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The Effectiveness Of Group Play And Group Counseling For Children With Aggressive Behaviors

Jennifer Marie Brehm

University of Northern Iowa

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THE EFFECTIVENESS OF GROUP PLAY AND GROUP COUNSELING FOR CHILDREN WITH AGGRESSIVE BEHAVIORS

An Abstract of a Thesis
Submitted
In Partial Fulfillment
of the Requirements for the Degree
Education Specialist

Jennifer Marie Brehm
University of Northern Iowa
August 2001
ABSTRACT

The purpose of this study is to investigate the effectiveness of group play treatment and group counseling interventions for decreasing developmentally inappropriate aggression of children. Group play treatment and group counseling are described in relation to the aggressive behaviors of children. Efficacy of the interventions is presented based on published literature only because no significant effects were found in the study. The Systematic Screening for Behavior Disorders is also presented.

The subjects are children in the first-grade and their ages ranged from 6 to 7. There are three treatment groups (i.e., a play group, a counseling group, and a control group). A total of fifteen students were selected. Five students were assigned to a play group treatment, five were assigned to a group counseling treatment, and five were placed in a placebo control group. In each group two of the children had behavioral problems, while the other three children had no recognized behavior problems (n = 5, target = 2, model peers = 3). The Systematic Screening for Behavior Disorders Peer Social Behavior scale was used as an observation tool and constituted the dependent variable measure.

It was learned that the ability to determine the effectiveness of group play treatment and group counseling based on the playground observations of aggressive behaviors was not possible in this study. Aggressive behaviors were infrequent and therefore not evident enough to determine effectiveness of the treatment groups.
Additional studies on group play therapy and group counseling, particularly in relation to the aggressive behaviors of children, need to be conducted and the results disseminated.
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This Study by: Jennifer Marie Brehm

Entitled: THE EFFECTIVENESS OF GROUP PLAY AND GROUP COUNSELING FOR CHILDREN WITH AGGRESSIVE BEHAVIORS

has been approved as meeting the thesis requirement for the Degree of Education Specialist

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DEDICATIONS

To my husband, Jerry, and my parents, William and Lou Ann Zellmer, whose support and encouragement have allowed me to pursue my educational and professional dreams and goals.
ACKNOWLEDGMENTS

There are many people who have contributed to the completion of my thesis. First I would like to mention my parents who have always encouraged me to achieve what I want in life and to do my best. They have been by my side and given me needed guidance. I feel forever in debt to them. Second, my wonderful husband, Jerry. He openly listened to my frustration and always kept encouraging me to continue. I would also like to thank my husband’s parents. They’ve supported my endeavors and offered Jerry and I help and guidance when needed.

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My thesis committee members also deserve recognition. They spent countless hours going over drafts, revising my study, offering suggestions, and attending meetings with me. Dr. Donald Schmits particularly spent a great deal of time guiding me through the process and helping with data collection. I would also like to acknowledge Mrs. Claire Struck and Mrs. Amy Schultz. They were flexible and willing to offer their services to me whenever needed. Without their help, I could not have carried out my study. In addition, I would like to thank the children who participated in the study, and their parent’s for giving permission. Without the children’s willingness to participate, this study could not have been carried out.
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CHAPTER ONE
INTRODUCTION

Purpose

The purpose of this study was to determine the effectiveness of play group therapy, group counseling therapy, and no therapy for children with problem behaviors. The researcher wanted to see if one, both, or neither treatment, over a five-week period, were effective in eliminating or decreasing problem behaviors in young children. The researcher hypothesized that both play group and group counseling treatment would be effective in helping the children learn more appropriate behaviors. In addition, the children receiving no treatment would have no change in their behavior patterns.

Operational Definitions

This section identifies key terms that are frequently used in this paper. Definitions are provided to assist in the understanding of the researcher’s intended use of the terms. The following definitions are given for each of the Peer Social Behavior codes of the Systematic Screening for Behavior Disorders (Witt, Elliot, Kramer, & Gresham, 1994):

Social Engagement (SE).

An exchange of social signals between two or more children that involve either verbal or nonverbal interaction. Social engagement is coded when the target child is physically oriented toward another child, is exchanging social signals of a reciprocal, purposeful nature with them, and/or produces verbal behavior in some form during the recording interval.
Participation (P).

When the target child is participating in a game or activity with two or more children that have clearly specified and agreed upon set of rules, the participation category is coded. Examples include kickball, four-square, dodgeball, soccer, basketball, tetherball, hopscotch, and so forth. Games or activities that would not be considered examples include tag, jump rope, follow the leader, and other unstructured games.

Parallel Play (PLP).

When the target child is engaged in some activity within five feet of another child, but is not interacting (either verbally or nonverbally) with him or her, the parallel play category is coded. Although the activities the children are engaged in may be identical, the target child and other child are behaving independently of each other. Examples of parallel play include playing in a sandbox next to another child, running in a group, or playing on a swing set by other children. A child engaged in self-talk (i.e. verbal behavior not directed toward anyone else) would be coded parallel play if the child met the other conditions of the parallel play category.

Alone (A).

When the target child is not within five feet of another child, is neither socially involved nor socially engaged, and is not participating in a game or structured activity with other children, the alone category is coded. Examples include sitting, standing, shooting baskets, kicking balls off walls, and so forth. A child engaged in self-talk would be coded as alone if the child met the other conditions of the alone category.
No Codeable Response (N).

When the target child's playground or free-play behavior cannot be accurately coded in one of the above five categories, e.g., the child is out of view or talking to an adult during recess, the no codeable response category is coded. This category is only coded if there is no codeable behavior for an entire 10-second interval.

Limitations of Study

The major limitation of this study is the low number of target subjects. Observing numerous students in various free-play settings is very time consuming. Since only two observers were used, a small number of subjects also had to be used. The matter of confidentiality of student and school information was a concern to educators and parents and protecting the confidentiality limited the choice of dependent variable measures.

