Running head: PLAY THERAPY IN A PRIMARY SCHOOL SETTING

The Use of Child Centered Play Therapy in a Primary School Setting

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Table of Contents

List of Tables

Abstract

This paper is divided into four Sections: 1) Introduction, 2) Methods, 3) Results, and 4)

Discussion. The Introduction begins by explaining the purpose and significance of the current

study as well as the research hypothesis and objective. Next, the recent growing concern about

school violence and its link to childhood social skills is discussed. The social characteristics of

students involved in school violence are then outlined followed by a description of various

school violence prevention programs and the role of school counselors in preventing school

violence. Next is a description of several specific types of social skills training groups and

typical problems found with such groups. The function of play with regard to childhood

development is then discussed followed by an introduction to Child Centered Play Therapy. The

benefits of Child Centered Play Therapy in the school system, particularly with high-risk

students who show signs of aggressive or shy and withdrawn behaviors are then summarized.

Next is a discussion of the nature and benefits of group Child Centered Play Therapy as well as

the potential effectiveness of combining Child Centered Play Therapy with a social skills

training group for the treatment of high-risk students. The Introduction Section ends with a brief

conclusion based on the literature reviewed. The Methods Section is divided into three

subsections. The first identifies the characteristics and demographics of the study participants.

The next subsection outlines the psychometric properties of the instrument used to measure the

study outcomes. The third and final methods subsection describes the procedures utilized in the

study. The Results Section includes the raw data obtained for both the experimental and control

groups. The data is presented in Tables 1 and 2, which are included in the Results Section. The

Discussion Section follows with four subsections. The first includes information about the

results in relation to the research question and hypothesis of the current study. The second

subsection links the results of the current study to previous theory and research. The third

subsection discusses the limitations of the current study while the fourth includes suggestions

and recommendations for practice and future research.

The Use of Child Centered Play Therapy in a Primary School Setting

Perpetrators of school violence have often been the victims of peer aggression (Dill, Vernberg, Fonagy, Twemlow, & Gamm, 2004; Dwyer, Osher, Warger, 1998; Gazelle & Ladd, 2002; Glasser, 2000; Sandhu, 2000; Vossekuil, Reddy, Fein, Borum, & Modzeleski, 2000). Because of this connection, anti-bullying and character education programs in schools have become popular methods used in an attempt to improve the social and emotional health of students (Carlson, 2003; Dill et al.; Gazelle & Ladd; Orpinas, Horne & Staniszewski, 2003; Schaefer, Jacobsen, & Ghahramanlou, 2000; Shechtman, 2002;). These programs often involve groups that teach social skills. Such groups may not, however, help high-risk students who are in need of psychotherapy (Shechtman) nor do they necessarily ensure generalization of the newly learned skills to other settings (Evans, Axelrod, & Sapia, 2000; Schaefer et al). In addition, groups focusing on the acquisition of social skills often ignore the importance of experiential learning (Landreth, Baggerly, & Tyndall-Lind, 1999; Shechtman), instead focusing on language acquisition and verbal skills, in which children are lacking (Landreth et al.). Child Centered Play Therapy utilizes the child's natural form of communication and is effective with children who demonstrate the social and behavioral characteristics that indicate a potential for future high-risk behavior (Barrett, 1975; Brandt, 1999; Dogra & Veeraraghavan, 1994).

Purpose and Significance of Study

This study seeks to provide evidence that Child Centered Play Therapy is effective in improving the social/emotional health of primary school students. It is the author's hope that this study will a) support in the advocacy of school counseling programs and positions, especially primary and elementary counselors, which are typically not mandated positions, b) demonstrate that counseling, more specifically Child Centered Play Therapy, can serve as a adjunct to the

learning environment by helping students maximize their school experience, and c) demonstrate that early identification and intervention is effective toward addressing social/emotional concerns in the classroom.

Research Hypothesis and Objective

The current study seeks to provide evidence that students who are involved in both a social skills counseling group and Child Centered Play Therapy will make more progress with social/emotional growth in the classroom than those who are involved in only the social skills counseling group.

School Violence

School shootings during the past few years have brought the issue of school violence and its relationship with bullying and social aggression to the forefront of America's thinking (Dill et al., 2004; Gazelle & Ladd, 2002). According to the U.S. Department of Education and the U.S. Department of Justice (2003), 32 school associated violent deaths occurred in the United States between July 1, 1999 and June 30, 2000. Of these deaths, 24 were homicides and 8 were suicides. This same report indicated that, in the year 2001, 20% of all public schools experienced at least one serious violent crime such as rape, sexual assault, robbery, and aggravated assault.

Orpinas et al. (2003) stated that serious injury or death at school due to interpersonal violence is not common, however, the prevalence of nonfatal physical aggression, verbal taunting, name-calling, and emotional abuse is quite high. Students between the ages of 12 and 18 were found to be victims of approximately 2 million nonfatal crimes of violence or theft at school in the year 2001 and 8% of students reported being bullied in school within the previous six months (The U.S. Department of Education and the U.S. Department of Justice, 2003). Fight Crime: Invest in Kids (2003) reported that 3.2 million students in 6th through 10th grade are

victims of bullying each year, while 3.7 million bully other students.

The Link Between School Violence and Social Skills

The potential to commit acts of violence in school has been correlated with childhood social and emotional problems (Cairns, Cairns, Neckerman, Ferguson, & Gariepy, 1989; Carlson, 2003; Dill, et al., 2004; Fight Crime: Invest in Kids, 2003; Frey, 2000; Furlong, 2000; Vossekuil et al., 2000; Wentzel & Wigfield, 1998) such as depression, loneliness, social dissatisfaction, and school avoidance (Gazelle & Ladd, 2002). According to Carlson, behavioral and social indicators are the most frequent issues identified and discussed with regard to school violence. Those children who are at risk of future behavior problems characteristically lack core social and emotional competencies (Wentzel & Wigfield). Furlong also noted that attitudes held by students are associated with involvement as perpetrators or victims of violence and pointed out the importance of continued examination of the characteristics of students who are involved in violence.

Characteristics of Students Involved in School Violence

Dwyer et al. (1998), Glasser, (2000), and Sandhu, (2000) reported that alienation, disaffection, powerlessness, and revenge were all motivating factors for students committing violent acts at school. Dwyer et al. and Sandhu found that some of the students who committed violent acts were alienated from their peers and motivated by rejection. Vossekuil et al. (2000) found that, in two-thirds of the violent acts they examined, perpetrators had been bullied, threatened, or attacked prior to a shooting and more than half were motivated by revenge. Fight Crime: Invest in Kids (2003) also linked peer victimization with emotional difficulties. Their report stated that children who are victims of bullying are five times more likely to be depressed. Bullied boys are four times more likely to be suicidal and bullied girls are eight times more

likely to be suicidal.

According to Gazelle and Ladd (2002) some children are more vulnerable to being victimized than others. Gazelle and Ladd pointed out the importance of identifying and working with potential victims, although it is important not to put the blame or the responsibility of preventing violence on the victim. Victims of social aggression may be passive or provocative (Griffin & Gross, 2004). Passive victims, who are typically described as anxious and insecure, appear to be the most common type of victim and are likely to withdraw when attacked by others. In contrast, the provocative victim is one who is victimized, but might also act as perpetrator. This type of victim typically lacks social skills and generally elicits negative reactions from all children, not just the aggressive ones (Griffin & Gross). This means that the provocative victim is generally friendless, which may increase the child's risk of psychological and social problems (Griffin & Gross).

Dill et al. (2004) found that shy or socially withdrawn children, who were rejected or victimized by peers and believed that aggression was legitimate, reported an increase in negative affect or psychological distress over time. The indication is that negative affect or distress, development of shyness or social withdrawal, and peer victimization have reciprocal influences upon one another. Dill et al. suggested that shyness might be one of the first steps leading to rejection and harassment by peers and might prevent the development of friendships, which, as pointed out by Griffin and Gross (2004), is often a protective factor in bullying situations.

Warden and Mackinnon (2003) investigated links between children's social behavior and popularity, ability to empathize, and social problem solving strategies. They found that prosocial children were more popular than bullies or victims and those victims who also acted as bullies experienced the most amount of peer rejection. In addition, prosocial children demonstrated

more empathy than bullies or victims. Warden and Mackinnon also found that both prosocial

children and victims responded more constructively to socially awkward situations than did

bullies. Finally, bullies were less aware than prosocial children of the potential negative

consequences of their solution strategies.

<center>*School Violence Prevention Programs*</center>

As a result of the violence occurring in the educational system, many schools have

attempted to address the issue by installing metal detectors and increasing locker searches

(Gazelle & Ladd, 2002). Gazelle and Ladd stated that such actions do not alter the problematic

factors that are interacting to produce violence because violence is interpersonal in nature.

Efforts should therefore focus on the individual, family, peer group, community, and societal

problems that are influencing the violence. Because violence occurs between people, efforts to

reduce violence should focus on developing strong, healthy relationships between people

(Gazelle & Ladd).

Carlson (2003) and Dill et al. (2004) stressed the importance of prevention programs and

policies in schools due to the increasingly apparent connection between victimization and

resulting psychological and social outcomes, including school violence. Evans et al. (2000)

stated that the severity of children's mental health problems, such as low self-esteem, antisocial

behavior, and interpersonal problems (Schaefer et al., 2000) that stem from negative peer

interactions warrant prioritizing the development and implementation of effective school based

interventions. Orpinas et al. (2003) pointed out that many schools have begun implementing

some strategies, policies and/or programs to prevent or reduce school aggression. These

programs typically seek to diminish risk factors and increase protective factors with the purpose

of minimizing violence.

According to Gazelle and Ladd (2002), it is important that interventions are long term solutions that address relational problems through the promotion of healthy relationships and social emotional adaptation for vulnerable children. Effective prevention programs should not only attempt to decrease peer victimization, but should also focus on increasing social and self-regulatory skills to help children cope with emotional distress (Dill et al., 2004; Gazelle & Ladd).

