skewness and kurtosis. There were two subscales that showed kurtosis of over absolute value 3 (TRF Aggression and TRF Social Problems). These outlier scores were removed which showed a kurtosis of less than absolute value 3. Homogeneity of variance was examined with Levene's test showing no concerns. A two-way within-subject and between group analysis of variance (ANOVA) was conducted to evaluate the effect of a small group intervention from pre to post assessments within each group and between the three groups (i.e. CCGPC, psychoeducation, and control group). An a priori alpha level of .05 was established as a criterion for determining statistical significance. Effect size of eta squared was calculated to determine the practical significance of the results. Partial eta squared effect sizes were calculated to determine treatment effect for magnitude of the difference that could be attributed to the treatment and practical significance (Blanco, 2010; Baggerly & Bratton, 2010). The guidelines for η^2 effect size for practical significance followed those stated by Cohen (1988): .01 =

small, .06 = medium, and .14 = large. The hypotheses were tested and what follows are the results of the data collected.

Hypothesis Testing

Hypothesis 1

The first hypothesis predicted that the difference between teacher reports on pre- and post-test scores assessing the dependent variable externalizing behavior would show that the CCGPC group is as effective as the psychoeducational group when compared to a control group. The hypothesis measured externalizing behavior by assessing the difference between the pre-test and post-test scores on the TRF. The particular subscales measured were Attention, Aggression, and Rule Breaking, and the Externalizing Behavior composite score. The TRF pre- and post-test scores were for the participants in CCGPC, and compared those participants' scores to the students who received a typical group psychoeducational program and a non-therapeutic control group. A two-factor Repeated Measure ANOVA was used for each of the subscales to test this hypothesis.

The two categorical variables used to group the teachers' ratings of the externalizing behavior scale scores were test time (pre and post) and group intervention (CCGPC, psychoeducational, and non-therapeutic control). The two-factor ANOVA was used to test the TRF subscales of Attention, Aggression, Rule Breaking and the composite score Externalizing Behavior including a main effect for Test Time, a main effect for Group, and a two-way interaction effect (Test Time X Group). The interaction effect for Test Time by Group for each scale was used to test hypothesis 1.

The first two-factor ANOVA was conducted using test time (pre- and post-test) and the group intervention (CCGPC, psychoeducational, and non-therapeutic control

group) as the independent variables. Scores on the TRF subscale of Attention were used to address the dependent variable of externalizing behavior. The analysis of the main effect for group indicated a statistical and practical significant difference between pre- and post-test for Attention, F(1, 68) = 31.59, $p < .01$, partial $\eta^{2 =}$= .317. Regardless of the group, all students' scores were higher on the pre-test (M = 64.13) than the post-test (M = 60.06). See Table 2 below. The interaction between test time and group was not statistically significant, F(2, 68) = 1.55, $p = .22$, partial η^2 = .044. The small effect size of the interaction (partial η^2 = .044) indicates practical significance. Post hoc tests were not conducted because the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the subscale Attention; however, there was no significant difference between any of the groups.

Table 2.

Mean and Standard Deviations for TRF Attention Subscale

	Group	M	SD	N
Pre-test	CCGPC	65.27	6.34	26
	Psychoed	61.46	5.53	24
	Control	65.76	9.31	21
	Total	64.13	7.27	71
Post-test	CCGPC	59.81	6.52	26
	Psychoed	59.00	7.07	24
	Control	61.57	9.28	21
	Total	60.06	7.57	71

A two-factor ANOVA was conducted using the test time (pre- and post-test) and the group intervention, using scores on the TRF subscale of Aggression to assess the dependent variable of externalizing behavior. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Aggression,F(1, 65) = 14.44, $p < .01$, partial $\eta^2 = .182$. Regardless of the group, all students' scores were higher on the pre-test ($M = 62.87$) than the post-test ($M = 60.44$). See Table 3 below. The interaction between test time and group showed no statistical significance, but a small effect size showed some practical significance, F(2, 65) = .58, $p = .57$, partial $\eta^2 = .017$. Post hoc tests were not conducted because the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the subscale Aggression; however, there was no significant difference between any of the groups.

Table 3

Mean and Standard Deviations for TRF Aggression Subscale

	Group	M	SD	N
Pre-test	CCGPC	62.76	4.65	25
	Psychoed	61.17	5.16	23
	Control	64.95	6.60	20
	Total	62.87	5.58	68
Post-test	CCGPC	59.76	5.39	25
	Psychoed	59.70	5.12	23
	Control	62.15	4.12	20
	Total	60.44	5.01	68

A two-factor ANOVA was conducted using test time (pre- and post-test) and the group intervention, using scores on the TRF subscale of Rule Breaking to assess the dependent variable of externalizing behavior. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Rule Breaking, $F(1, 68) = 15.69$, $p < .01$, partial $\eta^2 = .187$. Regardless of group, all students' scores were higher on the pre-test ($M = 61.58$) than the post-test ($M = 58.72$). See Table 4 below. The interaction between test time and group did not show either statistical or practical significance, $F(2, 68) = .22$, $p = .81$, partial $\eta^2 = .006$. Post hoc tests were not conducted since the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the subscale Rule Breaking; however, there was no significant difference between any of the groups.

Table 4

Mean and Standard Deviations for TRF Rule Breaking Subscale

	Group	M	SD	N
Pre-test	CCGPC	61.81	7.10	26
	Psychoed	60.29	5.92	24
	Control	62.76	7.50	21
	Total	61.58	6.83	71
Post-test	CCGPC	58.85	8.19	26
	Psychoed	58.04	7.86	24
	Control	59.33	8.04	21
	Total	58.72	7.94	71

Lastly, a two-factor ANOVA was conducted using test time (pre- and post-test) and the group intervention, using scores on the TRF composite score of Externalizing

Behavior as the dependent variable of externalizing behavior. The analysis for the main effect for group indicated a statistically significant difference between pre- and post-tests for Externalizing Behavior, $F(1, 68) = 12.58$, $p < .01$, partial $\eta^2 = .156$. Regardless of the group, all students' scores were higher on the pre-test ($M = 63.23$) than the post-test ($M = 60.72$). See Table 5 below. The interaction between test time and group showed no statistical significance, but a small effect size showed some practical significance, $F(2, 68) = .39$, $p = .68$, partial $\eta^2 = .011$. Post hoc tests were not conducted since the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the composite score of Externalizing Behavior; however, there was no statistical significance between any of the groups. Hypothesis 1 was accepted for all analyses.

Table 5

Mean and Standard Deviations for TRF Externalizing Behavior Scale

	Group	M	SD	N
Pre-test	CCGPC	63.46	5.60	26
	Psychoed	61.54	5.11	24
	Control	64.86	6.35	21
	Total	63.23	5.75	71
Post-test	CCGPC	60.15	7.17	26
	Psychoed	59.54	5.75	24
	Control	62.76	5.66	21
	Total	60.72	6.34	71

Hypothesis Two

The second hypothesis predicted that the difference between pre- and post-test scores using classroom observations to assess the dependent variable externalizing behavior would show the CCGPC group is as effective as the psychoeducational group when compared to a control group. The hypothesis measured externalizing behavior by assessing the difference between the pre-test and post-test scores on the DOF. The particular subscales measured were Attention, Intrusive and Oppositional. The DOF pre- and post-test scores were for the participants in CCGPC, and compared those participants' scores to the students who received a typical group psychoeducational program and a non-therapeutic control group. A two-factor Repeated Measure ANOVA was used for each subscale to test this hypothesis.

The two categorical variables used to group the graduate students' ratings of externalizing behavior were test time (pre and post) and group intervention (CCGPC, psychoeducational, and non-therapeutic control). The two-factor ANOVA was used to test these subscales including a Test Time main effect, a Group main effect, and a two-way interaction effect (Test Time X Group). The interaction effect for Externalizing Behavior by Group was used to test hypothesis 2.

The first two-factor ANOVA was conducted using test time (pre- and post-test) and the group intervention (CCGPC, psychoeducational, and non-therapeutic control group) as the independent variables. Scores on the DOF subscale of Attention were used to measure the dependent variable, externalizing behavior, in this analysis. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-test for Attention, $F(1, 67) = 30.05$, $p < .01$, partial $\eta^2 = .310$. Regardless of the

group, all students' scores were higher on the pre-test (*M* = 61.23) than the post-test (*M* = 55.60). See Table 6 below. The interaction between Test Time and Group showed no statistical significance, but a small effect size showed some practical significance [F(2, 67) = .67, *p* = .52, partial η^2 = .020]. Post hoc tests were not conducted because the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the DOF subscale of Attention, however, there was no significance between any of the groups.

Table 6

Mean and Standard Deviations for DOF Attention Subscale

	Group	M	SD	N
Pre-test	CCGPC	60.36	7.49	25
	Psychoed	59.75	8.62	24
	Control	63.95	10.98	21
	Total	61.23	9.09	70
Post-test	CCGPC	55.24	6.27	25
	Psychoed	55.17	5.55	24
	Control	56.52	7.41	21
	Total	55.60	6.34	70

A two-factor ANOVA was conducted using the test time (pre- and post-test) and the group intervention, using scores on the DOF subscale of Intrusive as the dependent variable, externalizing behavior, in this analysis. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Intrusive, F(1, 67) = 16.01, $p < .01$, partial η^2 = .193. Regardless of the group, all students' scores were higher on the pre-test (*M* = 63.30) than the post-test (*M* = 58.96).

See Table 7 below. The interaction between Test Time and Group did not show either statistical or practical significance, F(2, 67) = .29, $p = .75$, partial $\eta^2 = .009$. Post hoc tests were not conducted because the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the DOF subscale of Intrusive; however, there was no significance between any of the groups.

Table 7

Mean and Standard Deviations for DOF Intrusive Subscale

	Group	M	SD	N
Pre-test	CCGPC	62.16	8.50	25
	Psychoed	61.29	8.89	24
	Control	66.95	9.48	21
	Total	63.30	9.14	70
Post-test	CCGPC	58.88	7.17	25
	Psychoed	56.67	6.66	24
	Control	61.67	10.29	21
	Total	58.96	8.21	70

A two-factor ANOVA was conducted using test time (pre- and post-test) and the group intervention, using scores on the DOF subscale of Oppositional as the dependent variable, externalizing behavior. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Oppositional, F(1, 67) = 13.34, $p < .01$, partial $\eta^2 = .166$. Regardless of the group, all students' scores were higher on the pre-test ($M = 62.47$) than the post-test ($M = 58.46$). See Table 8 below. The interaction between Test Time and Group did not show either statistical or practical

significance, F(2, 67) = .25, p = .78, partial η^2 = .007. Post hoc tests were not conducted since the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the DOF subscale of Oppositional; however, there was no significance between any of the groups. Hypothesis 2 was accepted for all analyses.

Table 8

Mean and Standard Deviations for DOF Oppositional Subscale

	Group	M	SD	N
Pre-test	CCGPC	60.08	8.68	25
	Psychoed	60.67	6.84	24
	Control	67.38	7.81	21
	Total	62.47	8.37	70
Post-test	CCGPC	57.00	7.47	25
	Psychoed	56.54	7.45	24
	Control	62.38	7.17	21
	Total	58.46	7.72	70

Hypothesis Three

The third hypothesis predicted that the difference between the child's self-reports on pre- and post-test scores assessing the dependent variable social skills would show the CCGPC group is as effective as the psychoeducational group when compared to a control group. The hypothesis measured social skills by assessing the difference between the pre- and post-test scores on the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC) (Harter & Pike, 1983). The particular subscale measured was Peer Acceptance. Children answered questions ("Which of these

pictures is most like you?") that used a likert-type score of 1-4 points. The PSPCSAYC pre- and post-test scores were for the participants in CCGPC, and compared those participants' scores to the students who received a typical group psychoeducational program and a non-therapeutic control group. A two-factor Repeated Measure ANOVA was used for the Peer Acceptance subscale to test this hypothesis.