The time span for pre-treatment, treatment, and post-treatment observations may have been too short. With only one week to do pre- and post-treatment observations, frequency was dropped to three observations for 7-minute duration each, for pre- and post-treatment. Possibly longer observation durations might yield different results as more time could permit more behaviors.

Another factor that reflected on fewer and shorter observations was that many children became ill during the observation weeks. If pre- and post-treatment data collection had been for two weeks, rather than one, it might have been possible to gather five days of observations with longer duration for each child instead of only three observations.
CHAPTER TWO
LITERATURE REVIEW

In this chapter, an overview of group play therapy, group counseling, and the Systematic Screening for Behavior Disorders will be presented. To introduce the behavioral attribute of aggression, a definition of aggression will be presented from each of the following approaches: psychoanalytic therapy, cognitive-behavior therapy, and person-centered therapy. Efficacy studies will be presented for group play therapy, group counseling, and the use of the Systematic Screening for Behavior Disorders.

Aggression

Aggression is a behavioral attribute that encompasses many different perspectives from various disciplines. This section will focus on three primary theoretical perspectives; psychoanalytic, cognitive-behavioral, and person-centered, to define aggression in a broad manner.

Psychoanalytic Definition

Causation and character of aggressive behavior can have many forms. Freud postulated the presence of two drives or instincts present in all individuals. Eros is the instinct of life, and Thanatos is the instinct of death (Eron, Walder, & Lefkowitz, 1971). Aggression is considered to be the expression of Thanatos. Psychoanalytic theory assumes that every person is genetically endowed with a given quantum of energy that is directed toward destructiveness and must be expressed in one form or another. If aggression is blocked in its external manifestation, then it seeks to express itself indirectly. For example, if all external expression is blocked, aggression is turned back
on the individual. Melanie Klein is a follower of Freud’s theory. Klein stated (Eron et al., 1971):

Innate aggressiveness is bound to be increased by unfavorable external circumstances and, conversely, is mitigated by the love and understanding that the young child receives, and these factors continue to operate throughout development. But although the importance of external circumstances is by now increasingly recognized, the importance of internal factors is still underrated. Destructive impulses, varying from individual to individual, are an integral part of mental life, even in favorable circumstances. (p. 19)

According to psychoanalytic theory, aggressiveness is expressed in various ways in the child’s play, either directly or indirectly (Klein, 1982). Often a toy is broken, water or paint is splashed about and the room generally becomes a battlefield. When the child is more aggressive, attacks may be made with knives or scissors on the table or on pieces of wood. It is therapeutically essential to enable the child to bring out his or her aggressiveness. The therapist must try to understand why at the particular moment the destructive impulses come up and observe their consequences in the child’s mind.

Feelings of guilt may follow after the child has broken an object in the playroom. The guilt refers not only to the actual damage done, but also to what the toy stands for in the child’s unconscious (e.g., a brother, sister, parent). Often the child will put aside the toy he or she has broken, showing dislike of the damaged object, due to a fear that the attacked person (represented by the toy) has become retaliatory and dangerous. The sense of persecution may be so strong that it covers up feelings of guilt and depression that are aroused by the damage done. One day the child may search for the damaged toy and try to repair it. When this occurs there will be a noticeable change in the child’s relation to the particular person the toy represents (Klein, 1982).
Children with aggressive behavior will often attack the therapist in various ways (Levy, 1982). For example, the child will spill water on the therapist, threaten to throw things at him or her, or physically attack the therapist. Psychoanalytic play therapists do not allow the child to inhibit their aggressive fantasies, do not show disapproval or annoyance at the child’s aggressive desires, but rather try to interpret the deeper motives and keep the situation under control (Klein, 1982).

**Cognitive-Behavior Definition**

Cognitive-behaviorists do not believe that people are born with preformed repertoires of aggressive behavior. Instead, they must learn to be aggressive via one of two major processes (Bandura, 1973). In the first process, behavior is shaped into new patterns via its consequences. During trial and error experimentation, unsuccessful responses are discarded and rewarded responses are progressively strengthened. Learning appropriate behavior is a process of discerning different consequences that accompany various actions. It is a less efficient process than having a good example to follow, a second major learning process.

According to cognitive-behavior theory, aggression is seen as a behavior that results in personal injury and/or in destruction of property (Bandura, 1973). The injury may be physical as well as psychological. Children are often confronted with provocative situations that precipitate some type of aggressive action. Aggressive actions tend to occur at certain times, in certain settings, toward certain objects or individuals, and in response to certain forms of provocation. Performance of injurious actions is extensively regulated by environmental cues.
In determining the nature and extent of future aggressive behavior, it is important to look at the learning conditions attendant upon the initial responses to frustration and the subsequent reinforcement history of those responses. Reinforcing factors are accorded an important role in the development of aggression. In trying to help children, psychologists also observe the frequency of the child’s aggressive behavior, its duration and intensity, and the behavior sequence as a whole (e.g., the precipitating event, the consequent event; Varma, 1996). Psychologists must also help children learn cognitive strategies for controlling their anger. Various self-monitoring methods should be taught to the child, followed by progress monitoring to determine effectiveness.