In a 2003 report, The National Association of School Resource Officers stated that over 70% of School Resource Officers surveyed felt that, in the previous five years, aggressive behavior among elementary school children had increased significantly. This information supports the notion that high-risk behavior is increasing and intervention efforts should begin at an early age. Research suggests that early intervention can prevent some of the psychological distress accompanied by victimization (Dill et al., 2004; Dwyer et al., 1998; Gazelle & Ladd, 2002; Glasser, 2000) and can alter aggressive behaviors before they are solidified (Cochran & Cochran, 1999).

Character education programs are designed to help children develop character traits that will enhance their understanding of self and their relationships with others (Pearson & Nicholson, 2000). Such programs are generally school wide approaches that include focus groups, school assemblies, hall displays, school and community projects, classroom rules, positive language, phrasing choices, direct instruction, learning partners, appreciation time, mentoring, journal writing, cooperative activities, literature based discussions, class meetings, parent links, counseling consultation, parent education, conflict resolution training, individual and group counseling, and social skills instruction (Pearson & Nicholson).

The Role of School Counselors in School Violence Prevention

School violence interferes with student success in school (Dahir, 2000). Thus, it is

important for school counselors to address school violence in order to have a positive impact

upon student success. According to Dahir, school counselors can have a positive impact on

student academic and social success by impacting the school environment and creating a

community that is positive and productive. Due to counselor training and the roles they ideally

fulfill in the schools, it is logical to view these professionals as a vital resource in violence

prevention (Dahir).

Increasingly, task forces addressing the issue of school violence and social aggression are

recognizing the role of counseling in the educational system:

- The Louisiana Department of Education (1998) called for placing a higher priority on

  counseling services.

- The New York Task Force on School Violence (1999) recommended that counselors

  participate in developing strategies to involve parents in their children's development and

  include families in counseling sessions.

- The Massachusetts Task Force, the Governor's Advisory Council on Youth Violence (1999),

  advocated for school counselors to be included in enhanced training for responding to violent

  youth.

- North Carolina's Task Force, Governor's Task Force on Youth Violence and School Safety

  (1999), advocated for additional study of the role of the counselor to determine how to

  enhance direct contact with students.

- South Carolina's Safe School Task Force (1999) called for a reduction in student-counselor

  ratios at all grade levels and for redefining the role of counselors to enable them to counsel

  and work directly with students.

Dahir (2000) stated that, because the goal of education is to produce individuals who can

effectively contribute to society, a competent school-counseling program supports success for all

students. Dahir further stated that school counselors should be perceived as partners in the

teaching and learning process. Cochran and Cochran (1999) indicated that, by providing services

to all students with emotional concerns and mental health needs, school counselors can improve

students' abilities to learn and grow and can enable teachers to spend more time and energy on

actual teaching. Cochran and Cochran specifically discuss the impact that children with conduct

disorder have on schools and classmates. Because the behavior of the child with conduct

disorder tends to violate the rights of others and disrupt the general school atmosphere, school

counselors inevitably spend much of their time listening to and assisting victims of the student

with conduct disorder. The same is true for their teachers and other school personnel. By

providing effective intervention in such situations, Cochran and Cochran pointed out that these

students, as well as those impacted by their behaviors, are provided with increased opportunities

to capitalize on the educational experience.

<center>*Group Work in Schools*</center>

Shechtman (2002) stated that schools are recognizing an increased need for

psychotherapy and are responding with the cost effective approach of group work. Shechtman

advocated for increased use of group psychotherapy in schools due to the recognition of

increased social and emotional needs of children, its proven effectiveness, its cost effectiveness,

and the unlikelihood that children will receive treatment outside the school setting.

Shechtman (2002) described three types of groups schools are currently utilizing: a)

educational/guidance, b) counseling, and c) therapy. Educational/guidance groups, which

primarily focus on social skills training, are generally used for primary prevention and typically

targeted for entire student populations. This type of group, often conducted by teachers, is

generally provided to improve classroom behavior, school performance, and peer relationships. Educational/guidance groups, according to Shechtman, are not likely to yield intrapersonal gains in self-esteem or locus of control. Such intrapersonal skills help children cope with emotional distress and are factors that likely decrease the potential for peer victimization (Gazelle & Ladd).

Counseling groups, typically led by mental health professionals, target children and adolescents who experience some developmental difficulties for which they need special assistance (Shechtman, 2002). Counseling groups are small groups and treat areas of deficit, focusing on self-esteem and social difficulties. Such groups encourage close relationships, sharing of private information, and the exchange of support and feedback. Counseling groups, according to Shechtman, can help to increase insight for those students who have mild difficulties.

The third group described by Shechtman (2002) is the therapy group. The therapy group is a small group conducted by an expert, which is aimed at those students who have severe adjustment or behavioral problems. According to Shechtman, the therapy group is effective with highly aggressive children. All three group types are appropriate for use in the schools and, when used together, can offer a comprehensive approach to treatment (Shechtman).

Specific Types of Social Skills Training Groups

To combat problems with social aggression and bullying, many schools have initiated social skills training groups which attempt to teach students social skills and enhance their overall social competence. Schaefer et al. (2000) stated that the development of appropriate social skills in a child is an important foundation for the establishment of adequate peer relationships, considered a protective factor in bullying situations (Griffin & Gross, 2004). Social skills groups are currently one of the most frequently practiced mental health interventions in

schools. Therefore, various programs have been developed in an effort to enhance social

competency for both aggressors and victims.

Schaefer et al. (2000) presented a 10-session social skills curriculum to enhance

children's social knowledge, help children translate their concepts into skillful interpersonal

behaviors, and foster skill maintenance and generalization of the newly learned social

competencies. This model uses an active and direct teaching approach based on the assumption

that social skills deficits lead to peer isolation and rejection (Schaefer et al.).

Salmon (2003) advocated for the use of the PEACE curriculum in schools to prevent

aggression and improve interpersonal skills. The PEACE curriculum includes parent

involvement, empathy training, anger management, character education, and essential social

skills training. Salmon put emphasis on the empathy-training portion of this program because,

she points out, violent students are fairly single minded in terms of feelings; most of them feel

only anger. Salmon stressed that empathy is critical in the development of positive social

behavior and is a critical skill needed in the world of work and in the world of relationship

building.

Fox and Boulton (2003) developed and evaluated the Social Skills Training (SST)

Program based on the notion that the behavior of the victim in some way contributes to their

victimization. They suggested that if victimized children can improve their social skills and

change how they behave with the bully, they would experience a reduction in victimization. Fox

and Boulton identified and discussed the possibility that poor social skills may result from either

skills deficit or competing emotions. Competing emotions refers to an excessive emotional

arousal, which interferes with the child's ability to respond appropriately in bullying situations.

The SST program, therefore, included social skills training as well as relaxation training and

cognitive therapy to address the interfering thoughts and emotions.

The Aim of the SST program was to help improve children's social skills and subsequently reduce individual risk to victimization (Fox and Boulton, 2003). The SST program attempted to 1) reduce behaviors which signal to others that he is an easy target, such as looking weak or scared, and 2) reduce behaviors that reinforce the bully's behavior, such as crying and surrendering. In a study, Fox and Boulton used the SST program, teaching socials skills and coping strategies to 28 nine to eleven year olds in an effort to help them make and maintain friendships. The social skills taught, included how to start and maintain conversations, how to join in with other kid's games, and how to give compliments and share things with others. The program also taught children verbal and non-verbal strategies, such as relaxation techniques, to help them deal with being bullied.

Evaluation of the SST program showed an increase in self-esteem for the experimental group, but no other significant improvements, in terms of social skills problems or victim status (Fox & Boulton, 2003). Fox and Boulton argued that, despite the limited success across multiple factors, as assessed in this particular study, increased self-esteem is a strong component necessary for reduced vulnerability to victimization. Therefore, they promote victim support groups as an important intervention and evaluate them to be beneficial, even if it does not lead to noticeable changes in behavior.

DeRosier (2004) stated that peer relationship problems are prevalent in schools and significantly influence children's school based adjustment, as well as increasing the risk for future negative outcomes. DeRosier developed a generic social skills group intervention (S.S.GRIN) that could be applied to a wide variety of social problems by targeting both prosocial and inhibitory skills. She utilized the program with 187 third grade students who were highly

disliked, socially anxious, and the victims of bullying. She found that, in comparison with the control group, the students who participated in S.S.GRIN showed increased peer liking, enhanced self-esteem and self-efficacy, along with decreased social anxiety. It was equally efficacious for all subtypes of peer problems targeted. Additionally, findings showed greater declines in aggression and bullying behavior and fewer antisocial affiliations.

Problems with Social Skills Training Groups

Evans et al. (2000) stated that the school setting is ideal for social skills training, as it provides the opportunity for both, individualization and generalization of skills with which children typically have difficulty. Evans et al. pointed out that social skills groups are one of the most frequently practiced mental health interventions in schools, though they typically result in minimal change because of failure to ensure that individualization and generalization to other settings takes place. Schaefer et al. (2000) questioned whether or not the gains made in social skills training sessions are maintained in natural settings, thus having a widespread and lasting impact. They indicated that even in studies producing significant gains in the treatment group's level of peer acceptance, approximately 40% of the individual children do not make such gains outside the sessions.

Typically, the same model of social skills training is applied to all children regardless of the presenting problem and is based on the assumption that children lack social knowledge (Evans et al., 2000; Gumpel & Golan, 2000). However, according to Evans et al., Gumpel, and Golan, many children know what to do, but lack the skills to do it. It is, therefore, important to know the type of deficits involved, as well as the factors contributing to the deficits. Such factors may include a lack of knowledge, lack of performance, or lack of social reinforcement (Evans et al.; Gumpel & Golan). Fox and Boulton (2003) also addressed the importance of matching the

intervention to children's deficits when choosing to teach social skills or address the issue of competing emotions and cognitions. Another difficulty found, with typical social skills training groups, is that adults frequently make the mistake of teaching skills that they think are appropriate. While often, these are not the skills that lead to peer acceptance amongst young children and within their specific social environment (Evans et al., 2000).