The two categorical variables used to group the children's self-ratings of peer acceptance were test time (pre and post) and group intervention (CCGPC, psychoeducational, and non-therapeutic control), using the Peer Acceptance subscale of PSPCSAYC. The two-factor ANOVA was used to test the subscale Peer Acceptance including a main effect for test time, a main effect for Group, and a two-way interaction effect (Test Time X Group). The interaction effect for Peer Acceptance by Group was used as an assessment to test this hypothesis.

A two-factor ANOVA was conducted using the test time (pre- and post-test) and the group intervention, using scores on the Peer Acceptance subscale (Pictorial Scale of Perceived Competence and Social Acceptance for Young Children) as the dependent variable, Social Skills. The analysis of the main effect for group did not indicate a statistically significant difference between pre- and post-tests for Peer Acceptance $F(1, 66) = .18$, $p = .67$, partial $\eta^2 = .003$. The total group score was higher on the pre-test ($M = 2.92$) than the post-test ($M = 2.89$). However, the students' scores for the CCGPC groups actually increased between pre-test ($M = 2.83$) and post-tests ($M = 2.96$). See Table 9 below. The interaction between Test Time and Group did not show statistical significance, but the small effect showed some practical significance, $F(2, 66) = 1.13$, $p = .33$, partial $\eta^2 = .033$. Post hoc tests were not conducted because the test time by group

interaction was not significant. This analysis showed no significance between pre- and post-tests for the groups and no significance between groups even though the mean for CCGPC increased between pre- and post-tests. Hypothesis 3 was not accepted.

Table 9

Mean and Standard Deviations for PSPCSAYC Peer Acceptance Subscale

	Group	M	SD	N
Pre-test	CCGPC	2.83	.81	26
	Psychoed	2.94	.79	23
	Control	3.00	.70	20
	Total	2.92	.77	69
Post-test	CCGPC	2.96	.93	26
	Psychoed	2.83	.78	23
	Control	2.89	.81	20
	Total	2.89	.84	69

Hypothesis 4

The fourth hypothesis predicted that the difference between teacher reports on pre- and post-test scores assessing the dependent variable social skills would show that the CCGPC is as effective as the psychoeducational group when compared to a control group. The hypothesis measured social skills by assessing the difference between pre-test and post-test scores on the TRF. The particular subscale measured was Social Problems. The TRF pre- and post-test scores were for the participants in CCGPC and compared those participants' scores to the students who received a typical group psychoeducational program and a non-therapeutic control group. A two-factor Repeated Measure ANOVA was used for the Social Problems subscale to test this hypothesis.

A two-factor ANOVA was conducted using the test time (pre- and post-test) and the group intervention, using scores on the TRF subscale of Social Problems as the dependent variable, Social Skills. The analysis of the main effect for group indicated statistically significant difference between pre- and post-tests for Social Problems, $F(1, 61) = 7.60$, $p < .01$, partial $\eta^2 = .111$. Regardless of the group, all students' scores were higher on the pre-test ($M = 60.13$) than the post-test ($M = 57.61$). See Table 10 below. The interaction between Test Time and Group did not show statistical significance, but the small effect showed some practical significance, $F(2, 61) = .36$, $p = .70$, partial $\eta^2 = .012$. Post hoc tests were not conducted because the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the TRF subscale of Social Problems; however, there was no significance between any of the groups. Hypothesis 4 was accepted.

Table 10

Mean and Standard Deviations for TRF Social Problems Subscale

	Group	M	SD	N
Pre-test	CCGPC	59.96	7.44	24
	Psychoed	59.43	5.60	23
	Control	61.29	4.51	17
	Total	60.13	6.07	64
Post-test	CCGPC	56.50	5.99	24
	Psychoed	57.35	5.85	23
	Control	59.53	5.71	17
	Total	57.61	5.90	64

Qualitative Data

Weekly meetings were held with the school counselors who conducted the groups in order to assure fidelity. The school counselors completed the fidelity checklist for each group and submitted them to the PI. Those who were in close proximity met at the same time, which allowed for sharing among the counselors. Others met individually by submitting their checklist electronically and talking on the phone.

The following example was shared by one of the school counselors who facilitated a control group. She stated that two children were talking to each other about their families while they were drawing a picture of an animal in the control group. One child said that her mom was in the hospital for using drugs again, and the other stated that her dad was in jail for trying to kill her mom. The school counselors emphasized that they did not process with the children during the control group, even though it would be normal in other settings for this to occur.

During the first session of the CCGPC group, one counselor stated, “two kids knew each other and two others felt like outsiders, but when the handcuffs came out they took turns with handcuffs. Then the boss tried to make sure everyone was included. At the end, the boss said it was the best day ever.” Two school counselors noted that when one of the students was absent, the others said they were disappointed. One group told the counselor that it wasn’t the same, nor as much fun. School counselors reported that the children enjoyed the experience of being the one in charge, and they looked forward to the week that they were in charge of the play. Several school counselors commented on how the children in all the groups would ask if it was their day for group. In one school, they were finishing up their last group session during the week prior to Winter

Break. The school counselor had to pick up the students during many holiday activities. Children in the CCGPC group chose to come to the group even when it meant missing their classroom holiday activities, but several participants in the psychoeducational group opted to stay in the classroom.

School counselors also commented on the learning that occurred during the CCGPC groups. One child commented, “I’m learning to do things I don’t want to do. I even have played with my little brother.” Another school counselor stated, “Each child is very nurturing.” Another school counselor commented after the last session of CCGPC, “So awesome how every child could be who they really are in guided play. It works!”

Another qualitative assessment tool was the self-assessment (Appendix G) that all the children completed at the conclusion of session one, four and eight. There were many comments on the self-assessments related to how much they liked the groups. One student in the CCGPC group wrote at the bottom of the session eight self-assessment, “I would try to be really ‘onest’ [*SIC*] to my friends a lot of times.” Session eight self-assessments showed 16 students out of 24 students in the CCGPC group agreed that they learned new skills that they were using in school. Also in session eight, 11 students out of 21 students in the psychoeducational group agreed that they learned new skills that they were using in school. However, 13 students out of 19 students in the non-therapeutic control group agreed that they learned new skills that they were using in school.

Summary

In summary, the results of the statistical analyses conducted to examine the hypotheses of this study suggested the following information. Hypothesis 1 predicted

that the teachers' reports on externalizing behavior would show CCGPC to be as effective as the psycho-education group model when compared to a control group. The statistical analysis supported this hypothesis by showing significant differences between pre- and post-test scores for externalizing behavior on the TRF. However, there was no significance between the groups. Hypothesis 2 predicted that the classroom observations related to externalizing behavior would show CCGPC to be as effective as the psychoeducational group when compared to a control group. The statistical analysis supported this hypothesis by showing significant differences between pre- and post-tests for each of the DOF subscales related to the dependent variable externalizing behavior. But, once again there was no difference between groups. The last two hypotheses examined the dependent variable of social skills. Hypothesis 3 predicted that the children's self-report on the subscale of Peer Acceptance would show CCGPC to be as effective as the psychoeducational group when compared to a control group. The statistical analysis did not support this hypothesis. Hypothesis 4 predicted that the teachers' reports of the subscale Social Problems would show CCGPC to be as effective as the psychoeducational group when compared to a control group. The statistical analysis supported this hypothesis by showing significant differences between pre- and post-tests for the Social Problems subscale on the TRF, but no significance between groups. The qualitative statements from students and school counselors seemed to substantiate what the data showed. Students overall enjoyed all the group activities. What follows is a discussion of the aforementioned results and the implications for school counselors and counselor education.

CHAPTER IV

DISCUSSION

This study sought to determine if there would be significant differences between Child-Centered Group Play Counseling (CCGPC) and a typical psychoeducational group model when compared to a non-therapeutic control group. The participants were primarily second and third graders. There was one fourth-grader who was selected for participation because of immature and controlling behaviors with others. This child had a late birthday and, therefore, was not much older than some of the third graders, and there were no second graders at this school due to the scheduling of the groups. In all of the schools, the group participants were selected because they exhibited disruptive classroom behavior or lacked appropriate social skills. The purpose of the study was to provide evidence that elementary school counselors could use CCGPC small group counseling with children who exhibit disruptive behavior and poor socials skills. A discussion of the results and the implications for school counselors, play therapists and counselor educators is offered below.

Hypothesis Testing

There have been several studies that have shown the effectiveness of psychoeducational small group models with school-aged children (Brantley & Brantley, 1996; DeRosier, 2004; Larkin & Thyer, 1999; Nelson & Dykeman, 1996; Schechtman & Ifargan, 2009; Webb & Myrick, 2003). This current study had four hypotheses that predicted that CCGPC would be as effective as psychoeducational group counseling in

reducing externalizing problem behaviors and increasing social skills with elementary students when compared to a control group. The four hypotheses stated:

1. Teachers' assessments (pre and post) would show that CCGPC small groups would be as effective as psychoeducational small groups when examining the externalizing behavior of children.

2. Classroom observation assessments (pre and post) would show that CCGPC small groups would be as effective as psychoeducational small groups when examining the externalizing behavior of children.

3. Students' self-perceptions (pre and post) would show that CCGPC small groups would be as effective as psychoeducational small groups when examining the social skills of children.

4. Teachers' assessments (pre and post) would show that CCGPC small groups would be as effective as psychoeducational small groups when examining the social skills of children.

Hypothesis 1 and 2 were supported by the statistical analyses indicating a statistically significant difference between pre- and post-test scores on the dependent variable externalizing behavior for participants in all groups. CCGPC was found to be as effective as the psychoeducational small groups on reducing externalizing behavior. Hypothesis 4 was also supported by a statistical analysis. The teacher report assessments indicated a statistically significant difference between pre- and post-test scores on the dependent variable social skills for participants in all groups. Hypothesis 3, which stated that students' self-perceptions (pre and post) would show that CCGPC small groups would be as effective as psychoeducational small groups when examining the social skills

of children, was not supported. The self-report assessment examining social skills (Peer Acceptance subscale) showed no statistical significance between pre- and post-tests. When examining all assessments, there was no significant difference with the between-group analyses. Even though this analysis supports the hypotheses, it does not indicate that either psychoeducational groups or CCGPC groups are more effective than the non-therapeutic control model where the participants listened to an Aesop's fable and drew a picture of an animal.

After examining the above results, the PI recognized two issues for discussion. The first issue is to examine possible reasons for the lack of significant differences between the three types of groups. It would seem that the two therapeutic group interventions would show significant differences from the non-therapeutic control group. The second issue is to examine the possible reasons for the lack of significant differences between the pre- and post-test self-assessments for social skills as measured by the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC). Since the other pre- and post-assessments showed significant differences, the question arises why the self-perception assessment would not show significance. These issues will be discussed in the following paragraphs.

Lack of Significant Differences between the Groups

One explanation for the significant difference in pre-test and post-test assessments for all small groups including the control group might be due to the Hawthorne Effect, a belief that improvement will occur simply because the participants receive special treatment and they know they are participating in a study. The results of the research of the Hawthorne Works of Western Electric Company in the 1920's showed that lighting

had no effect on worker productivity (Adair, 1984; Izawa, French & Hedge, 2011). This study that used a control group found that the worker productivity of the control group increased as much as the productivity of those who received variations in illumination (Adair, 1984; Izawa, French & Hedge, 2011). This assumption over the years, as reviewed by Adair has been attributed to three variables: special attention, awareness of participation in an experiment, and novelty. This current study clearly provided all three of the criteria. The children were given special attention by leaving the classroom with three of their peers. They signed an assent that was read to them by the school counselor explaining that they were going to be part of a research study. The small groups provided a novelty due to the playful and varied activities. Even the control group heard a funny story and did a playful motion at various times during the story.

Another explanation for the significance in all of the small groups is the belief in the power of the relationship between the child and the counselor. The task force sponsored by the American Psychological Association (APA) Division of Psychotherapy and the Division of Clinical Psychology concluded that the counselor relationship with the client accounts for why clients improve or fail to improve (Norcross, 2011). One characteristic of the counselor relationship is empathy. In another meta-analytic review of 57 studies, empathy, as expressed by the counselor, predicted treatment outcome regardless of the theoretical orientation (Elliott, Bohart, Watson, Greenberg, 2011).