**Person-Centered Definition**

According to person-centered theory (Landreth & Sweeney, 1997), aggression is a heightened form of frustration. Children with aggressive behavior can be difficult to live with, making impossible demands on those who care for them. Children with aggressive behavior often have a history of physical violence. Often there is a link between harsh or inconsistent parenting and children with aggressive behavior. They can be unhappy and confused yet unable to recognize their own need for help. They may have feelings of anxiety, temper tantrums, verbal outbursts, become withdrawn and distant, defiant, unresponsive, and have an inability to concentrate. Children with aggressive behavior have learned to see the world as hostile and they respond with hostile, aggressive behavior. The last thing children with aggressive behavior can recognize or respond to positively is someone offering help (Carroll, 1998).
Some children will exhibit feelings of rage and violence during play therapy (Carroll, 1998). The feelings of the child pertain to other relationships, not the therapeutic relationship. At such time it may be difficult for the therapist to remain objective. It is easy to sympathize with a child who has encountered traumatic experiences but to engage therapeutically in anger with him or her is difficult. At some point in therapy, most children will show the extent of their unhappiness by acting out. Children with aggressive behavior tend to do this by ensuring that the therapist feels it. One action is to insist that the therapist is useless and that it is a waste of time coming to therapy. The therapist is to remain affective, not get his or her feelings hurt, and focus on helping the child. Person-centered techniques that begin by accepting the child’s hostility as a valid response to his or her circumstances may be more successful.

Anger and aggression are understood, but violence is not tolerated. Destructive urges are acceptable but acting them out is not (Carroll, 1998). Once negative feelings have been expressed and accepted in the playroom, it is assumed the child can exhibit more positive behaviors (Landreth & Sweeney, 1997). The therapist allows the child to manage the unmanageable, to control in the fantasy of play what seems out of control in the real world. It is assumed that any aggression that is expressed in the playroom does not transfer to increased aggression outside of the playroom.

Summary of Models of Aggression

Psychoanalytic, cognitive-behavioral, and person-centered approaches look at aggression in different manners. However, all three techniques see aggression as a destructive action or behavior that can result in violence or destruction. Psychoanalytic
therapy recognizes broken objects and attacks made on persons, with or without weapons, as aggressive acts (Klein, 1982; Levy, 1982). Cognitive-behavioral therapy sees aggression as a behavior that can result in personal injury and/or destruction of property that is regulated by environmental cues (Bandura, 1973). Person-centered therapy sees aggression as a heightened form of frustration which can either be physical, psychological, or both. Overall, psychoanalytic approaches believe that aggression is genetic, whereas cognitive-behavioral and person-centered approaches believe that aggression is learned.

**Group Play Therapy**

Young children who exhibit either inappropriate aggressive behaviors or act out in peer interactions are often referred to group play therapy (O’Connor, 1993). In other words, most children who are referred to group play therapy have problems in their relationships with other people (Alexander, 1982). The primary function of group play therapy is improvement in the quality of the child’s peer social interactions (O’Connor, 1993). Group play therapy allows the young child to act out his or her feelings rather than verbalizing these feelings as would be expected with adults and older children (Nelson, 1982). Group play therapy is based on the assumption that children will modify behavior in exchange for acceptance by others (Ginott, 1999).

Group play therapy is an approach that improves, expands, and enhances the play therapy relationship to meet the existing needs of children (Landreth, 1999). The therapeutic relationship allows children to learn, encourage, and support each other, work out difficulties, share in pain and joy, discover what it is like to help each other, and
discover that they are capable of giving as well as receiving help. Children discover their own uniqueness along with the realization that other children are like them in that they have problems and concerns or anger and frustration. The realization that others also have problems helps to diminish the barriers of feeling alone. In group play therapy children learn that it is not just acceptable to be unique, it is valued (Sweeney & Homeyer, 1999). Still, the focus of treatment in group play therapy is always the individual child. Group goals aren't set and group cohesion is not pursued (Ginott, 1999).

Children in group play therapy learn important lessons about social interaction and develop the communication and interactive skills necessary for living satisfying and rewarding lives. The therapy is based on the belief that a child who has a sense of belonging in his or her social group will be open to learning experiences as well as to developing positive relationships with others (White & Flynt, 1999).

Group play therapy represents immediate social reality and enables children to test their behavior. Children can use the group to serve as a practice field in which they can become aware of their own feelings, how they feel about and act toward others, and how others perceive and act toward them (Landreth, 1999). Children are able to examine the aspects of their self that is regarded as negative as well as the ones that are regarded as positive, and to see them both as meaningful aspects of existence (Alexander, 1982). Children acquire an awareness of themselves and their relation to their parents and peers. The insight is often attained without the aid of interpretations and explanations. It is often a result rather than a cause of improvement (Ginott, 1999). Therefore, in the group
children learn not only what aspects of their behavior are socially unacceptable but also what elicits peer approval. Children can observe and experience that sharing of toys or ideas is acclaimed by society and also that their contributions are expected and welcome (Ginott, 1999).

In group play therapy, children are compelled to reevaluate their behavior and personality in light of peer reactions. When a problem arises, the group must handle a confrontation. The children must face the problem, reflect upon it and respond to the situation that provoked the difficulty (Ginott, 1999). Group play therapy allows children to experience the external reality as satisfying and helpful. To many children, reality has become charged with massive negative expectations and experiences. They perceive the world as hostile and unrewarding. These children have had previous group experiences, but in those groups they had to conceal more than reveal.

There are certain elements of group play therapy that contribute to the benefits children receive from participating (Sweeney & Homeyer, 1999). These elements include: (a) accepting the child totally; (b) extending a simple invitation to play without explanations, goals, reasons, questions, or expectations; (c) helping the child learn self-expression and enjoy respect; (d) permitting but not encouraging regressive behavior early in therapy; (e) permitting all symbolic behavior while limiting destructive behavior; (f) prohibiting children from physically attacking each other; (g) enforcing limits calmly, noncritically, and briefly; mentioning limits only as necessary; and (h) feeling and expressing empathy. Therefore, in the safety and growth-promoting setting of the play
therapy experience and the natural course of interaction with other children in the group experience, children learn about themselves, others, and life.

In group play therapy, patterns of behavior and problems emerge that are not present in the play of one child. Stimulation and interaction are evident in the activity of several children. Children assign themselves roles that are reflections or extensions of their basic problems. In such roles, the child either plays out the awareness of what he or she is or a hopeful fantasy of what he or she would like to be (Slavson, 1999). Children are allowed to sublimate inappropriate urges and substitute more appropriate behaviors (White & Flynt, 1999).