Conflict resolution training has also become a program frequently implemented in schools (Pearson & Nicholson, 2000). Cochran, Cochran, and Hatch (2002) pointed out that most conflict resolution models focus on negotiation, mediation, or arbitration. They emphasized that such approaches often position the adult in the role of problem solver. When adults focus on the need to think of a solution or give advice, children doubt their ability to solve their own problems. Children, therefore, lost valuable opportunities to efficiently and creatively resolve conflicts, impeding the development of empathy, self-efficacy, and meaningful friendships (Cochran et al.). However, some conflict resolution training programs (Bickmore, 2002; Johnson & Johnson, 1994, 2004; Stevahn, Munger, & Kealey, 2005) have been specifically designed to place children in the role of problem solver, mediator or arbitrator. Such programs have shown positive results. For example, the conflict resolution training program developed by Johnson and Johnson (1994) decreased teacher-managed conflicts by 80%.

Shechtman (2002) indicated that schools are the ideal location for psychological and emotional interventions, although she points out, schools typically utilize cognitive behavioral approaches. Possibly, because schools often limit themselves to the treatment of children's cognitive functioning. Additionally, cognitive behavioral approaches are generally structured, time limited, and short-term which is conducive to the school environment (Shechtman). Such approaches provide guidance and training in areas of social skills deficits. They do not, however,

provide the opportunity for experiential learning (Shechtman). According to Landreth, Baggerly, and Tyndall-Lind (1999), traditional school counseling approaches often ignore the importance of experiential learning, instead focusing on language acquisition and verbal skills, in which children are lacking.

In response to increasing concerns for the safety of our youth, schools are adopting programs that typically focus on teaching social skills and moral principles such as responsibility and self-control (Pearson & Nicholson, 2000). Landreth (2002a, 2002b) stated that such principles can not be taught to children. Rather, according to Landreth (2002b), responsibility and self-control must be learned through experience. Play provides children with such experiential opportunities (Landreth, 2002a, 2002b). According to Landreth, Baggerly, and Tyndall-Lind (1999), it is essential to recognize how a child's cognitive, emotional, physical and psychological differences affect his ability to communicate. Because children do not have the ability to communicate verbally, play allows them to communicate in a way that meets their unique needs (Landreth, Baggerly, & Tyndall-Lind).

The Functions of Play

Bergen (2002), Gmitrova, Gmitrov (2004), Hendler Lederer (2002), Saltz, Dixon, and Johnson (1977) discussed the importance of play in a child's cognitive, social, and academic development. In a study on preschoolers, Saltz et al. found that physical enactment of fantasy experiences had a sizable effect on cognitive development and impulse control. Gmitrova and Gmitrov used a play intervention method in various small mixed-age groups that was found to be effective in enhancing the development of social and cognitive abilities. They found that children thought more, learned more, remembered more, spent more time on task, and were more productive in well-implemented cooperative groups than in directive, competitive structures and

organization of the playing process. The children in the experimental group exhibited less

reliance on the teacher and greater reliance on peers for help in care taking and problem solving

situations. This resulted in a significant increase in cognitive functioning. Prosocial and creative

play has also been found to improve verbal intelligence, ability to form concepts or define words,

and the capacity for verbal associative thinking (Garaigordobil Landazabal, 2005).

Bergen (2002) stated that, due to increased emphasis on standardized test performance,

many schools have unfortunately reduced the amount of time focused on play activities, while

increasing direct instruction time. This shift from play to direct instruction ignores the role that

play has on cognitive abilities, such as metacognition, problem solving, and social cognition

(Bergen). Play, according to Bergen, also facilitates academic readiness in areas such as literacy,

mathematics, and science. Sturgess (2003) also discussed the increasing threats and limits to

children's play and the resulting effects on healthy childhood development. Sturgess advocated

for the adequate allocation of time and space for children's play.

According to Landreth (2002a), play occurs at all times in all places and is the singular

central activity of childhood. According to Landreth (2002a), it is essential that play not be

confused with work. Work is goal focused and directed toward accomplishing a task by

accommodating the demands of the immediate environment (Landreth, 2002a). Conversely, play

is intrinsically complete and does not depend on external rewards (Landreth, 2002a). Play

assimilates the world to match the child's concepts (Landreth, 2002a).

Play is valuable in that it allows the child to discharge energy, act aggressively in socially

acceptable ways, learn to get along with others, achieve difficult goals, relieve frustrations, and

prepare for the duties of life (Landreth, 2002a). Symbolic play, according to Landreth (2002a),

allows the child to change experiences that seem unmanageable in reality into manageable

situations. This provides a sense of control and security. Through engagement in self-directed

exploration, symbolic play provides the child with an opportunity to cope effectively with life's

difficulties and engage in a self-healing process (Landreth, 2002a; Landreth, Baggerly, &

Tyndall-Lind, 1999).

Child Centered Play Therapy

Child Centered Play Therapy was developed in 1947 by Virginia Axline (1947). As a

student of Carl Rogers, Axline's rationale for Child Centered Play Therapy was based on

Roger's (1957) philosophy of personality development and his corresponding person centered

approach to psychotherapy (Guerney, 2001). Rogers proposed that, for constructive personality

change to occur, six basic conditions are necessary and sufficient. The conditions include: 1)

awareness of personal and psychological contact between two people, 2) the client's state of

incongruence, 3) the therapist's state of congruence and genuineness, 4) the therapist's

experience of unconditional positive regard, 5) the therapist's experience of empathy for the

client, and 6) the communication to the client of the therapist's empathic understanding and

unconditional positive regard.

Consistent with Roger's (1957) theories, the therapist ensures that the experience strictly

remains the child's statement of his self. This is accomplished by keeping the therapist's

attitudes, feelings, judgments, suggestions, rebukes, praises, approvals, and disapprovals out of

the experience and the relationship (Axline, 1982). The therapist, as an accepting and

appreciative presence, becomes the audience before which the child plays out his innermost

feelings and attitudes (Axline, 1982). Through the child's medium of communication, which is

play, he is given a safety zone in which to externalize his inner self (Axline, 1982). Thus, he is

able to know himself better and, it is through this increase in self-knowledge that he is able to

utilize his capacities in more adequate ways (Axline, 1982).

Guerney (1982) outlined the unique tenets of child-centered play therapy, which, she pointed out, distinguishes it from all other play therapy methods. First, the child, not the therapist, directs the content of the therapy. Second, the approach is focused on the child, not the symptom or problem. Third, the child's internal frame of reference is fully accepted by the therapist. Fourth, the approach must be followed in its totality. Fifth, practitioner's utilizing the approach must be deeply committed to the tenets and principles on which it is based.

According to Landreth, Baggerly, and Tyndall-Lind (1999), the objective of Child Centered Play Therapy is to provide the child with a positive growth experience in the presence of an understanding, supportive adult who responds in ways that enable and empower children to discover their internal strengths. Play therapy provides the child with an arena in which to act out a wide range of experiences and feelings (Guzzi DelPo & Frick, 1988; Landreth, 2002b). The therapeutic relationship developed during child-centered play therapy provides a means through which conflicts can be resolved and feelings can be communicated (Guzzi DelPo & Frick; Landreth, Baggerly, & Tyndall-Lind).

Landreth (2002a) indicated that it is the therapist's responsibility to interact with the client at his level and to utilize the medium of communication in which the client is most comfortable. Because children lack the cognitive and verbal abilities to express their feelings, play is their natural form of communication (Guzzi DelPo & Frick, 1988; Landreth, 2002a; Landreth, Baggerly, & Tyndall-Lind, 1999). Additionally, children are not emotionally developed to the extent that they are able to focus on the intensity of feelings in a way that can be adequately expressed through verbal means (Landreth, 2002a). Because children are comfortable with play, they will express themselves more fully and more directly during spontaneous and

self-initiated play than they will through verbal expression (Landreth, 2002a; Landreth,

Baggerly, & Tyndall-Lind). In fact, children's feelings are often inaccessible at a verbal level

(Landreth, 2002a).

<div align="center">*Child Centered Play Therapy in Schools*</div>

Child Centered Play Therapy is suitable for use in schools because it is preventative and

appropriate for use with children experiencing a broad range of developmental needs (Landreth,

2002a; Ray, Bratton, Rhine, & Jones, 2001). Landreth (2002a) pointed out that the objective of

elementary schools is to assist in the intellectual, emotional, physical, and social development of

children by providing learning opportunities. The objective of play therapy in this setting is to

help children derive benefits from the learning experiences offered in schools.

Mader (2000) also discussed the value of Child Centered Play Therapy in the school

setting; although she utilizes the term play counseling to ease anxieties that the term therapy may

have on parents and school personnel. For use in the school setting, Mader has made a slight

variation to Axline's seventh basic principle of play therapy. This principle indicates that the

Child Centered Play Therapist does not attempt to hurry the therapy along as it is a gradual

process and is recognized as such by the therapist (Axline, 1982). According to Mader, this

principle was intended for a clinical setting that can accommodate longer-term intervention. The

school counselor, who is confronted with problems relative to limited resources, cannot

accommodate such long-term intervention (Mader).

Mader (2000) pointed out that, although Child Centered Play Therapy is typically a long

term intervention, after six weeks she is generally able to determine if a) the student has made

sufficient progress to terminate the sessions, b) the student requires additional sessions to make

progress, or c) the student is in need of longer term intervention that should be accessed outside

the school setting.

Child Centered Play Therapy with High Risk Students

Studies have shown that Child Centered Play Therapy is effective with children who demonstrate the social and behavioral characteristics that indicate a potential for future high-risk behavior (Barrett, 1975; Brandt, 1999; Dogra & Veeraraghavan, 1994). Dogra and Veeraraghavan found that children with a diagnosis of aggressive conduct disorder who received 16 sessions of non-directive play therapy showed a reduction in fighting, bullying, violence against adults, and temper tantrums. Brandt found that, for children experiencing emotional and behavioral problems, play therapy was a viable treatment intervention. Brandt's results showed significant improvement with internalizing behavior problems, as well as, overall reductions in parenting stress and externalizing behavior problems when compared to the control group. Barrett found significant improvements in the social adjustment of five to nine year old children receiving play therapy.