According to the above studies, improvement occurs in counseling as a result of the counselor relationship and empathy expressed by the counselor, regardless of the treatment approach. School counselors spend time building relationships with all children in the school through their participation in school-wide programs and guidance

lessons in every class. In this study, the participants were invited to attend a small group with their peers and a counselor. They already had a relationship with the school counselor. This relationship doesn't stop if the counselor is engaging in a non-therapeutic task. To the children, the school counselor provided three types of small groups and they participated in one of these groups. In the control group, the school counselors did not process the moral of the Aesop fable or talk about how this applies to them. However, the participants had a relationship with the counselor and they felt comfortable sharing with others in the group. The qualitative results illustrated this point by an example that one school counselor shared during the fidelity check meeting. While coloring pictures during the session, two children in the control group seemed comfortable sharing about traumatic experiences that had happened in their homes. The school counselors emphasized that they did not process with the children during the control group, even though it would be normal in other settings for this to occur. This is one example of the effect of a small group experience where the counselor relationship, which had been established in other settings, allowed the children the freedom to share in this setting.

The Hawthorne Effect and the safe relationship with an adult could potentially have affected the results for the children in the control group. The children were aware that they were chosen to participate in a special project, each week they were able to leave the classroom for this project, and they had fun activities that they did during the groups. This also substantiates the findings of the meta-analyses of the APA task force in the importance of the counselor relationship and empathy.

Lack of Significant Differences in Pre- and Post-Scores on PSPCSCYC

The PSPCSCYC is a self-perception assessment used for young children who may not be able to read or write. Two pictures are shown to the child, the adult reads a question about those pictures, and the child chooses which picture is most like him or her. The Peer Acceptance subscale that was used for this study focused on the child's perception of his or her relationship with peers. Mantzicopoulos (2006) found that young children, especially in kindergarten and first grade, tend to have an overly positive view of their relationships with others. However, as children move into second and third grade this view tends to diminish (Mantzicopoulos, 2006). Using the PSPCSCYC, Mantzicopoulos studied children's self-evaluations of peer acceptance (n = 87) from preschool to second grade. Preschoolers showed the highest self-perceptions for peer acceptance and second-graders showed the lowest self-perceptions of peer acceptance (Mantzicopoulos, 2006). In line with these results, it is possible that in the current study, the participants' view of their relationships with others began to change during the weeks that they were in the study. Mantzicopoulos also found that the children's perception of peer acceptance did not correlate with the teachers' ratings on the subscales of the Social Skills Rating System (SSRS) (Gresham & Elliott, 1990). This corresponds with the results of this current study that showed the teacher reports on the TRF, Social Problems, to show a significant difference between pre-test and post-test scores.

In addition to Mantzicopoulos (2006), this shift in awareness is noted in Piaget's cognitive development stages in children (Santrock, 2009). Children usually move from the pre-operational to concrete operational stage of cognitive development at

approximately age seven (Orton. 1997; Santrock, 2009). So it seems that around second and third grade, children begin to think more logically and become more aware that their own reasoning might be different from others (Santrock, 2009). Erikson's stages of psychosocial development take a turn also around the age of seven when children face the dilemma of Industry vs. Inferiority (Santrock, 2009). Erikson tied these stages of development to a basic need and the resolution of a crisis (Santrock, 2009). He believed that if children were unable to have their basic needs met during a stage of psychosocial development, they would experience difficulties (Halstead, Pehrsson & Mullen, 2011; Santrock, 2009). During Erikson's Industry vs. Inferiority stage of development, children's basic need is a sense of competence (Halstead, et al., 2011). The negative result might be that the child will feel inferior, incompetent or unproductive as compared to peers (Santrock, 2009).

It is possible that during the weeks of the current study the participants became more aware of their interrelationship with others. Cognitively, the participants began to reason more logically, or they saw the discrepancy between their abilities and others. Also, during this developmental stage, the participants might have struggled with the task of industry versus inferiority. They might have a greater sense of inferiority as they move into the early months of the school year. While the teachers began to see signs of growth in the participants' relationship with their peers, the children had not yet made the connection.

Implications of the Findings

Implications for School Counselors

School counselors in the elementary school have the privilege of observing

children change in their development both cognitively and emotionally. They see children from ages 5 until age 11 or 12, and have the opportunity to see them change in different ways and at different times. School counselors are also an integral part of the team process to help children in the area of behavioral development. School counselors work with the teams to determine behavioral interventions that will assist the children in becoming academically successful (ASCA, 2005).

In light of the many responsibilities school counselors have, they could benefit from the use of evidence-based small group models that will aid in decreasing disruptions in the classroom and increasing social skills. In light of their already full schedules, it also would be important that such groups not require additional planning time. CCGPC could possibly be the solution for such a group model. Once a room is set up and the group selection is made, there is little planning needed for CCGPC. There is no need for lesson plans that require specific materials. Also, with the CCGPC model, the grade, gender and age can be mixed. In establishing the group participants, it is only important that there is no more than one grade level difference.

In the CCGPC model, children practice the act of letting others be in "charge" and controlling what the group does. The reason for this practice in groups is the development of a two-fold relationship: between the counselor and the child, and the child with the other children. This child-to-child relationship was demonstrated in the current study by some of the qualitative comments that the school counselors noted during the weekly fidelity checks. Even though the children in a CCGPC group did not know each other previously, the children built relationships during the non-directed play from the first session. School counselors noticed relationships had occurred as students

missed specific children when they were absent. The school counselors also reported excitement each week from the anticipation of being the one in charge. Even when faced with a dilemma of missing the classroom holiday activities, some children in the CCGPC group opted to come to the group session instead, while those in the psychoeducational group stayed in their classroom.

Psychoeducational groups, by design, teach skills; however, school counselors commented on the learning that occurred during the CCGPC groups. Children in the CCGPC group actually stated how they were now doing things they hadn't previously done. In the qualitative results, the self-assessments from session eight showed that most students in the CCGPC group felt that they had learned new skills they were using in the school. So this study demonstrated that, with proper training in the Child-Centered play therapy approach, school counselors could set up an environment and respond in ways that would be beneficial in improving the behavior of those in the group.

Implications for Play Therapists

Play therapists who practice in settings other than the school will find the CCGPC small group model takes little preparation, and children with different types of behavior problems will benefit from the experience. Those in agencies, private practice, or hospital settings could also utilize CCGPC when they have four children within one school year's difference who exhibit disruptive behavior or poor social skills. As was explained for school counselors, once the room is set and the selection of children is made, the group could progress under the designed structure without much effort in planning the group.

The current study focused on children who exhibited disruptive behavior or poor social skills. A large number of children with these behaviors end up in the offices of play therapists. The underlying issues that cause the behavior may be varied: grief, divorce, parents who have recently separated, domestic violence, or abuse. The combination of children in the groups, regardless of the underlying issue, did not seem to affect the benefits that the children received. In a psychoeducational group, play therapists attempt to select children who have similar backgrounds. It may be difficult to schedule children into groups when there is a concern of selecting those with the same issues at specific times. However, the CCGPC model could provide more opportunities for the play therapist to select children from his or her caseload without this concern.

Implications for Counselor Educators

The Association for Play Therapy (APT) encourages universities to provide a play therapy elective within their graduate counseling programs. A graduate play therapy course could provide the basic knowledge for early counseling interns to work with children. According to the sample play therapy syllabus on the APT website (Association for Play Therapy, 2010) one objective of an introductory play therapy course would focus on identifying developmentally appropriate toys and materials for the practice of play therapy. Another objective states that the class participants will demonstrate basic play therapy skills (Association for Play Therapy, 2010). These skills include tracking, reflecting of content and emotions, and limit setting. Some suggested activities for an introductory play therapy course include observation of a play therapist conducting a child session and practicing these skills by role-playing with another class member.

The skills presented in the introductory play therapy class are necessary for the CCGPC model that was used in this current study. Most of the school counselors who facilitated the CCGPC in this study had the added credential of Registered Play Therapist, and all were trained through at least one university course in their graduate counseling program. Without a solid training in the basic knowledge of play therapy, the counselor would not be able to conduct the CCGPC groups effectively.

Limitations of the Study

Several limitations were identified that could influence the results of this study. The first limitation is the selection of the students in order to obtain a large sample size. Even though the appropriate paperwork was completed to begin the selection process quickly after the school year began, it was difficult to obtain the number of TRF qualifying pre-test scores of 60 on externalizing behavior subscale scores. Teachers often did not know the students in their class well enough at the early point in the school year to know how to answer the questions on the TRF pre-tests. Also, teachers were busy with lesson planning and beginning of the year meetings that made it difficult to take the time to complete the TRF assessments. Many times the entire selection procedure started again with another child in order to complete the group make-up. This delay was discouraging for the school counselors who were ready to begin the group intervention. Realizing the necessity of completing eight weeks before winter break, one school dropped from the study, and others had less than the anticipated twelve students in their school.

A second limitation is the difficulty in completing eight weekly sessions in all small groups. Five schools completed the entire eight weeks, which consisted of 55

participants, before the winter break. The other two schools had 22 participants, and did not complete the sessions until after winter break. Even though the last groups were not conducted until after winter break, the post-tests were completed at the same time as the other schools. One of the drawbacks had to do with scheduling. It can become difficult in a school setting when there are so many events and people to coordinate. There were times when it was time for the group to begin and a teacher would not allow a student to leave because of a behavior concern or the completion of school work. There were other times when a special assembly or school activity happened at the same time as the group. Consequently, in light of these interruptions, the effect of the small group intervention may not have been completely realized by the time the post-tests were given. An additional factor that needs to be considered, given the 8-week time frame, and the groups ending just prior to the winter break, is that challenging behaviors occur naturally during the weeks leading up to a holiday. It is possible that this could have also been an affect on the post-test data. As difficult as it was to complete eight weekly sessions, several studies show that a minimum of 16 sessions is optimum for therapeutic value (Bratton, Ray, Rhine & Jones, 2005; Muro, Ray, Schottelkorb, Smith & Blanco, 2006). Using this guideline, research would not have ended prior to winter break, but continued until 16 weeks had been conducted.

Another limitation of the study is that two of the schools had different individuals other than the school counselor facilitate one or more of the small groups in their building. Those school counselors who facilitated the CCGPC groups were all trained in the Child-Centered play therapy approach by at least one university course. However, in one school there was a different school counselor facilitating the psychoeducational

model and a school social worker facilitating the control group. In another school there was a graduate intern, a former teacher in the building and in her second semester as an intern, who conducted the psychoeducational group and the control group. Even though these persons met weekly with the PI along with the other school counselors to insure fidelity, there might not have been the same relationship with this person as there was with the school counselor. As stated previously, the school counselor spends a great deal of time building a relationship with the students. In the groups that were facilitated by someone other than the school counselor, there was not the same relationship with the counselor. This may have had an impact on the results of the study.

The design of the study allowed for a control group, but this control group met as often as the other two groups so that teachers would not know which children were participating in which group. In retrospect, the Aesop's fables that were used in the non-therapeutic control group could bring forth a struggle in the child between good and evil. Jungian play therapists might believe that this control group actually provided another type of play therapy approach. The school counselors commented at each fidelity check how difficult it was not to reflect on the moral of the fable or tie the story to real life situations. Even though the school counselor read the story and the children drew a picture of an animal, the stories could have presented a subliminal message. A better research design might have been a no treatment control group, where students did not meet at all.

Recommendations For Future Research

The data support three of the four hypotheses showing that CCGPC is as effective as the evidence-based psychoeducational model for small group counseling to reduce

externalizing behaviors and increase social skills. The results of the study provide a greater understanding toward a new intervention model in the elementary schools. Implications for school counselors, play therapists and counselor educators have been included. Further research is needed to examine the greater impact that CCGPC might provide.

Further research could begin by focusing on the above limitations to this study. The first two recommendations pertain to scheduling of the groups in other studies. First, it is recommended that more time should be allowed for the selection of the participants. Conducting the groups after winter break might be a better time when the teachers would be more knowledgeable about the students' behaviors. However, the schedule disruptions during second semester might be more difficult if group times conflict with annual reading and math testing.