Objects, relationships with others, and actual situations constitute true reality to the child (Slavson, 1999). They are more real than ideas or words. In group play therapy, the child is given the opportunity to test his or her powers and mastery. He or she either fails or succeeds, and as a result evolves perceptions concerning his or her own powers and abilities. The child begins to realize him- or herself as a person, evaluates his or her powers, measures them against the realities of his or her environment, and adjusts his or her behavior in accordance with their feelings of weakness or strength. Therefore, play becomes a measure of the self in relation to reality.

Aggression is often displaced in play groups. A child may bang against things in the room or may hammer a toy. To redirect hostile feelings, the child may destroy toys, tools, and materials. Instead of directly attacking the therapist or other children, as a substitute for a parent, the child may paint or deface the walls and furniture (Slavson, 1999).
The toys in a group play therapy setting give the child a means of acting out feelings and experiences which he or she is incapable of expressing verbally, due not only to their threatening emotional content, but also because of the child’s limited experience with language (Alexander, 1982). Toys usually represent a freeing, playful atmosphere, which allows the child to free him- or herself to more open and trusting relationships. Through group play therapy, the child begins to see him- or herself as a worthwhile individual, a person that others can like and respect.

**Group Selection and Size**

A basic prerequisite for children to be admitted to group play therapy is a capacity for social hunger- a need to be accepted by peers and a desire to attain status and maintain esteem in a group. In return for peer acceptance, the child is willing to modify impulses and change his or her behavior (Ginott, 1999). The child begins to play, talk, and behave like other group members.

One general rule for the selection of groups is the younger the children, the smaller the group (Sweeney & Homeyer, 1999). Young children are just beginning to learn how to function in groups of any kind outside of their family. If too many young children are put in a group together, the children may intimidate one another rather than facilitate communication and improvement.

Another general rule for the selection of groups is to keep the group balanced (Ginot, 1999; Sweeney & Homeyer, 1999). For example, it may be appropriate to avoid composing a group of children who have experienced the same trauma. This may be necessary to avoid an escalation of traumatic behaviors and emotions. It is recommended
to have one or two children who have behavior concerns and the remaining children no behavior concerns. It is also suggested that a group not have a majority of one gender. If there is two girls, there should be two boys also.

Finally, the age range of children in group play therapy should generally not exceed twelve months (Ginot, 1999; Sweeney & Homeyer, 1999). The difference between a three-year-old and a six-year-old is too great for most therapeutic purposes.

**Group Setting and Materials**

Group play therapy should take place in a room besides the therapist’s office. A room that is twelve by fifteen feet is suggested (Sweeney & Homeyer, 1999). A playroom that is too small can lead to frustration and aggression between group members, whereas, a playroom that is too large can increase uncontrolled behavior and a lack of interaction.

Play materials will vary according to theory and purpose. Landreth (1991, p. 116) suggests that in general, the play materials should be selected to support the following purposes: (a) facilitate creative expression; (b) facilitate emotional expression; (c) engage children’s interests; (d) facilitate expressive and exploratory play; (e) allow exploration and expression without verbalization; (f) allow success without prescribed structure; and (g) allow for noncommittal play. It is inappropriate to provide enough toys of any one type so that each child in the group can have one. This inhibits the opportunity to learn to share and resolve conflict with limited play materials (Sweeney & Homeyer, 1999).
Length and Frequency of Sessions

The length of each group session is generally determined by the age of the child members. The younger the children are, the shorter the session. The therapist must consider the attention span of the children. For preschool children and early elementary-age children, a group play therapy session may last for twenty to forty minutes. For older children, the group may last over an hour. The duration and frequency of the group will also vary depending upon the purpose of the group and the severity of the presenting problems (Sweeney & Homeyer, 1999).

Benefits and Rationale

To close this section, it is helpful to explore some of the benefits and rationale for group play therapy with children. Sweeney (1997) summarized eight basic advantages of therapeutic play groups:

1. Groups tend to promote spontaneity in children, which may increase their level of participation in the play. The therapist communicates permissiveness to give children the freedom to risk engagement in various play behaviors.

2. The affective life of children is dealt with at two levels- the intrapsychic issues of individual group members and the interpersonal issues between the therapist and the group members.

3. Children observe the emotional and behavioral expressions of other group members and learn coping behaviors, problem-solving skills, and alternative avenues of self-expression. They gain the courage to explore.
4. Children experience the opportunity for self-growth and self-exploration. Children reflect on and achieve insight into self as they learn to evaluate and reevaluate themselves in light of peer feedback.

5. Groups provide opportunities to anchor children to the world of reality through the implementation of limit setting and reality testing.

6. The therapist is able to gain insight into the children's presentation in their everyday lives.

7. The group provides the opportunity for children to develop interpersonal skills, master new behaviors, offer and receive assistance, and experiment with alternative expressions of emotions and behavior. This allows children to practice for everyday life.

8. The presence of more than one child in the play therapy setting may assist in the development of the therapeutic relationship for some children. This helps reduce the anxiety of children who are unsure about the playroom and the therapist.

**Research on Group Play with Aggressive Behaviors**

Johnson, McLead, and Fall (1997) conducted a descriptive study concerning the effects of person-centered play therapy on children with special needs. They purported that most counseling interventions for children were directive strategies designed to reduce the incidence of unacceptable behavior. They stated that directive strategies did not address the secondary problems of unsuccessful communication of thoughts and feelings and lack of control over self and the environment. As stated by Johnson, McLead, and Fall, “Consideration of these secondary problems suggests that labeled
children would benefit from an environment where self-expression is encouraged, relationships are characterized by acceptance rather than by disapproval and judgement, and a sense of control and a belief in their abilities to cope effectively with the world are fostered" (p. 31). This is the type of environment that person-centered play therapy establishes.