Child Centered Play Therapy with Aggressive Children

Carroll (1998) described the aggressive child as one who has learned to see the world as hostile and responds in kind. The aggressive child will likely have difficulty recognizing and responding positively to someone who is offering help (Carroll). Carroll pointed out that directive approaches with aggressive and defiant children are most likely ineffective as such approaches require a certain amount of cooperation, which these children find impossible (Carroll). Although Child Centered Play Therapy is often challenged as the approach of choice with children who act out (Guerney, 2001), it is more effective with aggressive children because the practitioner is able to accept the child's hostility as a valid response to his or her circumstances (Carroll).

According to Landreth (2002a), the toys that are available in play therapy allow for the release of intense pent up emotions for which children do not have verbal labels to describe or express. Toys such as handcuffs, pretend guns, ropes, toy soldiers, mean puppets, rubber knives, and Bobo dolls provide children with the means to express anger, hostility, and frustration. Children with aggressive tendencies find the permissive and accepting environment satisfying, which allows them to move on to more self-enhancing positive feelings (Landreth, 2002a). Further, according to Guerney (2001) and Landreth (2002a, 2002b), aggressive behavior displayed in the playroom provides the therapist with the opportunity to respond with appropriate limit setting and in turn provides the child with the opportunity to learn self-control. Therapeutic limits assist the aggressive child in learning to make the distinction between motivating feelings and his actions and, over the course of therapy, how to exercise the necessary self control both within and outside the play session (Guerney; Landreth, 2002b). Additionally, play therapy allows the therapist and child to experience the aggressive behavior and actively relate to it versus just talking about it (Landreth, 2002a, 2002b).

Cochran and Cochran (1999) advocated for the use of Child Centered Play Therapy with students who display the aggressive behaviors associated with conduct disorder. According to these authors, Child Centered Play Therapy allows the opportunity for the child to develop a relationship built on acceptance, empathy, and unconditional positive regard. Such a relationship is essential to the treatment of students with conduct disorder because it provides them with the opportunity to doubt and challenge the negative thought patterns they typically possess (Cochran & Cochran). With the assistance of the counselor, the child is able to begin generalizing new beliefs to relationships with teachers and peers (Cochran & Cochran).

Child Centered Play Therapy with Shy, Withdrawn Children

Carroll (1998) discussed the silent withdrawn child and provided several possible explanations for this type of behavior. One explanation given was that the practitioner's office might, in fact, be the only peaceful place where the child is able to escape from the demands and expectations of the adult world. Silence may also reflect anxiety resulting from feelings of helplessness or a possible lack of exposure to verbal communication in the home (Carroll). The child may also be using silence as a tool to mask his anger. In this situation, according to Carroll, the silence may indicate defiance and refusal to join the relationship or an inability to express the feelings. Children are often overwhelmed by feelings they cannot control and may therefore retreat from all relations and become helpless. With the non-directive approach, it is the child's choice whether or not he will converse or remain quiet. Thus, the non-directive approach may be especially effective with these children as the practitioner is able to accept the child's silence and communicate an understanding of the child's anxiety until he or she is able to relax and begin to play (Carroll).

According to Landreth (2002b), certain toys are particularly effective for children who; are resistive, anxious, shy, or withdrawn. Toys such as cars, boats, planes, and cash registers allow withdrawn children to play in noncommittal ways and without the need to reveal feelings.

Child Centered Group Play Therapy

Landreth and Sweeney (1999) stated that child-centered group play therapy combines the distinct advantages of child-centered play therapy with the recognized benefits of group process. Landreth (2002a) described group therapy as a psychological and social process that allows for a natural interaction with one another promoting self learning as well as learning about others. It is through interaction that children can help one another assume responsibility in interpersonal

relationships. This allows them to naturally and immediately extend these interactions with peers outside the therapy sessions (Landreth, 2002a). Despite the group format and the significant impact of group mates on one another, the focus of treatment in group play therapy is the individual child. Group goals do not exist nor is group cohesion sought (Ginott, 1982; Landreth, 2002a).

Child centered group play therapy is based on the abiding trust in the group's ability to develop its own potential through its movement in a positive and constructive direction (Landreth & Sweeney, 1999). The child centered group facilitator does not accept responsibility for the group but encourages the group members to assume this responsibility while providing the basic therapeutic conditions of empathy, acceptance, warmth, and unconditional positive regard (Landreth & Sweeney). The instruments for change in this approach are the emerging therapeutic relationships between the facilitator and participants, and between participants themselves (Landreth & Sweeney).

The goal of group play therapy is to bring about enduring personality changes (Ginott, 1982). Ginott proposed that group play therapy is based on the assumption that children will modify their behavior in exchange for acceptance. Children, according to Ginott, have a need to be accepted by peers. In order to achieve acceptance from their peers, children will modify impulses and change their behavior. They accomplish these changes in the group setting by simulating the play, talk, and behavior of their group mates. Additionally, according to Sweeney, (2003), children have the capacity and natural tendency to seek out and establish relationships.

For several reasons, it has been proposed that group play therapy is more powerful and expedient than individual work with children (Sweeney, 2003). First, the presence of other children facilitates the establishment of a desired relationship between the therapist and each

child, especially during initial contact. This is likely to ease the tension that children typically

feel at the onset of therapy (Ginott, 1982; Sweeney & Homeyer, 1999). Beyond the initial

contact, the presence of other children induces spontaneity and participation (Ginott; Sweeney &

Homeyer). While individual play therapy provides for free associative catharsis, group play

therapy also provides for vicarious and induced catharsis (Ginott; Sweeney & Homeyer). Many

children participate as spectators or observers in activities they crave but fear. By observing

group mates engaging in activities they also long to participate in, they find it easier to do the

same (Ginott; Sweeney & Homeyer). Group mates help each other discover the permissiveness

of the playroom and the leniency of the practitioner (Ginott; Sweeney & Homeyer). This allows

the hesitant child to actively participate in activities he would not have engaged in otherwise

(Ginott; Sweeney & Homeyer). Simply observing others gives a child the courage to attempt

things he or she wants to do (Ginott; Landreth, 2002a; Sweeney & Homeyer).

Ginott (1982), Sweeny, and Homeyer (1999) stated that groups are conducive to the

attainment of insight. Self-knowledge is developed through experiences with others (Ginott;

Sweeney & Homeyer). The group experience compels children to reevaluate their behavior and

personality in light of their peer's reactions to them (Ginott; Sweeney & Homeyer). Problems

within the group result in confrontation, which forces the child to face the problem, reflect upon

it, and respond to it (Ginott). According to Ginott, character is shaped by experiences with

persons and situations. This child in need of character modification requires an understanding

therapist, a peer group that has demands, an environment that offers remedial models, and a

situation that requires corrective actions (Ginott; Sweeney & Homeyer). The group play therapy

experience meets these conditions and is therefore the treatment of choice for those children who

are in need of character correction (Ginott).

Group play therapy also provides the child with the opportunity to test reality (Ginott, 1982; Sweeney & Homeyer, 1999). Reality testing begins as soon as the child enters treatment. The therapist's reactions, responses of group mates, and the nature of the materials are all sources for reality testing. The group setting serves as a tangible social microcosm (Ginott; Sweeney & Homeyer). It is in this environment that social techniques can be discovered, rehearsed, and mastered (Ginott; Sweeney & Homeyer). Group members compel one another to become aware of their responsibilities within relationships (Ginott; Sweeney & Homeyer). The presence of other children anchors the treatment experience in reality (Ginott; Sweeney & Homeyer).

Play therapy offers children the opportunity to enjoy pleasures that are considered unacceptable in society (Ginott, 1982). Such behaviors include thumb sucking and touching of the genitals. Often, it is the materials in play therapy such as sand, water, clay, paint, and mud, which bring substitute satisfaction and consolation for the loss of these original pleasures. Group play therapy provides a greater range of sublimatory activities than individual therapy (Ginott). In individual play therapy, the child tends to repeat sublimatory activities session after session while the group approach reduces the child's propensity for repetitions. Group mates compel each other to use different materials and to engage in various activities, thus increasing the child's stock of sublimatory outlets (Ginott).

Child Centered Play Therapy and Social Skills Instruction

Fox, Boulton (2003), Guerney (2001), and Shechtman (2002) suggested that interventions aimed at the reduction of aggressiveness and the enhancement of social skills be combined to offer a more comprehensive approach to treatment. Shechtman recommended the combination of educational/guidance groups, counseling groups, and therapy groups in the

school system. Guerney proposed that Child Centered Play Therapy combined with specific

social skills training could be promising. She warned that if attempted, the two interventions

must be done at different times and must be absolutely and clearly separated for both child and

therapist.

Conclusion

In closing, students who are involved in acts of school violence display social difficulties

at a young age, both as aggressors and victims (Cairns, Cairns, Neckerman, Ferguson, &

Gariepy, 1989; Carlson, 2003; Dill, et al., 2004; Fight Crime: Invest in Kids, 2003; Frey, 2000;

Furlong, 2000; Gazelle & Ladd, 2002; Vossekuil, Reddy, Fein, Borum, & Modzeleski, 2000;

Wentzel & Wigfield, 1998). It is imperative that schools address the problem with school wide

character education programs as well as therapeutic interventions for individuals who are

identified as high risk. While character education programs typically include social skills

training, such training frequently fails to individualize the skills or knowledge being taught

(Evans, Axelrod, & Sapia, 2000; Schaefer, Jacobsen, & Ghahramanlou, 2000; Shechtman, 2002).

In addition, social skills training does not typically encourage generalization of learned skills to

the child's natural environment (Evans et al.; Schaefer et al.; Shechtman). Child Centered Play

Therapy provided individually and in group settings, addresses the issues of individualization

and generalization by using a method of communication that meets the unique needs of children

and by providing children with experiential opportunities (Guerney, 2001; Landreth, 2002a;

Landreth, 2002b; Landreth, Baggerly, & Tyndall-Lind, 1999; Landreth & Sweeney, 1999).