Second, it is recommended that in scheduling the groups, the counselor should plan for extra weeks due to possible time conflicts. As stated previously, flexibility is the norm in a school environment. If eight weeks have been allotted for an eight-week group, it is probable that the group will actually need ten weeks. In this study, it was intended that the group would be completed by winter break. Upon reflection, future research might look at completing four of the sessions before winter break, and four of the sessions after winter break. A stronger study would examine 16 sessions of group counseling by continuing sessions throughout the school year.

Further research needs to examine other variables that might have impacted the fact that even the participants in the control group improved during the time of the intervention. One variable is that school counselors or school counselor interns

conducted all of the small groups. In five of the schools, the control groups were facilitated by play therapists. A similar study that used teachers or aides to conduct the control group might provide different results. Counselors are trained to build relationships through empathy and appropriate responses. Do play therapists with training in the Child-Centered play therapy approach exhibit an even greater emphasis on relationship skills with children? Does this look different from those found in counselors trained to build relationship through empathy and other responses?

Even though the results indicated no significance between the three groups, a longitudinal study to examine students' behavior several months into the second semester would be beneficial. It would be interesting to see if participants in any of the groups continued to make progress as compared to those in other groups, over a longer period of time in the groups. Another type of longitudinal study could focus on providing CCGPC for the control group for eight weeks. At the end of this intervention, the teachers could complete another TRF assessment for all participants. This third assessment could examine if these students continued to improve with statistically significant results, while comparing these results to those who had the psychoeducational and CCGPC interventions earlier.

A "no treatment" control group would eliminate the three issues of the Hawthorne Effect. In the "no treatment" approach, the students would not be pulled from class for a group experience. The parents would still sign consent forms, and children would sign the assent forms. They could be told that they would receive a group experience later. It would also remove the novelty factor presented in the Hawthorne Effect summations.

Lastly, the population of this study included primarily Caucasian and European Americans (62%). CCGPC can be adapted to any environment by choosing appropriate toys and materials familiar to the participants. Further research should explore urban, rural and even international populations using the CCGPC model. This study explored the use of school counselors conducting the groups; however, many urban and rural schools, as well as schools in other countries do not have the budget for school counselors. Schools could contract with county mental health agencies to provide counseling in the school setting. Therapy bags that include the toys and materials used in CCGPC could be carried between schools. Those counselors who are trained in Child-Centered play therapy could use the CCGPC model to form groups in many diverse environments. Further research could examine the effectiveness of these groups with diverse populations.

Conclusion

In summary, this study sought to determine if there would be significant differences in elementary school students when they received weekly Child-Centered Group Play Counseling (CCGPC) sessions. The study compared the CCGPC model to a typical psychoeducational group model and a non-therapeutic control group. The results supported three of the four hypotheses demonstrating that CCGPC small group counseling is as effective as the evidence-based psychoeducational model when used with children with externalizing behavior problems or poor social skills as measured by teacher reports and classroom observations. The third hypothesis was not supported, which suggests that the children who participated in the groups did not perceive that they had improved in their social skills with their peers, even though the teachers believed that

the students had improved. This study gives impetus for more counselors to utilize the Child-Centered therapy model in various settings including schools, agencies, hospitals and private practice.

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Appendix A

Informed Consent Document

Project Title: The Effectiveness of Small Group Counseling in the Elementary Schools

Introduction

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. This research study is to compare the effectiveness of three types of small group models with second and third graders. Your child has been selected to be a participant in one of these groups. The weekly 30-minute groups will be held during the school day in the school counselor's office for eight weeks.

Researchers

Principal investigator and Doctoral Candidate: Mary L. Fry, M.S., Regent University, Counselor Education and Supervision.

Dissertation Chair: Vickey Maclin, Psy.D., Regent University, Clinical Psychology Doctoral Program

Committee: Mark Newmeyer, Ed.D., Regent University, Department of Counselor Education and Supervision

Jennifer Baggerly, Ph.D., University of North Texas-Dallas, Counseling and Human Services.

Description of Research Study

Several studies have been conducted looking at small group counseling in the elementary school. Few of them have explained the effect of small group counseling on disruptive classroom behavior and appropriate social skills among peers.

If you decide to participate, then you will join a study involving research of two different small group counseling models compared to a small group that is not a counseling model. Each group will have four students as participants. Groups will be held weekly for 30 minutes. If you say YES, then your participation will last for eight weeks. Classroom teachers will complete a standardized behavior checklist for each student prior to the beginning of the group, and after the completion of the last group. Graduate Counseling students will also be completing some student assessments before and after the eight-week groups.

Exclusionary Criteria

Either you or your child's teacher asked you to allow your child to participate in these groups. The classroom teacher and the school counselor feel that your child has the mental and emotional capability to participate in a group experience. Your signature below indicates that to the best of your knowledge, you agree with their assessment of your child's capabilities.

Risks and Benefits

Risks. If you decide to allow your child to participate in this study, then you understand that there may be a risk of your child missing a part of the academic school day. There may also be some stigma attached to the fact that your child is leaving the classroom for a small group in the counselor's office. The researchers have tried to

reduce these risks by working with the classroom teacher's schedule allowing the child to not be absent from the same subject every time. The researchers also have consulted with the school counselor and the classroom teacher to watch for any signs of possible negative effects related to the "pull out" process. And, as with any research, there is some possibility that your child may be subject to risks that have not yet been identified.

Benefits. The main benefit for participating in this study is that you may see some positive results in your child's behavior. Your child's grades may improve, and your child may have less disruptive behavior in class, and have more positive interactions with his/her peers. Other students in the class may benefit by an increase in positive classroom atmosphere.

Costs and Payments

The researchers are unable to give you any payment for participating in this study.

New Information

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

Confidentiality

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but the researchers will not identify you.

Withdrawal Privilege

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. The researchers reserve

the right to withdraw your child's participation in this study, at any time, if they observe potential problems with his/her continued participation.

Compensation for Illness and Injury

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of injury or illness arising from this study, neither Regent University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Mary L. Fry, at the following local phone number (913) 971-3737, maryfry@regent.edu, or Dr. Dr. Lee Underwood, current Human Subjects Review Committee (HSRC) co-chair at leeunde@regent.edu, or (757) 352-4461, who will be glad to review the matter with you.

Voluntary Consent

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, and that you understand this form, the research study, and its risks and benefits. The school counselor and/or school principal should have answered any questions you may have had about the research. If you have any questions later on, then the school counselor or the researchers should be able to answer them:

Mary L. Fry, MS, maryfry@regent.edu

Dissertation Chair: Vickey Maclin, PsyD., Regent University, Clinical Psychology Doctoral Program

Mark Newmeyer, Ed.D., (757) 352-4828, mnewmeyer@regent.edu

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. Lee Underwood, the current HSRC co-chair, at (757) 352-4461, or Dr. Mark Newmeyer, (757) 352-4828, mnewmeyer@regent.edu. And importantly, by signing below, you are telling the researchers YES, and that you agree to participate in this study. The school counselor should give you a copy of this form for your records.

Subject's Printed Name & Signature	**Date**
Parent / Legally Authorized Representative's Printed Name & Signature (If applicable)	**Date**
Witness' Printed Name & Signature (if applicable)	**Date**

Investigator's Statement

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	**Date**

Appendix B

Assent Document (participant)

Project Title: The Effectiveness of Small Group Counseling in the Elementary Schools

Introduction

Researchers are people who want to know if something actually works the way it's supposed to work. One researcher who is a school counselor would like to see which type of small group counseling helps children be better friends at school with others. The purpose of this form is to give you information that will help you decide if you want to be in one of these small groups at your school. At the bottom of the form, you will be asked to circle YES or NO, to let the researcher know if you want to be in one of the small groups at your school.

Description of Research Study

Some children in your school are going to meet in the school counselor's office, or another room like the school counselor's office, once a week for about 30 minutes. If you circle YES at the bottom of this form, then your participation will last for eight weeks. You can only be in one of the groups if your parent(s) have also signed a form giving the researcher consent for you to participate.

Before your group begins, your classroom teacher will answer some questions about how you are doing in class. A university student will meet with you for a few minutes before the groups begin to show you some pictures, and ask you which picture is most like you. The same questions will be answered after the last group session. At the

end of some of the group sessions you will answer some questions to see if you think the small group is helpful.

Confidentiality

All information about you in this study is strictly confidential unless required by law. The results of this research may be used in reports, presentations and publications, but the researcher will not say your name.

Withdrawal Privilege

It is OK for you to say NO. Even if you say YES now, you are free to say NO later. Also, if there seems to be any problems by your participation in the small group, the school counselor may talk to you individually about the problem and may even ask you to stop attending the small group sessions.

Voluntary Consent

By circling YES and signing this form, you are saying several things, and they are:

1. I have read this form, or someone has read it to me.
2. I understand that the small groups are part of a research study.
3. I understand that I will miss class for 30 minutes once a week for eight weeks, but my teacher and school counselor will try to schedule these during a time when I will not miss out on learning something new.
4. My school counselor or the person who explained this form to me answered all of my questions.
5. I understand that the school counselor will be able to answer any additional questions I may have about this project, after the groups begin.

And importantly, by signing below, you are telling the researcher that your parent(s) have said YES to your participation and you are also saying YES, that you want to participate in this study. The school counselor can give you a copy of this form if you wish.

Circle - YES or NO.

Participant's Printed Name:	Date
Participant's Signature:	
Witness' Printed Name:	Date
Witness' Signature:	

Investigator's Statement

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	Date

Researchers:

Mary L. Fry, MS, maryfry@regent.edu

Vickey Maclin, PsyD, vmaclin@regent.edu

Mark Newmeyer, Ed.D., (757) 352-4828, mnewmeyer@regent.edu

Appendix C

Toys for Child-Centered Group Play Counseling

Nurturing	Aggressive	Creative/ Expressive	Real Life	Board Games
Baby doll	Handcuffs	Art supplies: construction paper, markers, crayons, watercolor paints	Cash register & money & credit card	Trouble
Dr. Kit	1 swim noodle cut in half	Play dough (1 color)	Cars, trucks, airplane	UNO
Tea set	Soldiers (2 different colors)	Stickers (variety), felt, beads, buttons, yarn, wiggly eyes, popsicle sticks	Doll house, furniture, small people	Hands Down
Play Food	Shark, snake, alligator	Puppets or stuffed animals: 4 animals (2 aggressive and 2 friendly)	Farm animals, zoo animals	Chutes & Ladders
			Cell phones (2)	Jenga

			Dress up clothes	
			Rescue vehicles: police, fire truck, helicopter, ambulance	

Appendix D

Child-Centered Group Play Counseling Procedures

Counseling Skills

Structuring skill is necessary to set the tone at the beginning and end of the group sessions. When the group arrives in the counselor's office, the students are asked to sit around a table or in a circle on the floor. At the first session, the counselor states, "This is our group playtime. At the beginning of every group, we will all sit down before we start our activity for the day. I have four slips of paper that have a number on them. The person who draws the slip of paper that has a number '1' will decide the activity that we do the first time we meet; the one who draws a number '2' will decide the activity for the second time, and so on. You will each have a chance to decide what we will do two times during our group playtime. There are lots of choices in here, and the one in charge for the day gets to decide. At the end of each session, we will come back to the table (floor) and talk briefly about how our session went. Now let's draw our numbers." At the end of each session, the counselor gives a 5-minute warning at 20 minutes. After 2 minutes, the counselor says, "Our session is over and you have 3 minutes to pick up." Then, after the toys are picked up, the children sit down at the table (floor) and go around the circle to tell one thing that they liked about today, or one thing that they learned about today.

Empathic Response is a skill where the counselor reflects back what the child is doing (tracking), and how the counselor thinks the child is feeling. As the four children play in the playroom, the counselor will respond periodically to what one or several of the children are doing. For example, the counselor might say, "Sammy, you decided to

play with the puppets today. It looks like you are enjoying making the puppets talk to the others."