The purpose of the Johnson et al. (1997) study was to determine if six weekly 30-minute sessions of person-centered play therapy effectively addressed the secondary problems of children with special needs in the schools. Six children ranging from 5 to 9-years-old were selected based upon their diagnoses. Problem areas included attention-deficit/hyperactivity disorder, unpredictable behavior in the classroom, mentally disabled with severe deficits in receptive and expressive communication, autism, significant delays in all areas of development, cerebral palsy, and obsessive-compulsive disorder. Results were based on the researcher’s analyses of the play therapy. No statistical measurements were included in the study as evidence of the effectiveness of person-centered play therapy used with children with aggressive behaviors. Results showed that person-centered play therapy facilitated the children’s expression of feelings and increased their skills in coping with the issues in their lives. The feelings and thoughts were unconditionally accepted by the therapist, which provided the children opportunities to express feelings, experience control, and develop coping skills.

Elliot and Pumfrey (1972) examined the effects of person-centered play therapy on maladjusted boys. The Bristol Social-Adjustment Guide (BSAG) was administered to the teachers of 28 boys who were identified as socially maladjusted, low-average
intelligence, and poor reading attainment by the teachers. Sixteen boys who obtained the highest number of adverse pointers on the BSAG were selected for the experiment and randomly assigned to either a control or an experimental group. Eight were assigned to receive person-centered play therapy for nine weekly one-hour sessions and 8 were assigned to the control group to remain in their regular classes. Neither group received special help with their reading other than that normally given by their classroom teachers, which is a weakness of the study. To accurately measure reading attainment, the researchers needed to assign an experimental group to obtain help in their reading skills.

The hypotheses tested by Elliot and Pumfrey (1979) were that improvement in social adjustment would occur following play therapy, and that person-centered play therapy would not improve reading attainment in the absence of any specific instruction. There were no significant differences between the experimental and control groups either in improvements of social adjustment or in reading attainment. Sessions of person-centered play therapy did not result in significant improvement in the experimental group. Rank order of improvement in adjustment after therapy was significantly related to intelligence and neuroticism. One year later, 11 of the 16 boys had improved in social adjustment. Elliot and Pumfrey conclude that the study demonstrates a long-term improvement in social adjustment, along with the abilities of children to continue to improve after therapy has terminated.

Moustakas (1955) conducted an experimental study on the frequency and intensity of negative attitudes expressed in person-centered play therapy from well-adjusted and disturbed young children. A group of nine well-adjusted children and a
group of nine disturbed children, all four years of age, were selected. Disturbed children were described by their parents and teachers as children with severe problems in their contacts with other children and adults and in their home relationships. Each child was seen in at least four person-centered play therapy sessions by the same therapist. Of 241 negative attitudes expressed, 10 groups were formed to classify the different types. The 10 groups consisted of: regression in development, diffuse anxiety, orderliness anxiety, hostility toward people, hostility toward home and family, hostility toward parents, hostility toward siblings, hostility toward therapist, diffuse hostility, and cleanliness anxiety. The t-test statistic was used to analyze the researcher’s findings. Types of negative attitudes expressed by well-adjusted children and disturbed children were similar. For well-adjusted children, the most frequent negative attitude was hostility toward siblings. The most frequent negative attitude for disturbed children was diffuse hostility. Diffuse hostility and hostility toward people in general were expressed frequently in both groups of children.

In Moustakas (1955), disturbed children expressed a significantly greater percentage of attitudes of diffuse hostility, hostility toward home and family, cleanliness anxiety, orderliness anxiety, and regression in development. Well-adjusted children expressed a significantly greater percentage of attitudes of hostility toward siblings. Differences between the groups in hostility toward parents, people, and therapist, and diffuse anxiety were not significant. Overall, the disturbed children expressed considerably more intense anxiety and hostility than the well-adjusted children. The disturbed group also showed a greater number of negative attitudes with greater average
severity of feeling. The study showed that well-adjusted children do not differ from disturbed children in the kinds of negative attitudes they express. However, they do express them less frequently and less strongly.

Summary of Group Play

Group play therapy focuses on improving the quality of the child's peer social interactions (O'Connor, 1993). Group play therapy allows the young child to act out his or her feelings rather than verbalizing these feelings (Nelson, 1982). Children in group play therapy learn important lessons about social interactions and developing the communication and interactive skills that are necessary for living satisfying and rewarding lives (White & Flynt, 1999). Children use the group to serve as a practice field in which they become aware of their own feelings, how they feel about and act toward others, and how others perceive and act towards them (Landreth, 1999). Therefore, children acquire an awareness of themselves and their relations to their peers.

In the group play therapy setting, toys should give the child a means of acting out feelings and experiences which he or she is incapable of expressing verbally (Alexander, 1982). In addition, group size should be small, especially with younger children, and balanced with gender, age, and severity of problems. Group play therapy should be conducted in a room besides the therapist's office. Session duration and frequency will vary depending on the age of the children, the purpose of the group, and the severity of the presenting problems (Sweeney & Homeyer, 1999).

Numerous studies have been conducted on person-centered play therapy with children who display aggressive behaviors. Johnson et al. (1997) conducted a descriptive
study on children with special needs. They found that person-centered play therapy facilitated the children's expression of feelings and increased their skills in coping with the issues in their lives. Elliot and Pumfrey (1972) conducted an experimental study that looked at the effects of person-centered play therapy on maladjusted boys. Using t-tests to measure differential effectiveness, no significant improvements were found in social adjustment or reading attainment when the experimental group was given sessions of person-centered play therapy. Moustakas (1955) conducted an experimental study on the frequency and intensity of negative attitudes expressed in person-centered play therapy from well-adjusted and disturbed young children. Moustakas concluded that well-adjusted children do not differ greatly from disturbed children in the kinds of negative attitudes they express.