Methods

This Methods section will be divided into three subsections. First, the characteristics of

the participants will be described. Second, the psychometric properties of the AML Behavior

Rating Scale- Revised (AML-R), the instrument used to measure social and emotional problems, will be described. Third, procedures will be described about how data was collected.

Participants

Study participants were students attending a non-urban, primary school in New York State. The school serves approximately 900 students in kindergarten, first, and second grades. Caucasian students account for 96% of the school's population while 3% are African American, 1% are Hispanic, and .5% are Asian/Pacific Islander. 51% of students are male while 49% are female.

Experimental Group

Participants in the experimental group included 10 students in kindergarten, first, and second grades. Six participants were male while four were female. Five participants were kindergarten students, two were first grade students, and three were second grade students (see Table 1). All participants in the experimental group were Caucasian.

Selection of experimental group. The school counselor provided a referral list of 17 students who were experiencing social/emotional difficulties in the classroom and who were also involved in a social skills counseling group. Final selection for participation in the experimental group was based on obtaining parental consent and scheduling. Seven potential participants were eliminated from the study due to lack of parental consent to participate and/or scheduling difficulties.

Assignment to group or individual sessions. Students were then assigned to individual or group Child Centered Play Therapy sessions based on school counselor recommendations, grade level, and scheduling needs. Four male students were assigned to group play therapy; three of the four were kindergarten students, and one was a first grade student. Six students were assigned to

individual play therapy; two of the six were male while four were female. Two of the six

participants seen individually were kindergarten students, one was a first grade student, and three

were second grade students (see Table 1).

Control Group

Participants in the control group consisted of 10 students. The control group consisted of

eight males and two females. Three participants were kindergarten students, three were first

grade students, and four were second grade students (see Table 2). Nine of the control group

participants were Caucasian and one was African American.

Selection of the control group. The school counselor provided a referral list of 13

students who were experiencing social/emotional difficulties in the classroom and who were

involved in a directive social skills group. Two students were eliminated from the control group

due to failure of the teacher to complete the pre or post-test.

Table 1: Experimental Group Data

Name	Sex	Grade	Session Type	# of sessions (CCPT)	# of sessions (SS)	A scale pre	A scale post	M scale Pre	M scale post
David	M	K	Group	8	7	19	19	5	8
Fred	M	K	Group	7	7	18	18	9	9
Alan	M	K	Group	8	5	17	17	18	14
Andy	M	K	Individual	9	6	7	4	8	7
Kelly	F	K	Individual	6	6	14	16	13	14
Michelle	F	1	Individual	9	7	14	15	10	9
Sally	F	2	Individual	9	6	15	12	11	9
Christian	M	2	Individual	4	6	13	15	16	13
Christine	F	2	Individual	8	7	16	14	10	9
Mike	M	1	Group	5	7	17	20	13	14
TOTAL				73	64	150	150	113	106
MEAN				7.3	6.4	15	15	11.3	10.6

Table 2: Control Group Data

Name	Sex	Grade	# of sessions SS	A scale pre	A scale post	M scale pre	M scale post
Marty	M	K	7	18	16	15	17
Albert	M	K	6	13	12	10	9
Nathaniel	M	K	9	14	17	9	9
Kurt	M	2	7	17	16	14	7
Ashley	F	1	6	8	9	12	13
Kim	F	2	9	13	8	9	6
Nick	M	1	8	6	4	8	7
Mark	M	2	7	10	10	9	13
Tom	M	1	5	4	5	7	8
Anthony	M	2	6	17	14	8	8
TOTAL			70	120	111	101	97
MEAN			7	12	11.1	10.1	9.7

Instrument

The AML Behavior Rating Scale- Revised (AML-R) (Children's Institute Inc., 2000)

(see Appendix A) was used as the pre and post-test to determine participants' level of

social/emotional health. The AML-R is a 12-item, quick assessment tool that is completed by

teachers to identify children who are experiencing adjustment problems in school. The AML-R is

used with children from preschool through sixth grade (Children's Institute Inc.)

Teachers rate children's behavior in the classroom using a 5-point scale that represents the

frequency with which those behaviors have been observed in the classroom within the previous

month: The ratings are as follows:

1. Never: The behavior has never been observed.

2. Seldom: The behavior was observed once during the past month.

3. Moderately Often: The behavior was seen more often than once a month, but less often

    than once a week.

4. Often: The behavior was seen more often than once a week, but less often than daily.

5. Most or all of the time: The behavior has occurred with great frequency, averaging once a day or more (Children's Institute Inc., 2000).

The AML-R takes approximately one minute per child to complete and yields a total score, as well as subscale scores, which reflect three general behavior domains of:

- Acting out, aggressive behaviors (subscale A)

- Moody, shy, anxious behaviors (subscale M)

- Learning difficulties (subscale L) (Children's Institute Inc., 2000).

The A, M, and L scales are determined by adding the values of each item comprising each scale. In addition to these scales, the Total Score provides an overall indicator of a child's adjustment problems in school. To determine the Total Score, the A, M, and L scores are added together (Children's Institute Inc., 2000).

Reliability and Validity of the AML

The following conclusions have been made regarding the validity and reliability of the AML (Cowen, Dorr, Izzo, Madonia, & Trost, 1971; Cowen et al., 1973):

1. The AML items intercorrelated significantly within scales and to some extent across scales. Item-scale correlations were high, indicating internal consistency. Component subscales also correlated somewhat with each other.

2. Factor analysis showed a fairly evident, simulated, 3-factor solution (A, M, and L). The M factor is the most intricate and least stable of the three and can be broken down into specific components.

3. Norm tables were developed for sub scales and total scales for kindergarten, first, second, and third grades. All scales were found to be more sensitive at the maladjusted level than

at the adjusted end of the continuum.

4. It was found that teachers judge primary grade boys as considerably more maladjusted

    than girls and grade repeaters as considerably more maladjusted than nonrepeaters.

    Considerable grade level differences were found to be in the direction of increasing

    judged maladjustment as children proceed through school. More specifically, by third

    grade, girls seemed to get closer to boys in M factor maladjustment.

5. The AML was found to correlate strongly with four other early detection assessment

    tools as well as their component subscales. Of the several screening devices studied, the

    AML was found to be the easiest and the quickest to complete.

6. AML items, scale scores, and the total score were all found to discriminate significantly.

7. The AML A and L items and scales unmistakably and fittingly identified children who

    were judged clinically to act out or to have learning problems. The M items and the M

    scale score failed to do so.

The findings support the AML's psychometric soundness. The scale was found to be reliable, internally consistent, and relatively clear factorially. It was also found to possess considerable face, concurrent, empirical, and discriminant validity. The AML's structural properties of ease, clarity, and conciseness add to its appeal as a mass, quick screening device (Cowen et al., 1971; Cowen et al., 1973).

Procedures

The study was conducted at the experimenter's internship site. The experimenter first explained and sought approval for the study from the supervising site counselor. The supervising counselor then provided the experimenter with a referral list of potential participants. Once the referral list was obtained from the supervising counselor, information about Child Centered Play

Therapy (see Appendix B), an explanation of the process, and consent forms (see Appendix C) were sent to the parents and guardians of potential participants. Upon receipt of parental consent, teachers completed the AML-R pre-test to measure acting out, aggressive behavior, moody, shy, withdrawn behavior, and learning difficulties. Teachers were also given a list of times the experimenter had available for the sessions and were asked to indicate which of the available times the student would be available to attend. Teachers for the participants assigned to the control group were also asked to complete an AML-R pre-test.

Students in the experimental group were then assigned to individual or group Child Centered Play Therapy sessions based on school counselor recommendations, grade level, and scheduling needs. The participants in the experimental group attended a 30-minute play therapy session every 6th school day.

Participants in the experimental group were scheduled for 9 play therapy sessions between March 17 and June 10. Due to student or facilitator absences, field trips, and on two occasions participant refusal, the number of sessions varied from 4 to 9.

Participants in the experimental group and the control group attended a 30-minute social skills counseling group every 6th school day between March 17and June 10. The experimental group attended 5 to 7 social skills counseling groups (see Table 1) while the control group attended 5 to 9 social skills counseling groups (see Table 2). The number of sessions varied according to student absences. After the final play therapy and social skills counseling session, teachers for the experimental group and the control group completed an AML-R post-test.

Description of Child Centered Play Therapy Sessions

The experimenter facilitated all Child Centered Play Therapy sessions. During this time, students had the opportunity to play at a variety of play centers. The play centers consisted of a

rice table, a creative center (consisting of a felt dollhouse, several dolls, a puppet theatre, several puppets, a play stove/oven, a play sink, plastic dishes and silverware, plastic food, a cash register, and costumes), a building center (consisting of Legos and cardboard bricks), and an art center (consisting of construction paper, markers, crayons, scissors, glue, and a marker board).

During these sessions, the student had the freedom to play as he chose or to remain silent. The sessions began with the facilitator informing the student that this was Special Play Time and that during Special Play Time, he could say anything he wanted and could do almost anything he wanted. Each student was further informed that if it came to something he could not do, the facilitator would let him know. Students were also informed during the first play therapy session that the facilitator would not tell anyone else what he said or did during Special Play Time unless the facilitator was concerned about the student's safety. Students were informed that they, however, were free to talk to other people about what they said or did during Special Play Time.

Throughout the play therapy sessions, the facilitator tracked the student's actions and actively reflected the child's thoughts and feelings. Therapeutic limits were only set on behaviors or actions that threatened the safety or well being of the student, the facilitator, or the items in the playroom. Limits were established by first empathizing with the student's desire to perform the act in question and then by informing him that this was one of the things he could not do during Special Play Time. If the student continued with the behavior, the facilitator again empathized with the student's desire to commit the act and informed him that if he chose to continue with the act, he would be choosing to end Special Play Time for that day. If the student continued the behavior, the facilitator again empathized with the student's desire followed by informing the student that because he had chosen to continue the behavior, he had chosen to end Special Play Time for that day.