Imaginary Play is used when a child or children ask the counselor to play with them. It is not necessary during CCGPC for the counselor to interact with the child. The counselor might say, "This group time is available for you to play with each other. Instead of playing with you, I will watch and keep the room and each of you safe." If the counselor is needed in the particular child-directed activity, then she/he may choose to enter the activity when asked. However, it is not the counselor's role to direct or enforce the rules of the play.

Limit Setting is used to keep the room and the children safe. Limits are not set until they are needed, but are stated firmly. However, limits are not to be punitive. Limits should be set if a child is going to hurt himself, the other children, or the toys/room. The counselor follows a 3-step approach in an effort to allow the child or children to change their behavior.

The first time that a limit needs to be set, the counselor is to acknowledge the child's feelings and specific action that is unacceptable, communicate the limit giving the specific action that the child cannot do during the group playtime, and target an acceptable alternative to that action. For example, "Susie, it looks like you're angry. I know that you want to throw the game at Sam, but throwing things at someone cannot be done during the group playtime. You may choose to use your words to tell Sam that you are angry."

The second time that the same limit needs to be set, the counselor reminds the child of the previous limit, and states that if it happens again, that child's session is over

for the day. If it happens again, the counselor calmly asks the child to return to the class, and notifies the classroom teacher that he/she is on the way back. This three-step process allows the child an opportunity to change a behavior before having to return to the class.

Enforcing the Control of the Leader. At the beginning of each session, the counselor asks the leader what they have decided to play with the group. If one person decides not to play what the leader has chosen, the counselor reflects that to the group, but allows the natural interaction of the other students to occur. Often, the one student decides to join the others as the time progresses. Sometimes the other students encourage that person to join in, and sometimes the student decides it looks like the others are having fun. However, if more than two students decide not to play what the leader has chosen, the counselor needs to set a limit by saying, “Today is John’s turn to make the decisions. You need to let him be the leader. When it’s your turn, then you can decide what to do.”

Appendix E

Psychoeducational Group Sessions (Simmonds, 2003)

Session 1: Recognizing Anger

Opening Activity. Make name-tent and draw picture of themselves on name-tent. Introduce eight-week group model. Counselor reviews group guidelines for respect for others in the group.

Learning Activity. Distribute "Yes" and "No" card to students. Counselor reads statements from a list of "I get angry when…." (Simmonds, 2003, p. 24). Students hold up the appropriate card following each statement, according to whether they get angry in that situation. If the statement does not pertain to student, he does not hold up any card. Counselor asks questions regarding the purpose of the activity, other situations that students can share that trigger anger, whether it's ok to get angry, which ways it's ok to express anger, and if people always feel the same amount of anger.

Closing Activity. Students are asked to demonstrate to others what they look like when they are angry. Compare the way they look when they are angry to the picture they drew of themselves on their name-tent. During the coming week, think about safe people they can turn to when they get angry, and positive ways they can handle their anger.

Session 2: But It Wasn't My Fault

Opening Activity. Counselor briefly reviews the guidelines of respect for the group. Students roll a cube box that has questions written on each side. They answer the question that is face up after the roll. Questions include: (1) Name a good thing and a not-so-good thing from your past week; (2) Tell something about yourself that no one

else in this room knows; (3) Describe a time that you felt very angry but you controlled yourself; (4) Name something that you really like about your family; (5) Name one thing that you like to do on the weekends; and (6) Name something that often makes you feel very angry.

Learning Activity. Counselor introduces a role-play demonstration where the counselor teaches but one of the students is talking. When the counselor asks the student to stop talking, the student says, “It wasn’t me. I wasn’t talking.” The counselor and another student repeat the same scenario. Then, the counselor instructs the other two students to talk while she is teaching but tells them to blame the other two students. This time when the counselor is teaching, she immediately tells the first two students to stop talking, they say, “It wasn’t us! We weren’t talking! It was them!” The counselor leads discussion as to the positive ways to handle a situation when they are blamed for something they didn’t do, telling the truth in order to build trust, and when to take responsibility for mistakes.

Closing Activity. Counselor reads a rap poem titled, “I will not fight with you today” (Simmonds, 2003, p.32). She passes the rap poem out to the group so that they can divide up the lines and take turns saying them in a rap rhythm. Students are asked to try to memorize the poem during the coming week.

Session 3: What’s Under all that Anger?

Opening Activity. Students are given a copy of the rap poem from the previous week. They read the poem together in rap format. Counselor leads a discussion their new plan for not hurting others. Students are encouraged to talk about things that happened during the previous week that made them angry.

Learning Activity. Counselor leads a discussion on how underneath our anger are usually other feelings like jealous, sad, scared, embarrassed, hurt, lonely, or worried. Counselor passes out a worksheet with a body drawn on it (Simmonds, 2003, p. 41). Students are to color the body picture according to how they feel inside using the colors next to each feeling. Time is given for each student to discuss his drawing.

Closing Activity. The counselor sets out the core feeling cards face up on the table (Simmonds, 2003, p. 40). Students take turns choosing a core hurt that they most often use to cover up with anger. The students are asked to give an example of an experience they've had with that core feeling. Counselor asks the students to practice identifying their core feelings underneath their anger in the coming week.

Session 4: Your Personal Power

Opening Activity. Counselor reviews the core feelings underneath the anger from last week by passing a koosh ball to a student and saying a feeling. The student is to tell a situation when they had that feeling.

Learning Activity. Counselor introduces a role-play scenario that demonstrates a situation where a person gets angry at something someone else does, but he maintains his personal power and doesn't do what the "provoker" hopes he will do (Simmonds, 2003, p. 46 & 48). Following the role-plays, the counselor asks questions about keeping control in situations when someone else is provoking us, and why it sometimes makes us feel good to pick on others. Counselor gives each student the "Controlling Anger" worksheet (Simmonds, 2003, p. 49). Students are asked to find the picture that corresponds to each step.

Closing Activity. Students are asked to take home the Controlling Anger worksheet and memorize the five steps.

Session 5: It's All in HOW You Say It

Opening Activity. Counselor challenges the group by asking them to recall the five steps to controlling their anger.

Learning Activity. Counselor reviews the "Helpful Comebacks" worksheet (Simmonds, 2003, p. 54) by giving examples of each situation. A written insult card is handed out separately to each student. The student is to read the insult to another student and act as genuine as possible. The person who receives the insult needs to respond with a statement that does not escalate the situation. If the responder has difficulty, the counselor can give that person help with the response cards. Other students are to rate the responder from 1 to 5 as to how well the content and attitude of the response sounded. Each student will act out both roles.

Closing Activity. Counselor passes out two slips of paper to students and asks them to write down two ways that they demonstrate to others that they are peacemakers. Counselor keeps the slips of paper for the next session.

Session 6: Creating Positive Change

Opening Activity. Counselor uses the peacemaker cards from the closing activity from previous week and adds troublemaker cards to the set. Counselor shuffles cards and places in the center of the table, asking students to take turns drawing a card. After reading the card, they are to say whether that is a peacemaker card or a troublemaker card.

Learning Activity. Counselor writes the I-message format on a board and gives several situations where this statement can be used (Simmonds, 2003, p. 56). Students are asked to share a time in the past week when they got angry. The student is asked to use the I-message format for that situation that made them angry. Counselor distributes the "Family Anger" worksheet (Simmonds, 2003, p. 59). Students share ways that they see their family express anger and complete the worksheet.

Closing Activity. Counselor hands out "I'm feeling ____ because …." slips (Simmonds, 2003, p. 58). Students are encouraged to use this phrase sometime during the week after someone provokes them.

Session 7: Consequences

Opening Activity. Counselor has situation cards face down on the table. Students take turns picking a card and stating an I-message for that situation. Counselor encourages their attempts.

Learning Activity. Counselor leads a discussion on the choices we make that sometimes cause consequences. Counselor shuffles "Consequence Cards" (Simmonds, 2003, p. 64) and places them in the center of the table. Students are to pick a card and read it to the others. All are to decide on several consequences that would possibly happen from the action on the card.

Closing Activity. Counselor discusses consequences that are positive. Students are to think of situations when there was a positive consequence. After this discussion, counselor encourages students to examine the consequences that happen this week and be prepared to share a couple with the group.

Session 8: Bullying

Opening Activity. Counselor leads discussion on consequences that students had this week. Students were encouraged to share both positive and negative consequences.

Learning Activity. Counselor has printed large sheets of paper listing possible responses to bullying (Simmonds, 2003, p. 60). These sheets of paper are taped around the room and the counselor asks the students to read the statement on each piece of paper. Students are asked to stand under the sign that says the action that they are most likely to do after being bullied. Counselor leads a discussion about the consequences of the actions that they would do after being bullied. Students are to take the paper off the wall and write at least five positive or neutral things they could do instead after thinking through the consequences. Counselor allows students to share their ideas with the others.

Closing Activity. Counselor distributes "Final Evaluation" worksheet (Simmonds, 2003, p. 71-72) and asks students to share some of the things they learned during the group. Counselor distributes "Certificate of Participation" (Simmonds, 2003, p. 73) to each student.

Appendix F

Control Group Activities (Enderle, 2004)

These fables are fun and can provide an educational experience where the students may learn about opposites, but there is no therapeutic value. Each week the facilitator will read the story and lead the students in an activity as directed in the book.

Session 1: The Lion and the Mouse–An In and Out Story (Enderle, 2004, p.5-7.)

The facilitator reads the story. When the students hear the word *out* they stick out their tongue, but when they hear the word *in* they put it back in. Following the reading, the students color a picture of a lion.

Session 2: The Frog and the Ox–A Big and Little Story (Enderle, 2004, p. 26-27.)

The facilitator reads the story. When the students hear the word *big* they spread their arms wide. When they hear the word *little,* they put their pointer fingers together, but leave a small space the size of a bug. Following the reading, the students color a picture of a frog.

Session 3: The Fox and the Crow–A Left and Right Story (Enderle, 2004, p. 28-30.)

The facilitator reads the story. When the students hear the word *left,* they raise their left hand. When they hear the word *right,* they raise their right hand. Following the story the students color a picture of a fox.

Session 4: The Grasshopper and the Ant–An Early and Late Story (Enderle, 2004, p. 32-35.)

The facilitator reads the story. When the students hear the word *early,* they lean forward. When they hear the word *late,* they lean back. Following the story, the students color a picture of a grasshopper.

Session 5: The Boy Who Cried Wolf–An Over and Under Story (Enderle, 2004, p. 36-38.)

The facilitator reads the story. When the students hear the word *over,* they put their hands on top of their head. When they hear the word *under,* they put their hands under their chin. Following the story, the students color a picture of a boy.

Session 6: The Travelers and the Bear–A Near and Far Story (Enderle, 2004, p. 39-42.)

The facilitator reads the story. When the students hear the word *near,* the students pur their finger on their nose. When the students hear the word *far,* the students point their finger away from them. Following the story, the students color a picture of a bear.

Session 7: The Fox and the Stork–A Tall and Short Story (Enderle, 2004, p. 45-48.)

The facilitator reads the story. When the students hear the word *tall,* the students sit up straight. When the students hear the word *short,* they scrunch down in their chair. Following the story, they color a picture of a stork.

Session 8: The Raven and the Swan–A Black and White Story (Enderle, 2004), p. 49-52.)

The facilitator reads the story. Students have a piece of paper with a picture of a black raven on one side and a white swan on the other side. When the students hear the word *black*, the students flash the black raven. When the students hear the word *white,* the students flash the white swan. Following the story, the students are given a white sheet of paper and a black crayon. They can either draw a raven or a swan.

Appendix G

Group Member Feedback Form

Adapted from DOCUMENT 16: (Missouri Comprehensive Guidance Program Responsive Services Component: Small Group Counseling Module)

Small Group Counseling: Group Members' Perceptions

Directions: Please complete the Student Feedback Form at the end of the first, fourth and eighth session.