**Group Counseling**

Elementary school counselors are among the few groups of helping professionals who work from a preventive model as well as providing remedial services to children. Group counseling is the most time efficient and parsimonious means of providing counseling in the school and it is more effective than individual counseling for many children (White & Flynt, 1999). Group counseling is based on the philosophy that if school counselors help children at an early age to socialize appropriately and develop a positive attitude toward learning, they will become productive, well-adjusted children. Thus, prevention is a large component of the group counseling program.

Group counseling allows children to examine their understanding of themselves and thereby helps them interpret their behaviors. It helps children achieve a sense of
identity: who they are, where they are, what it is they are doing, and where they are going (self-discovery, self-realization, self-direction) (Hansen, Warner, & Smith, 1976). Group counseling allows them to observe the problems, struggles, behaviors, interaction styles, and coping mechanisms of the others in the group (Posthuma, 1999). The children are then able to compare this information with their own problems or behaviors.

Group counseling enables children to develop feelings of belonging and awareness of others, to increase socialization skills, to experience increased self-confidence, and to offer opportunities for the exchange of ideas (Posthuma, 1999). The integration of information is likely to produce a combination of supportive and confrontive messages that can soften any good-bad or right-wrong dichotomies. The group counselor gives supportive feedback to cushion the confrontations, which creates an environment in which members are more receptive and feel less need to be defensive and block out negative feedback. The support of the group can promote the self-confidence necessary to attempt new and different ways of behaving.

The involvement in the group counseling process for each member is dependent on the degree of attractiveness the group holds for them. Members are attracted to the group if they like the other members, the leader, and the activities; if they think the group can help them; or if they see others enjoying or benefiting from the group (Posthuma, 1999). The more attractive the group is to each member, the more involved they will become. In addition, if the group members feel a sense of cohesiveness within the group, they will be more productive because they feel a sense of trust and caring. According to Rudestam "The more cohesive a group is, the more group control there is over the
attitudes and actions of its members, the more conformity and commitment to group norms, and the greater acceptance of group values” (p. 53).

For children with more serious problems the group is more powerful than a counselor in individual counseling. Children receive feedback of their interactions from other group members. This feedback from peers is more important than any information given by the counselor (Hansen et al., 1976). Children value the opinions and feedback of their peers. It makes them feel accepted in the group.

When disequilibrium occurs through a presence of negative feelings in the group it causes members to react. Any intense situation, such as the sharing of intimate feelings or a deep emotional reaction, can elicit feelings of discomfort or embarrassment. Group members then make efforts to regain a sense of balance in the emotional climate (Posthuma, 1999).

Children who partake in group counseling conform to group standards and characteristics. These include; (a) engaging in frequent interactions; (b) defining themselves as group members; (c) defined by others as belonging to the group; (d) sharing norms concerning matters of common interest; (e) participating in a system of interlocking roles; (f) identifying with one another as a result of having set up the same model, objective or ideals; and (g) pursuing interdependent goals (Hansen et al., 1976).

**Key Components of Group Counseling**

Most group counseling models recognize five key components to a group counseling process (Posthuma, 1999). The first is the orientation stage. In this stage the
group members are trying to find a sense of belonging. They try to form relationships with other group members in order to establish a form of security.

The second stage is dissatisfaction (Posthuma, 1999). At this time group members feel lost and uncertain with their roles and the roles of the other group members. Frustration, conflict, lack of unity, and testing-out behaviors may surface.

Resolution is the third stage of group counseling. This stage is characterized by members beginning to listen to what others are saying, resulting in the gradual development of consensual validation, group unity, and cohesion (Posthuma, 1999). Group members generally feel good about themselves and the group.

The fourth stage is production. At this time the group has developed a high level of trust and members feel free to get on with the group in a unified manner. The group members work collaboratively as a unit in an interdependent manner toward achieving a task (Posthuma, 1999). This goal becomes their main focus.

The final stage is termination. At this point, the group members review their experience, achieve understanding and insight, and analyze some of their problems, while preparing to disband from the group (Posthuma, 1999).

**Therapeutic Outcomes of Group Counseling**

Group counseling is considered useful since it brings children together to work on individual problems as a group. There are ten therapeutic factors that occur when individuals interact in a group counseling process (Posthuma, 1999):

1. Sharing information: the type of information shared in groups is dependent
upon the type of group, the counselor, and the members. The group may give advice, suggestions, guidance, interpretations, or instruction.

2. Gaining hope: the members must see the group as a helpful-hopeful treatment method.

3. Sharing problems: each group member is different, having his or her own set of unique problems. As members listen to disclosures by other members, they sense a similarity of concerns and issues.

4. Helping one another: group members must help one another by giving feedback, reassurance, suggestions, and support.

5. Experiencing the group as a family: the group must be felt like a positive family environment in which the members discuss and perhaps resolve issues from the primary family.

6. Developing social skills: the process of feedback affords the opportunity to learn about one’s maladaptive social behavior.

7. Imitating behaviors of others: members of the group have the opportunity to observe the behaviors of the other members. Through observations they become aware of which behaviors evoke positive and negative responses. By imitating these behaviors, each member can elicit the responses they desire.

8. Learning and trying out new behaviors: each group member will affect the other members in the same way as he or she affects people he or she has contact with in society. The members will receive feedback on their “way of being” and from these reactions and responses they have the opportunity to learn how they affect others.
9. Experiencing cohesion with others: during periods when a group is experiencing a feeling of unity or togetherness the members are more apt to contribute, take risks, interact, and be productive.

10. Expressing emotion: behaviors that are cathartic are the expression of feelings about the self or the expression of positive or negative feelings to others. When one group member expresses feelings it evokes similar output from other group members.

Group Selection and Size

Group counseling should be composed of individuals who have similar, but different problems. For example, it would be difficult to facilitate improvement among a group of children who all display aggressive behaviors. It is more beneficial to include some children who do not display aggressive behaviors to portray positive model behaviors. However, these model children may have problems in other areas of social or behavioral concerns. The counselor must be aware of the various dynamics of the group and adjust his or her expectations and behavior accordingly (Posthuma, 1999).