Students were provided with a warning five minutes prior to the end of each session and again one minute before the session ended. At the end of the play therapy session, the student was informed that Special Play Time was over for that day. The Student was then accompanied back to his classroom.

Description of the Social Skills Counseling Group

Either the experimenter or the supervising counselor facilitated the social skills counseling group. This group contained three sections. The first section consisted of a greeting. A new greeting was introduced every 6th school day, meaning the groups used a different greeting each session. During the greeting, each student addressed the student sitting next to him using a variety of words and or gestures to in order to welcome one another to the group. Such words and gestures included "hello," "howdy," "bonjour," "ola," "good morning/afternoon," "welcome," waving, etc. During this section of the group, students were directed to make eye contact, smile, sit still, and listen.

The second section of the social skills counseling group consisted of a sharing section. During the sharing section of the group, each student identified how he was feeling that day and why. The student then told the group he was ready for questions. Other students then had the opportunity to question the student about his feelings. During this section students were again guided to use good listening skills and taught to ask relevant questions.

The third section of the group consisted of a free playtime. During this time, students had the opportunity to play at a variety of play centers. The play centers were similar to those described for the Child Centered Play Therapy sessions with the addition of an activity center, which consisted of various games such as Chutes and Ladders, Candyland, Checkers, and Uno. During the free playtime, the facilitators provided students with feedback on interpersonal

interactions and assisted students in problem solving if/when conflicts arose.

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

This Results section summarizes the data obtained from the A and M scales of AML-R pre and post-test for each participant in the experimental and the control group, which will be used to evaluate the research question and hypothesis established in the previous sections. For each participant in the experimental and control group, the raw scores, total scores, and mean scores are presented. Data obtained for the experimental group is found in Table 1 while the data obtained from the control group is found in Table 2.

<div align="center">*Experimental Group*</div>

On the A scale, David scored a 19 on the pre and post-test showing no change in score. On the M scale, he had a sore of 5 on the pre-test and an 8 on the post-test showing an increase of 3 points.

Fred scored a18 on the A scale pre-test and post test showing no change. He scored a 9 on the M scale pre and post-test, again showing no change.

Alan scored a 17 on the A scale pre and post-test showing no change. His scores on the M scale pre and post-test were 18 and 14 respectively, indicating a decrease of 4 points.

Andy had a pre test score of 7 and a post-test score of 4 on the A scale showing a decrease of 3 points. On the M scale, he had a pre-test score of 8 and a post-test score of 7 indicating a decrease of 1 point.

On the A scale pre test, Kelly scored a 14. She scored a 16 on the post-test showing an increase of 2 points. The M scale pre and post test scores were 13 and 14 respectively showing an increase of 1 point.

Michelle's A scale pre test score was 14 while her post test score was 15 showing an

increase of 1 point. Her M scale pre-test score was 10. Her post-test score on the M scale was 9 showing a decrease of 1 point.

Sally scored a 15 on the A scale pre-test and a 12 on the post-test indicating a decrease of 3 points. On the M scale, her pre ad post-test scores were 11 and 9 respectively showing a decrease of 2 points.

On the A scale pre-test, Christian scored a 13 on the pre-test and a 15 on the post-test showing an increase of 2 points. On the M scale, he scored a 16 on the pre-test and a 13 on the post-test showing a decrease of 3 points.

Christine had a score of 16 on the A scale pre-test and a score of 14 on the post-test showing a decrease of 2 points. On the M scale, she had a pre-test score of 10 and a post-test score of 9 showing a decrease of 1 point.

Mike scored a 17 on the A scale pre-test and a 20 on the post-test showing an increase of 3 points. On the M scale, Mike had a pre and post test score of 13 and 14 respectively showing an increase of 1 point.

Experimental Group's Total Scores

The total score for the experimental group's A scale was 150 on both the pre and post-test showing no overall change in the score. This group had a total of 113 on the M scale pre-test and 106 on the post-test showing an overall decrease of 7 points.

Experimental Group's Mean Scores

The experimental group had an A scale pre and post-test mean of 15 showing no change in the average score for this scale. On the M scale pre-test, the experimental group had a mean score of 11.3. On the M scale post-test this group had mean score of 10.6 showing a decrease of .7.

Control Group

On the A scale, Marty scored an 18 on the pre-test and a 16 on the post-test showing a decrease of 2 points. On the M scale, he scored a 15 on the pre-test and a 17 on the post-test, again showing an increase of 2 points.

Albert scored a 13 on the A scale pre-test and a 12 on the post-test showing a decrease of 1 point. He also showed a decrease of 1 point on the M scale with scores of 10 and 9 on the pre and post-test respectively.

Nathaniel's A scale pre-test score was 14 while his post test score was 17. This showed an increase of 3 points on the A scale. On the M scale, he scored a 9 on both tests, showing no change in the score.

On the A scale, Kurt scored a 17 and 16 on the pre and post-test showing a decrease of 1 point. On the M scale, he scored a 14 on the pre-test and a 7 on the post-test showing a decrease of 7 points.

Ashley's pre-test score on the A scale was 8 while her post-test score was 9 showing an increase of 1 point. On the M scale her pre and post-test scores were 12 and 13 respectively. This again showed an increase of 1 point.

Kim scored a 13 on the A scale pre-test and an 8 on the post-test. This is a decrease of 5 points. On the M scale, Kim had a decrease of 3 points with pre and post-test scores of 9 and 6 respectively.

On the A scale, Nick had a decrease of 2 points. His pre-test score was a 6 and his post-test score was a 4. On the M scale, his pre-test score was an 8 and his post-test score was a 7, showing a decrease of 1 point.

Mark's A scale score remained the same with a pre ad post-test score of 10. His M scale

score increased 4 points going from a 9 to a 13.

Tom scored a 4 on the A scale pre-test and a 5 on the post-test showing an increase of 1 point. His score on the M scale also increased by 1 point going from a 7 to an 8

Anthony scored a 17 on the A scale pre-test and a 14 on the post-test. His score decreased by 3 points. His M scale pre ad post-test score remained the same at 8.

Control Group's Total Scores

The total score for the control group's A scale was 120 on the pre-test and 111 on the post-test showing an overall decrease of 9 points for this scale. On the M scale pre-test, the control group had a total score of 101. They had an overall score of 97 on the M scale post-test showing a total decrease of 4 points.

Control Group's Mean Scores

On the A scale pretest, the control group had a mean score of 12. This group had an A scale post-test mean score of 11.1 showing a decrease of .9. The M scale pretest mean score for this group was 10.1 while the mean post-test score was 9.7. This shows a decrease of .4.

Discussion

This section will discuss the implications of the results presented in the previous section. First, the results will be discussed in relation to the research question and hypothesis. Next, the relationship of the results to previous theory and research will be discussed. Finally, limitations of the study will be reviewed and suggestions for future directions will be made.

Discussion of Results and Hypothesis

The research hypothesis stated that participants who were involved in both a directive social skills group and Child Centered Play Therapy would make more progress with social/emotional growth in the classroom than those who were only involved in the directive

social skills group. This hypothesis, however, was not supported by the results of the experiment. On the A scale, the experimental group's mean scores on the pre and post-test were the same showing that, overall, this group did not show improvement on the A scale. The control group, however, had a decrease of .9 showing a slight improvement. On the M scale, the experimental group had a mean decrease of .7 showing minimal improvement. The control group also showed minimal improvement on the M scale with a mean decrease of .4. The experimental group therefore showed slightly more improvement on the M scale than the control group. Significant differences between the experimental group, who attended both a social skills counseling group and Child Centered Play Therapy sessions, and the control group, who only attended a social skills counseling group, were not found. In fact, neither group showed significant improvement.

Relationship of Results to Previous Theory or Research

The results of the current study fail to support theory and previous research that purport to show that Child Centered Play Therapy is effective with children who demonstrate the social and behavioral characteristics that indicate a potential for future high-risk behavior (Barrett, 1975; Brandt, 1999; Carroll, 1998; Cochran & Cochran, 1999; Dogra & Veeraraghavan, 1994; Landreth, 2002a, 2002b). Dogra and Veeraraghavan reported a decrease in aggressive, acting out behaviors in children who received Child Centered Play Therapy while Brandt found that this approach led to improvement on externalizing and internalizing behavior problems. Barrett also found that the approach led to overall improvement in social adjustment for 5 to 9 year olds. Carroll (1998) indicated that Child Centered Play Therapy was more effective with aggressive children than directive approaches because such children have difficulty accepting help or direction from others. With Child Centered Play Therapy, the practitioner is able to accept the child's hostility as a valid response to his or her circumstances (Carroll).

Landreth (2002a, 2002b) also advocated for the use of Child Centered Play Therapy stating that this approach allows the therapist and child to experience the aggressive behavior and actively relate to it versus just talking about it, which typically occurs in more directive approaches. Cochran and Cochran (1999) also stated that Child Centered Play Therapy is essential for work with aggressive students with conduct disorder as it allows them to be able to develop and generalize new, more positive, belief patterns to relationships with teachers and peers. With regard to shy withdrawn students, Carroll (1998) suggested that Child Centered Play Therapy was especially effective because this approach allows therapists to accept the children's shyness or silence and communicate an understanding of their anxiety until he or she is able to relax and begin to play.

While Carroll (1998) pointed out the many potential benefits of the Child Centered Play Therapy approach, she also pointed out faults with previous research (Carroll, 2000). Carroll (2000) pointed out that many of the studies published since 1947 illustrating the application and positive outcomes of play therapy were undertaken many years ago and the reporting is so brief that it is impossible to make a well informed judgment about their validity. For example, Landreth (2002a) lists several research studies that reported to show improved social and emotional adjustment among children receiving Child Centered Play Therapy, however these studies range in dates from 1947 to 1980 (Amplo, 1980; Andriola, 1944; Axline, 1948, 1964; Baruch, 1952; Conn, 1952; King & Ekstein, 1967; Miller, 1947; Moustakas, 1951; Pothier, 1967; Schiffer, 1957; Trostle, 1988; Ude-Pestel, 1977). The current study found no significant improvement in classroom social/emotional behavior of students in kindergarten, first, and second grades after receiving an average of 7.3 Child Centered Play Therapy sessions. While these results point to the fact that Child Centered Play Therapy is no more effective than the

social skills counseling group, there are some significant methodological concerns.