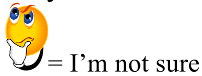
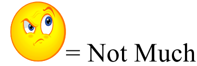
Name: ________________________________ Date: ___________________

When I started the group, I wanted to learn

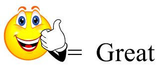
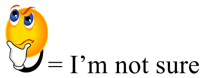
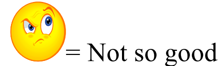
____

____

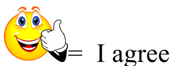
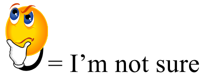
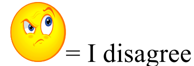
Instructions: Read each sentence. Put a circle around the face that shows how you think and feel right now about what you learned in the group.

= Lots  = I'm not sure  = Not Much

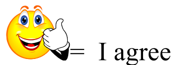
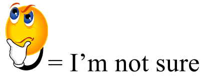
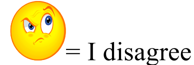
1. Overall, I would rate my experience in the counseling group as:

 = Great  = I'm not sure  = Not so good

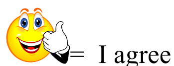
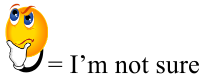
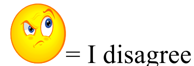
2. I enjoyed working with other students in the group

 = I agree  = I'm not sure  = I disagree

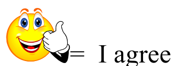
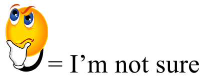
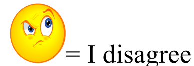
3. I enjoyed working with the counselor in the group.

 = I agree  = I'm not sure  = I disagree

4. I learned new skills and am using the skills in school.

 = I agree  = I'm not sure  = I disagree

5. If other students ask me if they should participate in a similar group, I would recommend that they "give-it-a-try"

 = I agree  = I'm not sure  = I disagree

Additional comments you would like to share with the counselor:

Appendix H

Fidelity Checklist CCGPC Groups Skills Checklist

School Counselor: ______________________________
Site: ____

Counselor's Non-verbal communication	+	0	-	None	**Counselor's Comments**	**Supervisor Comments**
Relaxed, Comfortable						
Open, Giving Attention						
Appeared Interested						
Allowed for spontaneity of interactions among children/participants						
Succinct in comments						
Rate of verbal interactions						

Comments & Questions:

Counselor's Responses:	+	0	-	None	**Counselor's Comments**	**Supervisor Comments**
Setting Structure to Session						
Limit Setting for Safety						
Reflecting Content						
Reflecting Feelings						
Facilitating Decision-Making Responsibility						
Esteem Building Responses						
Non-CCPT Responses?						

Appendix I

Fidelity Checklist for Psychoeducational & Control Groups

School Counselor: ______________________________

Site: ______________________________________

Comments & Questions:

Group Dynamics (Indicate on back of sheet):

Appendix J

Regent HSRC Approval

June 19, 2012

RE: Verification of Mary Fry's Human Subjects Review/Internal Review Board (HSRC/IRB)

I am writing this letter on behalf of Mary Fry to verify that the Human Subjects Review Committee/Internal Review Board (HSRC/IRB) at Regent University has approved. Ms. Fry's HSRC/IRB proposal submitted on June 3, 2012 titled "Effectiveness of Child Centered Group Play Counseling in the Elementary School" was approved and promises to be a significant contribution to the field of counseling and behavioral health.

The faculty in the Doctoral Program in Counselor Education and Supervision (DPCES) is grateful that your organization is providing this experience for Ms. Fry. Should you have additional questions, please feel free to contact me at 757-630-4442.

Respectfully Submitted,

Lee A. Underwood, Psy.D.,
Professor of Counseling
Co-Chair of HSRC/IRB

Appendix K

MidAmerica Nazarene University IRB Approval

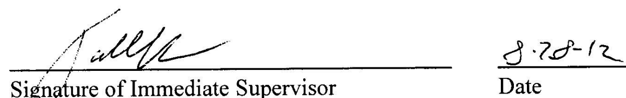
THIS IS THE APROVED FORMAT FOR **COVER PAGE** OF PROTOCOL FOR
NON-EXEMPT STUDIES

Effectiveness of Child Centered Group Play Counseling in the Elementary School
Specific Title of Research

Graduate Counselor Education
Department

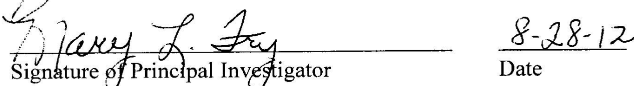
School of Behavioral Sciences and Counseling
School

MidAmerica Nazarene University



8-28-12

Signature of Immediate Supervisor — Date



8-28-12

Signature of Principal Investigator — Date

2030 East College Way	**Olathe**	**KS**	**66062**
Street Address	City	State	Zip

913.971.3737	**mlfry@mnu.edu**
Phone Number	Email Address

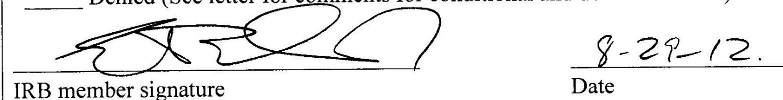
ACTION OF THE IRB

__X__ Full Acceptance

_____ Acceptance dependant on minor modifications

_____ Major modifications required

_____ Denied (See letter for comments for conditional and denied research)



8-29-12.

IRB member signature — Date

________________ — __________

IRB member signature — Date

Abridged Manuscript

Comparing Child-Centered and Psychoeducational Groups

for Externalizing Behaviors

Schools are required to provide education for all children in the least restrictive environment (AACAP, 2008), but even with effective classroom management strategies, some students still exhibit disruptive behaviors. School counselors are trained to help the children with emotional and behavioral needs to improve academically (American School Counselor Association, 2005); however, effective interventions for disruptive behaviors have several limitations. Particularly, the interventions do not match management strategies with the neurophysiological level of behaviorally disruptive young children (Gaskill & Perry, 2012). To address this limitation, research on developmentally appropriate interventions matching the neurophysiological level of behaviorally disruptive young children is needed (Gaskill & Perry, 2012). Child-Centered Play therapy is one such well-researched intervention (Baggerly, Ray, & Bratton, 2010; Gaskill & Perry, 2012).

Often students with disruptive behaviors also have a mental health disorder diagnosis as described in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR Edition (DSM-IV-TR)* (American Psychiatric Association, 1994). Some behaviors often seen in school-age children are Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). Teachers rely on school counselors to assist with the emotional and behavioral needs of children with these disruptive behaviors.

The American School Counselor Association (ASCA) student-to-counselor recommendation is 250-to-1 (ASCA, 2005); however, the national average in 2009 was 457-to-1 (U.S. Dept. of Education, 2009), which means that individual counseling is not attainable. Consequently, school counselors are encouraged to use a group model. In light of this, the purpose of this study was to examine the effectiveness of two types of group counseling in the elementary school. Specifically the group models selected were Child-Centered Group Play Counseling (CCGPC) and the typical group psycho-educational program (Simmonds, 2003), compared to a control group.

In elementary schools, group counseling can be conducted using a structured (psychoeducational) approach or an unstructured approach, sometimes called process groups (Dollarhide & Saginak, 2012). Using structured groups, the school counselor directs the activities and presents a lesson designed to help change a specific behavior. Activities can include role-playing, art activities, or games (Dollarhide & Saginak, 2012). Learning in the unstructured groups happens through group interactions and spontaneous behavior (Dollarhide & Saginak, 2012). In this current study the two types of group experiences were compared. Participants were second and third graders, and measures included teacher ratings, classroom observations and an assessment of the child's perception of peer acceptance.

The unstructured groups were based on the Child-Centered Play Therapy (CCPT) approach. In this approach play therapy is a developmental process where children express themselves in a safe environment with a trained professional (Landreth, 2002). In the school environment, the school counselor does not conduct "therapy." As such, in this study the term Child-Centered Group Play Counseling (CCGPC) is used. In

CCGPC, a relationship is developed between the counselor and each group member, and between each group participant (Landreth & Sweeney, 1999). With CCGPC the group members, not the counselor directs the group activities (Landreth & Sweeney, 1999). The counselor establishes a climate of empathy, acceptance, warmth, and positive regard (Landreth & Sweeney, 1999), and provides structure by starting and ending the sessions the same way. Additionally, limits are set to provide a safe environment.

In contrast with structured psychoeducational groups, the counselor takes an authoritarian role by planning activities (Geroski & Kraus, 2010). These activities help children learn skills to improve their behavior. In the first session counselors discuss limits, and ask for input from the members (Geroski & Kraus, 2010). Some topics for school psychoeducational groups include friendships, conflict resolution, study skills, and anger control. Studies have shown positive results for school psychoeducational groups (DeRosier, 2004; Larkin & Thyer, 1999; Nelson & Dykeman, 1996; Schechtman & Ifargan, 2009; and Steen & Kaffenberger, 2007; Web & Myrick, 2003;).

DeRosier (2004), developed a psychoeducational group intervention, called S.S.GRIN, which was designed to help third grade students who were socially anxious, peer-rejected, and victimized by bullying. After eight weekly sessions, aggressive children who had bullying and antisocial behaviors had significant treatment gains. But children with the same behaviors who did not participate had an increase in behaviors (DeRosier, 2004).

Webb and Myrick (2003) had a group intervention to improve ADHD symptoms in children. Using the Rational Emotive Behavior Therapy (REBT) model in a six-week group intervention, the counselors helped students learn about the effects of ADHD on

their behavior and academic performance. At the completion of the intervention, 94% of the school counselors reported the students had an increased level of confidence in consulting with teachers. Additionally, 93% found that students improved their perspectives about being a good student (Webb & Myrick, 2003).

The research with unstructured CCPT groups is limited when compared with psychoeducational group research. In two such studies, Baggerly (2004) and Baggerly and Parker (2005), the impact of a CCPT group model was studied. Baggerly & Parker's study consisted of a group of two children in a homeless shelter's onsite elementary school. The size was small due to the size of the playroom and the intense needs of the children. In this study the researchers measured mood and self-esteem. The results showed a large effect on Negative Mood, and a moderate effect on Negative Self-Esteem. Baggerly (2004) also used the Revised Children's Manifest Anxiety Scale (R-CMAS) to measure Physiological Anxiety and found that there was a moderate decrease in that variable.

Another study by Baggerly and Parker (2005) examined the effect of a CCPT group model with two African American boys in an elementary school. This qualitative study suggested improvement in the boys' African worldview and facilitated their self-confidence. There was also an effect on disruptive behavior, even though it was not the purpose of the study.

Brantley and Brantley (1996) compared two group models, structured and unstructured, with a control group. The unstructured groups did not follow the Child-Centered play therapy guidelines. These groups had more than two children in a group and met for eight weeks. Disruptive behaviors of fourth through sixth graders from at-

risk, inner-city schools were examined. Using structured groups (typical psychoeducational curriculum) and unstructured groups, the researchers found that the structured groups had a slightly higher rate of behavior change (73% versus 64%) than the unstructured groups (Brantley & Brantley, 1996).

Purpose of the Study

The purpose of this study was to compare CCGPC with psychoeducational group counseling when used by school counselors as an intervention for decreasing student disruptive behavior (specifically externalizing) behaviors and increasing social skills in the elementary school setting. There were two dependent variables: 1) decrease in externalizing behavior problems in the school setting, and 2) increase in social skills with other students. The independent variable was group counseling with three levels: psychoeducational group, CCGPC group, and a non-therapeutic control group.

METHODOLOGY

Population & Sampling

In accordance with Baggerly, Ray & Bratton's (2010) evidence-based criteria for play therapy researchers, a power analysis was conducted using G*Power 3.1.5.1 (Faul, Erdfelder, Lang & Buchner, 2009) to determine an adequate sample size. Specifically, an A priori was computed for an ANOVA: repeated measures, within-between interaction of three groups and three measurements for an effect size of .25. The power analysis indicated a sample size of 15 was needed when using the seven scales measuring the dependent variable Externalizing Behavior. A sample size of 30 was needed when using the two subscales measuring the dependent variable Social Skills.