Group size is another factor that must be considered when forming groups for counseling. The larger the group the greater the likelihood of having members who don’t participate. Often individuals are reluctant to speak out in a group, even more so if the group is large. As stated by Hepp (as cited in Posthuma, 1999), as the size of the group increases “fewer and fewer members say more and more, while more and more members say less and less” (p. 48).
Group Setting and Materials

The group room environment can play a role in affecting a child in three areas: developing interests and values, communicating performance expectations, and affecting participation in future environments (Posthuma, 1999). Therefore, the temperature of the room must be set at a comfortable level, seating arrangements should be set up in a circular environment, and the chairs should have straight backs to facilitate a cooperative, interactive, more focused group.

Length and Frequency of Sessions

The duration of group counseling sessions affects the degree to which members become familiar and trusting of one another and consequently their willingness to take risks and to function in independent ways (Posthuma, 1999). Sessions of less than one half-hour do not allow sufficient time for warm-up or closure. The frequency the group counseling meets is dependent upon the counselor, the group members, and the problems or behaviors being addressed.

Research on Group Counseling with Aggressive Behaviors

Research on group counseling for children with aggressive behaviors is very limited. A study conducted by Gumaer and Myrick (1974) looked at the behaviors of 25 children referred with disruptive behaviors. Disruptive behaviors were defined as not listening, talking out in class, getting out of their seats at the wrong time, failing to start class work when instructed, inattentive, or fighting or disturbing others. The counselor did observations on each of the children in their classrooms. The counselor then met and interviewed each child to determine attitudes towards school, teachers, and peers, along
with a family history. Once individual interviews were completed, groups were assigned. Each group met once a week for 45 minutes for 8 weeks.

Gumaer and Myrick's (1974) group counseling technique provided minimum structure, helped the children become a cohesive group, and focused attention on their behavior. The group identified three primary behaviors that need to be improved: talking out, leaving one's chair, and being discourteous to others. The counselor charted the three disruptive behaviors the group had identified. In addition, the counselor offered candy as a primary reinforcer for appropriate behaviors, followed with praise as a secondary reinforcer. The children gradually gained more refinement in group discussion, were more attentive, and occasionally gave each other feedback.

During the initial group counseling session of Gumaer and Myrick's (1974) study, disruptive behavior frequency was relatively high. Once the reinforcement procedures were implemented, the frequency of disruptive behaviors was immediately reduced. Over the 8 weeks, disruptive behaviors diminished considerably and approached zero. Teachers reported a transfer of appropriate behaviors from the counseling group to the classroom. However, without group counseling and reinforcement in the classroom, the children's behavior gradually returned to disruptive behaviors about 10 weeks after the study.

A study conducted by Tidwell and Bachus (1977) looked at 24 males who were referred for continued displays of aggressive behavior at school. The researchers hypothesized that aggressive behaviors would diminish if the values of helping others,
cooperation, empathy, and respect for the feelings of others, while learning several decision making skills were instilled through group counseling.

In the Tidwell and Bachus (1977) study, each session focused on a different topic: helping others, group decision making, empathic helpers, experiencing empathy, aggressive experiences, fictional fights, and the culminating experience. Each session involved the boys in an activity that taught proper reactions, behaviors, and decision-making skills. As each session progressed, the boys were required to recall the concepts that had been presented previously and integrate those ideas with the current ones. Even though this was a study, results that described whether the counseling groups were effective were not presented. Therefore, it is impossible for the reader to know if the values taught were effective in reducing aggressive behaviors and if they would be long lasting after the termination of group counseling.

Summary of Group Counseling

Group counseling allows children to examine their understanding of themselves and thereby helps them interpret their behaviors. It allows for self-discovery, self-realization, and self-direction (Hansen et al., 1976). Group counseling enables children to develop feelings of belonging and awareness of others, to increase socialization skills, to experience increased self-confidence, and to offer opportunities for the exchange of ideas (Posthuma, 1999). The support and feedback of the group promotes the self-confidence necessary to attempt new and different ways of behaving. Therefore, group counseling brings children together to work on individual problems as a group.
Group counseling should be composed of children who have similar, but different problems. Group size should be small in order for participation from all members to occur. Temperature of the room must be at a comfortable level, seating arrangements should be set up in a circular environment, and the chairs should have straight backs to facilitate a cooperative, interactive, more focused group. The frequency and duration of the group counseling meets is dependent upon the counselor, the group members, and the problems or behaviors being addressed.

Few studies have been conducted on group counseling, particularly with children with aggressive behaviors. Gumaer and Myrick (1974) conducted a study on children with disruptive behaviors that participated in group counseling. Over the treatment weeks, disruptive behaviors diminished considerably and approached zero. However, once treatment was terminated, the children’s behavior gradually returned to disruptive behaviors about 10 weeks after the study.

A study conducted by Tidwell and Bachus (1977) looked at males that displayed aggressive behaviors at school. The males participated in group counseling that taught prosocial, effective behaviors. Unfortunately, the study did not mention if the group counseling proved to be effective in reducing the aggressive behaviors in the males.

Overview of Research Studies Assessment Methods

The study conducted by Johnson et al. (1997) evaluated the effects of person-centered play therapy on children with special needs. The researchers transcribed and analyzed the therapy sessions from videotape recordings using Struass’s constant comparative method (1987, as cited in Johnson et al., 1977). The method included; (a)
an analyzing therapy sessions and creating initial categories to describe the play; (b) determining codes to represent categories of behavior; (c) reanalyzing transcripts and writing descriptive notes of their findings; (d) reexamined category descriptions with the purpose of realigning codes; and (e) continued analyzing transcripts for coded categories until 100% agreement was reached.