Limitations

Sampling Limitations

Several sampling limitations exist in the current study. Due to several factors, generalizability of the results is limited. First, the participants were not randomly selected, nor were they randomly assigned to the experimental or control group. Rather, the onsite supervising counselor referred participants for both groups. Second, the sample was limited to a selection of students in one rural, primarily Caucasian, primary school in New York State. This would make generalization to other races, states and/or urban areas difficult. Furthermore, the small sample size makes reliable measurements of change difficult to achieve and limits the ability to generalize to large populations.

Another limitation of the current study is the failure to control for possible mediating variables in the sample. Such variables include socioeconomic status, social, cultural, gender, and developmental differences, maturation, family dynamics, participation in outside counseling, and the prescription of medications. Such variables, which were not accounted for in the present study, may well have correlated to the outcomes.

Procedural and Methodological Limitations

Limitations with the general procedure and methods also existed in the current study. First, the experimenter who facilitated the Child Centered Play Therapy sessions, was a graduate student and, thus, not as experienced as many Child Centered Play Therapists. Additionally, the same individual did not facilitate the social skills counseling group consistently. The experimenter, the supervising counselor, or both facilitated these groups.

Another significant limitation of the current study was the duration of Child Centered

Play Therapy sessions. The number of 30-minute Child Centered Play Therapy sessions in the

current study varied from 4 to 9 with the average number of sessions being 7.3. Research

suggests that this number is not likely adequate. Reams and Friedrich (1994) studied the efficacy

of time-limited play therapy with maladjusted preschoolers and found no consistent support for

the hypothesis that time limited play therapy would improve the adjustment of maltreated

preschoolers who already were attending a therapeutic preschool. Leblanc and Ritchie (2001)

conducted a meta-analysis of play therapy outcomes with children to determine the overall

effectiveness of play therapy and the variables related to effectiveness. They found that the

duration of therapy appeared to be related to treatment outcomes, with maximum effect sizes

occurring with approximately 30 treatment sessions. Leblanc and Ritchie pointed out that, with

nondirective play therapy, there is a tendency for problem behaviors to be intensified during the

initial stages of therapy. This is because children participating in nondirective play therapy are

encouraged to express themselves with very few limits on their behavior. They are encouraged to

express feelings that often may be very hostile or socially defined as negative. Therefore, during

the early stages of therapy, negative outcome measures of behavior or relational skills are very

likely to be present (Leblanc & Ritchie). Carroll (2000) also pointed out that it is not uncommon

for children's behavior to deteriorate early in therapy.

Implications for Practice

While the results of the current study do not appear promising, it is the author's opinion

that the methodological limitations significantly influenced the outcome of the study. Most

importantly, the structure and number of Child Centered Play Therapy and social skills

counseling sessions were extremely restricted. The number of weekly 30-minute Child Centered

Play Therapy sessions averaged 7.3, while the number of social skills counseling sessions

averaged 6.4 for the experimental group and 7 for the control group. Previous research suggests that this may not be adequate. Leblanc and Ritchie (2001) advocated for a minimum of 20 Child Centered Play Therapy sessions. Landreth (2002a) stressed the importance of varying the structure of the sessions versus focusing on the number of sessions, depending on the unique and various need of the children. Landreth suggested experimenting with the play therapy schedule by deviating from the traditional one session per week and condensing the time between sessions.

Additionally, it is possible that students made improvements in ways that were not observed by the teacher or measured by the selected instrument. For example, Andy, who was an experimental group participant, was referred due to difficulties communicating. He was described as having, although not officially diagnosed with, selective mutism. Although not initially realized by the researcher, Andy rarely demonstrated this condition around his peers. It was generally with adults when this condition was observed and reported. The AML-R did not reflect this condition, as the questions did not ask about such behaviors with adults. Thus, Andy's M scale (measuring moody, shy, withdrawn behavior) pre and post-test scores were only 8 and 7 respectively. These numbers do not reflect the significant impairment demonstrated by Andy who rarely spoke to adults other than his mother. At the conclusion of the study, Andy's teachers reported that he had begun verbally communicating with them much more frequently. Again, such improvement was not reflected in the current study, as the AML-R did not measure this behavior.

Implications for Future Research

There is increased pressure on practitioners offering therapy to troubled children to provide evidence of the efficacy of their interventions. However, current research has not yet

provided the necessary evidence (Carroll, 2000; Fall, 1999; Leblanc & Ritchie, 2001; Reams & Friedrich, 1994). In her review of literature, Fall indicated that there are few studies addressing the issue of client change as a result of an individual school counseling intervention. Fall purported that play therapy interventions do not have the empirical support to enable a school counselor to make an informed decision about treatment modalities. Because of the widespread acceptance and use of play therapy as a form of intervention with children, there exists a need for validation of this treatment (Carroll; Fall; Leblanc & Ritchie; Reams & Friedrich). Leblanc and Ritchie stated that few well-defined and well-executed research examples of the effectiveness of play therapy exist. Current research often fails to provide adequate validation (Leblanc & Ritchie).

Carroll (2000) pointed out the substantial difficulties in measuring outcomes of therapeutic interventions with children. First, only those symptoms, which can be readily measured, are available. Psychological well-being is not readily measurable. Second, it may be impossible to determine whether the symptom relief may be due to the intervention or to maturation. Third, it is impossible for a researcher to include all possible variables in a research design. Carroll also pointed out that the timing of measurement also poses difficulties for the researcher as children progress at different rates. Additionally, it is not uncommon for children's behavior to deteriorate early in therapy, which can affect outcome measures (Carroll). Due to the problem of developing a sound quantitative research study, Carroll suggested a comprehensive overview of narrative case studies. Future research should therefore focus on therapeutic processes and client and therapist characteristics that lead to successful therapy.

References

Amplo, J. (1980). Relative effects of group play therapy and Adlerian teacher training upon

    social maturity and school adjustment of primary grade students. *Dissertation Abstracts*

    International, 41, 3001.

Andriola, J. (1944). Release of aggressions through play therapy for a ten year old patient at a

    child guidance clinic. *Psychoanalytic Review, 31*, 71-80.

Axline, V.M. (1947). *Play therapy.* Cambridge, MA: Houghton Mifflin.

Axline, V.M. (1948). Play therapy: Race and conflict in young children. *Journal of Abnormal*

    and Social Psychology, 43, 300-310.

Axline, V.M. (1964). *Dibs: In search of self.* Boston: Houghton Mifflin.

Axline, V.M. (1982). Entering the child's world via play experiences. In G.L. Landreth (Ed.),

    Play therapy: Dynamics of the process of counseling with children (pp. 47-57).

    Springfield, IL: Charles C Thomas.

Barrett, D. (1975). The effects of play therapy on the social and psychological adjustment

    of five-to-nine year old children. *Dissertation Abstracts International, 36* (08), 5032A.

Baruch, D. (1952). *One little boy.* New York: Dell.

Bickmore, K. (2002, Winter). Peer mediation training ad program implementation in elementary

    schools: Research results. *Conflict Resolution Quarterly, 20*, 2, 137-160.

Brandt, M.A. (1999). An investigation of the efficacy of play therapy with young children.

    Dissertation Abstracts International, 61 (07), 2603A.

Cairns, R.B., Cairns, B.D., Neckerman, H.J., Ferguson, L.L., & Gariepy, J.L. (1989). Growth

    and aggression: 1. Childhood to early adolescence. *Developmental Psychology, 25*, 320-

    330.

Carlson, L.A. (2003, June). Existential theory: Helping school counselors attend to youth at

      risk for violence [Electronic version]. *Professional School Counseling, 6*, 5, 310-316.

Carroll, J. (2000). Evaluation of therapeutic play: A challenge for research. *Child and*

      Family Social Work, 5, 11-22.

Carroll, J. (1998). *Introduction to therapeutic play.* Malden, MA: Blackwell Science Ltd.

Children's Institute Inc. (2000). *Screening and Evaluation Measures and Forms booklet.*

      Rochester, NY: Children's Institute, Inc.

Cochran, J.L., & Cochran, N.H. (1999, June). Using the counseling relationship to facilitate

      change in students with conduct disorder. *Professional School Counseling, 2*, 5,

      395-404.

Cochran, J.L., Cochran, N.H., & Hatch, E.J. (2002). Empathic communication for conflict

      resolution among children. *Person-Centered Journal, 9,* 101-112.

Conn, J. (1952). Treatment of anxiety states in children by play interviews. *Sinai Hospital*

      Journal, 1, 57-63.

Cowen, E., Dorr, D., Clarfield, S., Krelinng, B., McWilliams, S.A., Pokracki, F., Pratt, M.,

      Terrell, D., & Wilson, A. (1973). The AML: A quick-screening device for early

      identification of school maladaptation. *American Journal of Community Psychology, 1,*

      1, 12-35.

Cowen, E.L., Dorr, D., Izzo, L.D., Madonia, A., & Trost, M.A. (1971). The Primary Mental

      Health Project: A new way of conceptualizing and delivering school mental health

      services. *Psychology in the Schools, 8*, 216-225.

Dahir, C.A. (2000, May). The national standards for school counseling programs: A

      partnership in preparing students for the new millennium. National Association of

Secondary School Principals. NASSP Bulletin.

DeRosier, M.E. (2004). Building relationships and combating bullying: Effectiveness of a

school based social skills group intervention. *Journal of Clinical Child and Adolescent*

Psychology, 22, 1, 196-201

DeVoe, J.F., Peter, K., Kaufman, P., Ruddy, S.A., Miller, A.K., Planty, M., Snyder, T.D., &

Rand, M.R. (2003). *Indicators of school crime and safety* (NCES 2004-004/NCJ

201257). Washington, DC: U.S. Departments of Education and Justice.