Participants came from seven Midwest suburban and rural elementary school districts. School counselors in six of the schools had completed university graduate coursework in play therapy, and had experience in using Child-Centered Play Therapy (CCPT). One CCGPC facilitator, a retired school counselor and a Registered Play Therapist Supervisor, facilitated the CCGPC group sessions in the seventh school. Each school counselor met with classroom teachers to gather the names of second and third grade students. (A fourth grade student was later added in one of the schools.) In order to participate in the study, the students had to meet the following criteria: (1) exhibit at least one of the following behavior problems: arguing, angry outbursts, demanding attention, disobedience, or teasing; (2) have no current IEP that indicated the need for "ED" placement; and (3) have no current IEP that indicated the need for "Lifeskills" placement or for more than 2 hours of Special Education Resource Services a day, but could have an IEP designation of Developmental Delay (DD).

Parent permission was obtained, as was assent from each child. The classroom teachers for each student participant completed a TRF assessment (Achenbach & Rescorla, 2001) as a pretest. Students with pre-test score at 60 or above on the TRF subscales of Social Problems, Attention Problems, Rule Breaking Behavior, Aggression, or a composite score of Externalizing Behavior were asked to participate in the study. (A score in the At-Risk range is 65; a score above 70 is in the Clinically Significant range.) Some of the students' pre-tests scores did not qualify them, so the teachers and counselors referred other students. There were six students who did not meet the cut off score, but were included as participants in two of the schools, so that there was a minimum of three students in a group to have complete group structure.

Participants

The study included seven elementary schools with three groups in each school. There were a total of 79 participants who were randomly assigned within their school to one of the three groups. See Table 1 for participant demographics.

Table 1

Participant Demographics

	Number	Percentage
Grade		
2nd	n=40	51%
3rd	n= 38	49%
4th	n=1	.01%
Gender		
Male	n=49	62%
Female	n=30	38%
Ethnicity/Race		
Caucasian/White/European	n=52	66%
Latino(a)/Hispanic American	n=14	18%
African American	n=8	10%
Multiracial	n=5	.06%

Instruments

The researcher obtained evaluations from the teachers, an observer in the classroom, and the children themselves. The Teacher Report Form (TRF) (Achenbach & Rescorla, 2001), part of the Assessment System of Empirically Based Assessment (ASEBA), was used for the teachers' reports. The TRF subscales used to assess pre and post data for Hypothesis 1 were Attention, Rule Breaking and Aggression, as well as the composite score of Externalizing Behavior. The TRF subscale Social Problems was used to assess pre and post data for Hypothesis 4. The Direct Observation Form (DOF) (McConaughy & Achenbach, 2009), also an assessment of ASEBA, was selected for the classroom observations conducted by graduate students. The DOF subscales used to

assess data for Hypothesis 2 were Attention Problems, Intrusive and Oppositional. The graduate students also conducted individual assessments using the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC) (Harter & Pike, 1983). This instrument has four subscales, but the only one used in this study was the Peer Acceptance subscale.

Procedure

Once pre-test assessments were completed, students were randomly assigned to one of the three groups--a CCGPC group, a psychoeducational group, or a control group. Two of the seven schools had 12 student participants with four students in each group. Three of seven schools had 11 student participants--four students each in the CCGPC group and the psychoeducational group, and three students in the non-therapeutic control group. In one school, there were only nine students who qualified. Consequently, two other students who did not have qualifying scores were placed in the groups. This allowed the CCGPC and psychoeducational groups to each have four students. The final school only had seven students with qualifying scores on the TRF. These students were randomly placed in the three groups (three in CCGPC, two each in the psychoeducational group and control groups). Four students who did not have qualifying scores were placed in the groups, one in the CCGPC group, two in the psychoeducational group, and one in the control group. One of the students who initially qualified and had been randomly placed in the control group never attended the group sessions due to behavioral problems during group time. This student subsequently withdrew from the school. A replacement student was added to the control group at session four. The new student qualified on the pre-test TRF scores, but only attended five of the eight sessions.

Each of the three groups in all seven schools met concurrently for 30-minute sessions. Five of the schools completed all eight sessions prior to the post-tests, being administered before Winter Break. The other two schools completed the last two sessions after Winter Break.

Group Design

The school counselors who facilitated the groups received training by the PI. She also conducted weekly fidelity checks throughout the study. Confidentiality was maintained by each of the group facilitators. The teachers for each child did not know in which group the students participated. At the end of sessions one, four and eight, students in all of the groups completed a short self-reflection of their opinions on their group.

Child-Centered Group Play Counseling. The CCGPC group participants met in a play room/school counseling office for their group sessions. The rooms were all similar in size (approximately 12 X 15 feet) and each equipped with the same category of toys: nurturing, aggressive, real life, creative or expressive, and five age appropriate games.

The CCGPC counselor had each child draw numbers to determine the order of child leaders during the group time in the first session. The remainder of the group time was lead by the children. Each week one child was in charge of the activity based on the order of the number selected in the first session. After week 4, the order repeated itself through the remaining weeks. During the group activities the counselor used reflections and paraphrases to note what was happening during the play. When conflicts occurred, the counselor's role was to keep the students safe and reflect what was being expressed

during the conflict. The counselor did not lead the activities or state the rules of the games, and only set limits when necessary. Examples, according to Child-Centered Play Model, of when limits are set include: 1) possible injury to a child, 2) possible harm to the counselor, or 3) possible harm to the room or the toys. Another aspect of structure within the CCGPC model was the 5-minute warning given by the counselor to conclude each session.

Psychoeducational Group Counseling. The psychoeducational groups were conducted following the protocol of Simmonds (2003), but the curriculum was condensed from twelve sessions to eight. The group topics included recognizing anger, who's at fault, what's beneath the anger, controlling the anger, communication strategies, I-messages, the consequences of bullying, and celebrating peace.

Control Group. The students randomly selected to participate in the control group were also removed from the classroom to participate in activities. These children's group sessions were non-therapeutic. The control group met weekly for eight weeks and listened to an Aesop's fable (Enderle, 2004) the facilitator read. Following the story, the students drew a picture of an animal from the story.

Statistical Analysis

Each school was supposed to complete eight weekly sessions prior to Winter Break. Two of the schools were unable to complete the eight weeks due to scheduling conflicts and a snow day. One school had five sessions of CCGPC groups, and six sessions of the psychoeducational group and the control group, and another school had all three groups to complete six sessions. Each of the seven schools completed post

assessments the week prior to Winter Break, even if all eight sessions had not been completed.

Seventy-three of the 79 participants, had qualifying scores of 60 or higher on at least one of the TRF subscales: Social Problems, Attention, Aggression, or Rule Breaking. There was one participant randomly assigned to the control group who had behavioral outbursts in class that resulted in not being able to attend two groups. The child later changed schools, which resulted in discontinued participation in the study. Several weeks passed before realizing the student would need to withdraw from the study. Ultimately, another student who had a subscale TRF qualifying score of 60 was added during the fourth session. This same school had less than the ideal number of student participants, so a fourth grader was selected to participate in the study. The fourth grade teachers asked if this student could participate because of disruptive behavior. With the exception of the one fourth grader, the participants at the school were all third graders. As such, the participants had no more than one grade level difference. After random assignment, the fourth grader ended up in the CCGPC group. Because the PSPCSAYC has not been standardized for children in fourth grade, the fourth grade student's score was not included in the data set addressing Hypothesis 3. In addition, one of the teachers at this school did not complete the TRF post-assessment for a student in the psychoeducational group, which resulted in the student's data being removed from the analysis addressing Hypothesis 1 and 4.

Another school had two participants to move after the sixth session, and they did not complete the last two sessions. One of the students was in the control group and the other student was in the psychoeducational group, leaving three students in each of these

two groups. Nonetheless, the teachers completed TRF post-assessments for the two students. However, since post-test observations and the individual assessments (PSPCSAYC) were completed at the end of the final week of group, the graduate students were unable to complete the observations and individual assessments. Data for these two students was not used to address Hypothesis 2 and 3, but because TRF scores were used to address Hypothesis 1 and 4, the post-test score data was used to address those Hypotheses.

In yet another school, a student who participated in the CCGPC group intervention was absent when the graduate student conducted the post-test observations. A student at this same school who participated in the psychoeducational group sessions was absent during the individual post-assessment (PSPCSAYC). Both students were removed from the data sets used to address Hypothesis 2 and 3 respectively.

A student at another school voluntarily dropped out of the study, and was not included in any of the data sets. This student had been randomly assigned to the psychoeducational group. Furthermore, a teacher at this school did not complete the TRF post-assessment on two of the students until after Winter Break. One of the students had participated in the CCGPC group and the other student had participated in the psychoeducational group. Even though the assessment was completed after the Winter Break, the data for both students was included in addressing Hypothesis 1 and 4.

While there were 79 students who participated in the group study, in light of the concern with some of the participants data, the following number of participants were used for each hypothesis: 71 participants for Hypothesis 1, 70 participants for Hypothesis 2 and 4, and 69 participants for Hypothesis 3. The data were examined for

outliers, normality, and homoscedasticity. There were no missing data with the exception of the post-test data listed above.

Since this sample size was not large, the researcher did check for skewness and kurtosis. There were two subscales that showed kurtosis of over absolute value 3 (TRF Aggression and TRF Social Problems). These outlier scores were removed, which showed a kurtosis of less than absolute value 3. Homogeneity of variance was examined with Levene's test showing no concerns. A two-way within-subject and between group analysis of variance (ANOVA) was conducted to evaluate the effect of a group intervention from pre to post assessments within each group and between the three groups (i.e. CCGPC, psychoeducation, and control group). An a priori alpha level of .05 was established as a criterion for determining statistical significance. Effect size of eta squared was calculated to determine the practical significance of the results. Partial eta squared effect sizes were calculated to determine treatment effect for magnitude of the difference that could be attributed to the treatment and practical significance (Baggerly & Bratton, 2010; Blanco, 2010). The guidelines for η^2 effect size for practical significance followed those stated by Cohen (1988): .01 = small, .06 = medium, and .14 = large. The hypotheses were tested and what follows are the results of the data collected.

RESULTS

Research Question 1 and Hypothesis 1

Research question 1 focused on examining externalizing problem behaviors as measured by the difference between the pre- and post-test scores on the TRF (Attention, Aggression, Rule Breaking subscales, or the composite scale of Externalizing Behavior). A two-factor Repeated Measure ANOVA was used for each

of the subscales to test this hypothesis. The analysis of the main effect for group indicated a statistical and practical significant difference between pre- and post-test for Attention, $F(1, 68) = 31.59$, $p < .01$, partial $\eta^{2\,=}$= .317. Regardless of the group, all students' scores were higher on the pre-test (M = 64.13) than the post-test (M = 60.06). The interaction between test time and group was not statistically significant, $F(2, 68) = 1.55$, $p = .22$, partial η^2 = .044. The small effect size of the interaction (partial η^2 = .044) indicated practical significance. Likewise, the analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Aggression, $F(1, 65) = 14.44$, $p < .01$, partial η^2 = .182. Regardless of the group, all students' scores were higher on the pre-test (M = 62.87) than the post-test (M = 60.44). The interaction between test time and group showed no statistical significance, but a small effect size showed some practical significance, $F(2, 65) = .58$, $p = .57$, partial η^2 = .017. Also, the analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Rule Breaking, $F(1, 68) = 15.69$, $p < .01$, partial η^2 = .187. Regardless of group, all students' scores were higher on the pre-test (M = 61.58) than the post-test (M = 58.72). The interaction between test time and group did not show either statistical or practical significance, $F(2, 68) = .22$, $p = .81$, partial η^2 = .006. Lastly, the analysis for the main effect for group indicated a statistically significant difference between pre- and post-tests for the composite score of Externalizing Behavior, $F(1, 68)$ = 12.58, $p < .01$, partial η^2 = .156. Regardless of the group, all students' scores were higher on the pre-test (M = 63.23) than the post-test (M = 60.72). The interaction between test time and group showed no statistical significance, but a small effect

size showed some practical significance, F(2, 68) = .39, p = .68, partial η^2 = .011. Post hoc tests were not conducted on any of the scores since the test time by group interaction was not significant. Hypothesis 1 stated that the difference between reports on TRF pre- and post-test scores assessing externalizing behavior would show that CCGPC is as effective as the psychoeducational group program when compared to a control group. This hypothesis was accepted for all analyses.