Dill, E.J., Vernberg, E.M., Fonagy, P., Twemlow, S.W., & Gamm, B.K. (2004, April). Negative

affect in victimized children: The roles of social withdrawal, peer rejection, and

attitudes toward bullying [Electronic version]. *Journal of Abnormal Child Psychology,*

 32, 2, 159-174.

Dogra, A., & Veeraraghavan, V. (1994). A study of psychological intervention of children

with aggressive conduct disorder [Abstract]. *Indian Journal of Clinical Psychology, 21,*

28-32.

Dwyer, K., Osher, D., & Warger, C. (1998). Early warning, timely response: A guide to safe

schools. Washington, DC: U.S. Department of Education.

Evans, S.W., Axelrod, J.L., & Sapia, J.K. (2000, Summer). Effective school-based mental

health interventions: Advancing the social skills training paradigm [Electronic version].

Journal of School Health, 70, 5, 191-195.

Fall, M. (1999, February). A play therapy intervention and its relationship to self-efficacy and

learning behaviors. *Professional School Counseling, 2,* 3*, 194-205.*

Fight Crime: Invest in Kids. (2003). *Bullying prevention is crime prevention.* Washington,

D.C.: Author.

Fox, C.L., & Boulton, M.J. (2003, Winter). Evaluating the effectiveness of a social skills

      training (SST) programme for victims of bullying. *Educational Research, 45*, 3, 231-247

Frey, K.S. (2000, Summer). Second step: Preventing aggression by promoting social

      competence [Electronic version]. *Journal of Emotional and Behavioral Disorders, 8,* 2,

      102-113.

Furlong, M. (2000, Summer). The school in school violence: Definitions and facts [Electronic

      version]. *Journal of Emotional and Behavioral Disorders, 8*, 2, 71-81.

Garaigordobil Landazabal, M (2005). Prosocial and creative play: Effects of a programme on

      the verbal and nonverbal intelligence of children aged 10-11. *International Journal of*

      Psychology, 40, 3, 176-188.

Gazelle, H., & Ladd, G.W. (2002). Interventions for children victimized by peers. In P.A.

      Shewe (Ed.), *Preventing violence in relationships: Interventions across the lifespan*

      (pp. 55-79). Washington, DC: American Psychological Association.

Ginott, H.G. (1982). Group play therapy with children. In G. Landreth (Ed.),

      Play therapy: Dynamics of the process of counseling with children (pp. 327-341).

      Springfield, IL: Charles C Thomas.

Glasser, W. (2000). School violence from the perspective of William Glasser. *Professional*

      School Counseling, 4, 77-80.

Gmitrova, V., & Gmitrov, J. (2004). The primacy of child-directed pretend play on cognitive

      competence in a mixed-age environment: Possible interpretations. *Early Child*

      Development and Care, 174, 3, 267-279

Governor's Advisory Council on Youth Violence. (1999). *Prevention and response:*

      Analysis and recommendations regarding violence in Massachusetts's schools.

Boston, MA**.**

Governor's Task Force on Youth Violence and School Safety. (1999). *Final report:*

Governor's Task Force on Youth Violence and School Safety. Raleigh, NC.

Griffin, R.S., & Gross, A.M. (2004). Childhood bullying: Current empirical findings and future

directions for research [Electronic version]. *Aggression and Violent Behavior, 9,* 379-

400.

Guerney, L. (2001). Child-centered play therapy. *International Journal of Play Therapy, 10*, 2,

13-31.

Gumpel, T.P., & Golan, H. (2000). Teaching game-playing social skills using a self-monitoring

treatment package. *Psychology in Schools, 37,* 3, 253-263.

Guzzi Delpo, E. & Frick, S.B. (1988, Spring). Directed and nondirected play as therapeutic

modalities. *CHC, 16,* 4, 261-267.

Hendler Lederer, S. (2002, October). Collaborative pretend play: From theory to therapy

[Abstract]. *Child Language Teaching & Therapy, 18,* 3, 233-256.

Johnson, D.W., & Johnson, R.T. (2004, Winter). Implementing the "teaching students to be

peacemakers program." *Theory Into Practice, 43*, 1, 68-79.

Johnson, D.W., & Johnson, R.T. (1994, December). Effects of conflict resolution training on

elementary school students. *Journal of Social Psychology, 134*, 6, 803-817.

King, P., & Ekstein, R. (1967). The search for ego controls: Progression of play activity in

psychotherapy with a schizophrenic child. *Psychoanalytic Review, 54*, 25-37.

Landreth, G.L. (2002a). *Play therapy: The art of the relationship* (2nd ed.). New York:

Brunner-Routledge.

Landreth, G.L. (2002b, December). Therapeutic limit setting in the play therapy relationship.

Professional Psychology: Research and Practice, 33, 6, 529-535

Landreth, G.L., Baggerly, J., & Tyndall-Lind, A. (1999, Fall). Beyond adapting adult

counseling skills for use with children: The paradigm shift to child-centered play therapy

[Electronic version]. *The Journal of Individual Psychology, 55*, 3, 272-287.

Landreth, G.L., & Sweeney, D.S. (1999). The freedom to be: Child-centered group play

therapy. In D.S. Sweeney & L.E. Homeyer (Eds.), *The handbook of group play therapy:*

How to do it, how it works, whom it's best for (pp. 39-64). San Francisco, CA: Jossey-

Bass Inc.

Leblanc, M., & Ritchie, M. (2001, June). A meta-analysis of play therapy outcomes.

Counseling Psychology Quarterly, 14, 2, 149-164.

Louisiana Department of Education. (1998). *Safe school task force report.* Baton

Rouge, LA.

Miller, H. (1947). Play therapy for the problem child. *Public Health Nurse Bulletin, 39*, 294-

296.

Moustakas, C. (1951). Situational play therapy with normal children. *Journal of Consulting*

Psychology, 15, 225-230.

National Association of School Resource Officers. (2003). *2003 NASRO national survey*

of school based police officers. Retrieved March 3, 2005, from

http://www.asro.com/2003NASROsurvey.pdf

New York Task Force on School Violence (1999). *A common sense approach to keep*

New York's students and schools safe. Albany, NY.

Orpinas, P., Horne, A.M., & Staniszewski, D. (2003). School bullying: Changing the problem

by changing the school [Electronic version]. *School Psychology Review, 32,* 3, 431-445.

Pearson, Q. M., & Nicholson, J. (2000, June). Comprehensive character education in the

elementary school: Strategies for administrators, teachers, and counselors [Electronic

version]. *Journal of Humanistic Counseling, Education, & Development, 38,* 4, 243-

252.

Pothier, P. (1967). Resolving conflict through play fantasy. *Journal of Psychiatric Nursing and*

Mental Health Services, 5, 141-147.

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy:

Responding to the critics. *International Journal of Play Therapy, 10,* 1, 85-108.

Reams, R., & Friedrich, W. (1994, November). The efficacy of time-limited play therapy with

maltreated preschoolers. *Journal of Clinical Psychology, 50*, 6, 889-899.

Rennie, R. (2000). A comparison study of the effectiveness of individual and group play therapy

in treating kindergarten children with adjustment problems. *Dissertation Abstracts*

International, 63, (09), 3117A.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change.

Journal of Consulting Psychology, 21, 2, 95-103.

Salmon, S. (2003, Fall). Teaching empathy: The PEACE curriculum. *Reclaiming Children and*

Youth, 1, 3,167-173.

Saltz, E., Dixon, D., & Johnson, J. (1977). Training disadvantaged preschoolers on various

fantasy activities: Effects on cognitive functioning and impulse control. *Child*

Development, 48, 367-380.

Sandhu, D.S. (2000). Alienated students: Counseling strategies to curb school violence.

Professional School Counseling, 4, 81-86.

Shechtman, Z. (2002, Summer). Child group psychotherapy in the school at the threshold of a

new millennium. *Journal of Counseling & Development, 80, 3, 293-300.*

Schiffer, M. (1957). A therapeutic play group in a public school. *Mental Hygiene, 41*, 185-193.

State of South Carolina. (1999). *South Carolina's Safe Schools Task Force*. Columbia,

SC.

Stevahn, L., Munger, L., & Kealey, K. (2005, October). Conflict resolution in a French

immersion elementary school. *The Journal of Educational Research, 99*, 1, 3-18

Sturgess, J. (2003). A model describing play as a child-hosen activity – is this still valid in

contemporary Australia? *Australian Occupational Therapy Journal, 50,* 104-108.

Sweeney, D.S. (2003). Group play therapy. In C.E. Schaefer (Ed.), *Foundations of play*

Therapy (pp. 219-242). Hoboken, NJ: John Wiley & Sons, Inc.

Sweeney D.S., Homeyer L.E. (1999). Group play therapy. In D.S. Sweeney & L.E. Homeyer

(Eds.), The handbook of group play therapy: *How to do it, how it works, whom it's best*

for (pp. 3-13). San Francisco, CA: Jossey-Bass Inc.

Trostle, S. (1988). The effects of child centered group play sessions on social emotional growth

of three to six year old bilingual Puerto Rican children. *Journal of Research in*

Childhood Education, 3, 93-106.

Ude-Pestel, A. (1977). *Betty: History and art of a child in therapy*. Palo alto, CA: Science &

Behavior Books.

Vossekuil, B., Reddy, M., Fein, R., Borum, R., & Modzeleski, W. (2000*). U.S. Safe School*

Initiative: An interim report on the prevention of targeted violence in schools.

Washington, DC: U.S. Secret Service, National Threat Assessment Center.

Warden, D., & Mackinnon, S. (2003). Prosocial children, bullies and victims: An investigation

of their sociometric status, empathy and social competence. *British Journal of*

Developmental Psychology, 21, 367-385.

Wentzel, K.R., & Wigfield, A. (1998). Academic and social motivational influences on

students' academic performance [Electronic version]. *Educational Psychology Review,*

10, 155-175.

Wilson, K., & Ryan, V. (2001). Helping parents by working with their children in individual

child therapy. *Child and Family Social Work, 6,* 209-217.

Appendix A

AML Behavior Rating Scale-Revised

Appendix B

Information on Child Centered Play Therapy Sent to Parents

Appendix C

Letters to Parents and Consent Forms