Research Question 2 and Hypothesis 2

Research question 2 focused on examining externalizing problem behaviors as measured by the difference between the pre- and post-test scores on the DOF (Attention Problem, Intrusive or Oppositional subscales). A two-factor Repeated Measure ANOVA was used for each subscale to test this hypothesis. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-test for Attention, F(1, 67) = 30.05, $p < .01$, partial η^2 = .310. Regardless of the group, all students' scores were higher on the pre-test (M = 61.23) than the post-test (M = 55.60). The interaction between Test Time and Group showed no statistical significance, but a small-effect size showed some practical significance F(2, 67) = .67, p = .52, partial η^2 = .020. Likewise, the analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Intrusive, F(1, 67) = 16.01, $p <$ .01, partial η^2 = .193. Regardless of the group, all students' scores were higher on the pre-test (M = 63.30) than the post-test (M = 58.96). The interaction between Test Time and Group did not show either statistical or practical significance, F(2, 67) = .29, p = .75, partial η^2 = .009. Lastly, the analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for

Oppositional, F(1, 67) = 13.34, $p < .01$, partial $\eta^2 = .166$. Regardless of the group, all students' scores were higher on the pre-test ($M = 62.47$) than the post-test ($M = 58.46$). The interaction between Test Time and Group did not show either statistical or practical significance, F(2, 67) = .25, $p = .78$, partial $\eta^2 = .007$. Post hoc tests were not conducted on any of the subscales since the test time by group interaction was not significant. Hypothesis 2 stated that the difference between pre- and post-test scores using classroom observations to assess externalizing behavior would show CCGPC to be as effective as the psychoeducational group program when compared to a non-therapeutic control group. This hypothesis was accepted for all analyses.

Research Question 3 and Hypothesis 3

Research question 3 focused on the difference in social skills as measured by the difference between pre- and post-test scores on the Peer Acceptance subscale of the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter, 1983). A two-factor Repeated Measure ANOVA was used for the Peer Acceptance subscale to test this hypothesis. The analysis of the main effect for group did not indicate a statistically significant difference between pre- and post-tests for Peer Acceptance F(1, 66) = .18, $p = .67$, partial $\eta^2 = .003$. The score should increase to show positive results on social skills; however, the total group score was higher on the pre-test ($M = 2.92$) than the post-test ($M = 2.89$). It should be noted that the students' scores for the CCGPC groups actually increased between pre-test ($M = 2.83$) and post-tests ($M = 2.96$). The interaction between Test Time and Group did not show statistical significance, but the small effect showed some practical significance, F(2, 66) = 1.13, $p = .33$, partial $\eta^2 = .033$. Post hoc tests were not conducted because the test time by group

interaction was not significant. Hypothesis 3 stated that the difference between child's self-reports on pre- and post-test scores assessing social skills would show CCGPC to be as effective as the psychoeducational group program when compared to a non-therapeutic control group. This hypothesis was not accepted.

Research Question 4 and Hypothesis 4

Research question 4 focused on the difference in social skills as measured by the difference between the pre- and post- tests scores Social Problems subscale of the TRF. A two-factor Repeated Measure ANOVA was used for the Social Problems subscale to test this hypothesis. The analysis of the main effect for group indicated a statistically significant difference between pre- and post-tests for Social Problems, $F(1, 61) = 7.60$, $p < .01$, partial $\eta^2 = .111$. Regardless of the group, all students' scores were higher on the pre-test ($M = 60.13$) than the post-test ($M = 57.61$). The interaction between Test Time and Group did not show statistical significance, but the small effect showed some practical significance, $F(2, 61) = .36$, $p = .70$, partial $\eta^2 = .012$. Post hoc tests were not conducted because the test time by group interaction was not significant. The participants in all of the small groups improved significantly between pre- and post-tests on the TRF subscale of Social Problems; however, there was no significance between any of the groups. Hypothesis 4 stated that the difference between teacher reports on pre- and post-test scores assessing social skills would show CCGPC to be as effective as the psychoeducational group program when compared to a non-therapeutic control group. This hypothesis was accepted.

Qualitative Data

One qualitative assessment tool was the self-assessments that all the children completed at the conclusion of session one, four, and eight. Many comments on the self-assessments were related to how much the children liked the groups. One student in the CCGPC group wrote on the session eight self-assessment, “I would try to be really ‘[h]onest’ to my friends a lot of times.” Sixteen of the twenty-four students in the CCGPC groups indicated in the session eight self-assessments that they learned new skills they were using in school. Also in session eight, comments from those in the psychoeducational groups indicated that 11 of 21 students agreed they learned new skills that were being used in school. Contrary to what might have been expected, 13 of 19 students in the non-therapeutic control group also agreed that they learned new skills that were being used in school.

Another qualitative assessment was the comments that the school counselors wrote on their fidelity checklists. One of the school counselors who facilitated a control group stated that two children were talking with each other about their families while drawing a picture. One child said that her mom was in the hospital for using drugs again, and the other stated that her dad was in jail for trying to kill her mom. The school counselors in these groups emphasized that they did not process these comments with the children. One of the counselors for the CCGPC groups noted during the first session, “two kids knew each other and two others felt like outsiders; however, when the handcuffs came out they took turns with handcuffs. Then the boss tried to make sure everyone was included. At the end, the boss said it was the best day ever.” School counselors reported that the children enjoyed the experience of being the one in charge,

and they looked forward to the week that they were in charge. Two school counselors noted that when one of the students was absent, the others said they were disappointed. One group told the counselor that it wasn't the same, nor as much fun without the absent student. In one school, they were finishing up their last group session during the week prior to Winter Break. Children in the CCGPC group chose to go to group, even though they knew they would miss their classroom holiday activities. Several participants in the psychoeducational groups opted to stay in the classroom to participate in the classroom holiday activities. School counselors made comments on the learning that occurred during the CCGPC groups. One of a child's comment, as told by one of the school counselors was, "I'm learning to do things I don't want to do. I even have played with my little brother." Another school counselor stated, "Each child is very nurturing." Another school counselor commented after the last session of CCGPC, "So awesome how every child could be who they really are in guided play. It works!"

DISCUSSION

Lack of Significant Differences between the Groups

One explanation for the significant difference in pre-test and post-test assessments for all groups including the control group might be due to the Hawthorne Effect, a belief that improvement will occur simply because the participants receive special treatment and they know they are participating in a study. Results of the research of the Hawthorne Works of Western Electric Company in the 1920's showed that lighting had no effect on worker productivity (Adair, 1984; Izawa, French & Hedge, 2011). The study that used a control group and found that worker productivity of the control group increased as much as the productivity of those who received variations in illumination (Adair, 1984; Izawa,

French & Hedge, 2011). Adair, in a review, has indicated that the Hawthorne assumption has been attributed to three variables: special attention, awareness of participation in an experiment, and novelty. The current study clearly provided all three of the criteria in that children were given special attention by leaving the classroom with three of their peers. Children signed an assent read to them by the school counselor. This made them aware of their participation in a research study. Finally, the groups provided a novelty due to the nature of the playful and varied activities.

Another explanation for the significance in all of the groups is the belief in the power of the relationship between the child and the counselor. The task force sponsored by the American Psychological Association (APA) Division of Psychotherapy and the Division of Clinical Psychology concluded that the counselor relationship with the client accounts for why clients improve or fail to improve (Norcross, 2011). One characteristic of the counselor relationship is empathy. In another meta-analytic review of 57 studies, empathy, as expressed by the counselor, predicted treatment outcome regardless of the theoretical orientation (Elliott, Bohart, Watson, Greenberg, 2011).

According to the above studies, improvement occurs in counseling as a result of the counselor relationship and empathy expressed by the counselor, regardless of the treatment approach. In the control group, the school counselors did not process the moral of the Aesop fable or talk about how it applied to the children; however, the participants had a relationship with the counselor and they felt comfortable sharing with others in the group. In retrospect, the Aesop's fables that were used in the control group could have triggered a struggle in the child between good and evil and presented a subliminal message. Jungian play therapists might suggest that this control group actually provided

another type of play therapy approach. A better research design might have been a no-treatment control group, where students did not meet until after the conclusion of the study. In the "no treatment" approach, Hawthorne Effect could be eliminated because the students would not be pulled from class and there would be no novelty effect. The parents and children would still sign consent and assent forms, and be told that their group experience would be held at a later time.

The lack of significance between the groups could be explained by the short period of time between the pre- and post-test. Not only was it difficult to complete the eight weekly group sessions before Winter Break, but one might ask if the effect of the group intervention could be realized in such a short period of time. As difficult as it was to complete eight weekly sessions, several studies show that a minimum of 16 sessions is optimum for therapeutic value (Bratton, Ray, Rhine & Jones, 2006; Muro, Ray, Schottelkorb, Smith & Blanco, 2006). This research guideline would have meant extending the groups for an additional eight weeks, which might have been beneficial given the concern with challenging behaviors prior to the holiday break.

Lack of Significant Differences in Pre- and Post-Scores on PSPCSCYC

The PSPCSCYC is a self-perception assessment used for young children who may not be able to read or write. The Peer Acceptance subscale that was used for this study focused on the child's perception of his or her relationship with peers. It is possible that during the weeks of the current study the participants became more aware of their interrelationship with others. Cognitively, the participants began to reason more logically, or they saw the discrepancy between their abilities and others. Also, during this developmental stage of life, the participants might have struggled with the task of

industry versus inferiority, according to Erikson's stages of development (Santrock, 2009). They might have a greater sense of inferiority as they move into the early months of the school year. While the teachers began to see signs of growth in the participants' relationship with their peers, the children did not yet make that connection.

Implications for Counselor Educators and School Counselors

The Association for Play Therapy (APT) encourages universities to provide a play therapy elective within their graduate counseling programs, which could provide the basic knowledge for counseling interns to learn to work with children. An objective of a sample play therapy syllabus (Association for Play Therapy, 2010) for an introductory play therapy course is to focus on identifying developmentally appropriate toys and materials for the practice of play therapy. Another objective is for class participants to demonstrate basic play therapy skills (Association for Play Therapy, 2010). Such skills would include tracking, reflecting of content and emotions, and limit setting. Some suggested activities for an introductory play therapy course could include observation of a play therapist conducting a child session and then practicing by role-playing with another class member.

School counselors in the elementary school see children through age 11 or 12. They get to see children change developmentally both cognitively and emotionally. School counselors are also an integral part of the team process. Interventions are chosen to help children with behavioral development that in turn helps them be academically successful (ASCA, 2005). School counselors can use a group model that would not require additional planning time, and still aid in decreasing disruptions in the classroom and increasing social skills.

In the CCGPC model, once a room is set up and the group selection is made, there is little planning needed. Additionally, there is no need for lesson plans that require specific materials, and gender and age can be mixed. As long as there is no more than one grade level difference, even grade levels can be mixed.

It is accepted that psychoeducational groups teach skills, but the school counselors in this study saw that learning occurred during the CCGPC groups. Children in the CCGPC groups stated that they were doing things that they had not previously done. The qualitative self-assessments from session eight showed that most students in the CCGPC groups felt that they had learned new skills that they were using in school.

The population included in this study was primarily Caucasian (62%). CCGPC can be adapted to any environment by choosing appropriate toys and materials familiar to the participants. Further research should explore urban, rural, and even international populations using the CCGPC model to examine the effectiveness of these groups with diverse populations.

Conclusion

In summary, the results of this study supported three of the four hypotheses, which suggests that CCGPC group counseling is as effective as the evidence based psychoeducational model when used with children with externalizing behavior problems or poor social skills as measured by teacher reports and classroom observations. The third hypothesis was not supported, which suggests that the children who participated in the groups did not perceive that they had improved in their social skills with their peers, even though the teachers believed that the students had improved. This study gives

impetus for more counselors to utilize the Child-Centered therapy model in various settings including schools, agencies, hospitals, and private practice.

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