The study conducted by Elliot and Pumfrey (1972) evaluated the effects of person-centered play therapy on maladjusted boys. The Bristol Social-Adjustment Guide (BSAG) was administered to the teachers of 28 maladjusted boys. This was used to determine if the boy’s social maladjustment improved after receiving limited play therapy sessions. Significant improvements were not obtained.

The study conducted by Moustakas (1955) looked at the frequency and intensity of negative attitudes expressed in person-centered play therapy from well-adjusted and disturbed young children. The researchers developed a list of 241 negative behaviors. The researchers then tape recorded some of the therapy sessions, transcribed the tapes, and then noted the frequency and intensity of the negative behaviors.

The study conducted by Gumaer and Myrick (1974) looked at the effectiveness of group counseling in decreasing disruptive behaviors in children. The researchers consulted with teachers to identify children with behavior problems. Once the children were selected, the counselor individually interviewed each child informally. The researchers provided teachers with a pre- and post-group behavioral checklist that included seven behavioral items. The title or production of this instrument was not described in the study.
The study conducted by Tidwell and Bachus (1977) aimed at designing, developing, and implementing a group counseling procedure for decreasing fighting and injurious physical contact among elementary school boys. An actual assessment device to measure the effectiveness of the group counseling procedure was not used. Rather the researchers commented on what they observed.

By reviewing the assessment devices used in the research studies presented, it was found that only one study used an actual produced assessment device (i.e., Elliot & Pumfrey, 1972). The other studies simply based their results on observed opinions or assessment devices they developed specifically for their study. Therefore, the researcher for the study had to select a device that could be used to measure the aggressive behaviors of children. The Systematic Screening for Behavior Disorders was believed to fulfill that requirement since it looked at the various behaviors children displayed in free-play settings.

**Systematic Screening for Behavior Disorders**

The Systematic Screening for Behavior Disorder (SSBD) is a multiple-gate screening device for the identification of children with behavior problems (Witt et al., 1994). The multiple-gates the SSBD include are teacher nominations, teacher rating scales, and direct observations.

The first SSBD gate looks at teacher nominations, in which teachers identify three students in their classes that exhibit either externalizing or internalizing behaviors. Externalizing behaviors are directed outward toward the external social environment (Walker & Severson, 1992). Examples include; defying teachers, aggression,
noncompliance with teacher directions, arguing, having tantrums, disturbing others, stealing, and being hyperactive. Internalizing behaviors are directed inwardly and represent problems with the self. Examples include; low activity levels, shyness, timid or unassertive, withdrawal from social situations, desire to be alone, and acting in a fearful manner.

Children with externalizing behaviors are at risk for academic failure, are identified as underachievers, resist or defy adult-imposed rules, fail to meet adult expectations and usually have weak acceptance by their teachers (Walker & Severson, 1992). Most of their behaviors can be classified as oppositional. Children with internalizing behaviors are at risk for academic failure, lack social skills, have peer relationship problems, are neglected and rejected by peers, and lack social competence.

The second SSBD gate looks at teacher ratings of externalizing and internalizing behavior patterns. Teachers are asked to rate the three children as the highest and lowest for both externalizing and internalizing behaviors. Teachers use the Critical Events Checklist to assess whether each child has exhibited any of the 33 externalizing and internalizing behavior problems in the past six months (Witt et al., 1994). The Combined Frequency Index measures how often the student exhibits specific adaptive and maladaptive behaviors.

The third SSBD gate looks at each child's behaviors in both the classroom and on the playground. The first measure, Academic Engaged Time (AET), is recorded during independent seat work periods. The second measure, Peer Social Behavior observation
(PSB), measures the quality and nature of the student’s social behavior during recess periods (Witt et al., 1994).

The primary school applications of the SSBD are; (a) as an early screening and identification tool; (b) as an added source of information for comprehensive evaluation processes conducted by child study teams, and (c) as a program evaluation and research tool (Walker & Severson, 1992). Therefore, the SSBD alone does not provide sufficient information to: (a) determine whether a referred student qualifies for certification as Seriously Emotionally Disturbed or Seriously Behavior Disordered; (b) give complex diagnoses of complex patterns of problematic social behavior; or (c) give a complete assessment of a student’s social, behavioral, and/or academic adjustment. Other assessments, in addition to the SSBD, need to be administered in order to accomplish these goals.

The SSBD can be used to complement the child study team evaluation process (Walker & Severson, 1992). The SSBD can be used to: (a) evaluate the appropriateness and accuracy of teacher referrals; (b) identify the primary presenting problems in referrals from teachers; (c) determine whether the referred student is emotionally disturbed or socially maladjusted; (d) obtain assessments of the student’s adaptive/maladaptive behavior and formally observe in the referral setting; (e) collect information for use in intervention planning; and (f) review the referred student’s history.

Overall, the SSBD can be a useful assessment tool to help identify children who may have a behavior disorder. It should be implemented along with other assessment
tools and analyzed accordingly. It gives information not only from a teacher’s perspective but also from an outside observer’s perspective.

**Standardization Sample of the SSBD**

The national standardization sample for the SSBD was comprised of 1275 cases on the Stage Three observation measures. The cases were developed within 16 school districts in the following states; Washington, Illinois, Kentucky, Oregon, Utah, and Rhode Island. The sample was developed over a two-year span; 1987-88 and 1988-89. Non-white proportions of the school population across the 15 districts ranged from less than 1% to 29%. The proportion of students from low-income families ranged from 4.3% to 40%. Therefore, both non-white and low-income student statuses were broadly represented across the school districts in the standardization sample.

**Reliability of the SSBD**

Reliability and validity information for Stage Three of the SSBD is presented. Reliability and validity for Stage One and Stage Two are not discussed since they were not included in the study conducted by the author.

**Interrater reliability.** Interrater reliability was the primary criterion used to develop, evaluate, and revise the Stage Three observation codes (Walker & Severson, 1992). Since the Peer Social Behavior (PSB) scale is a five-category code with a 10-second recording interval, interrater agreement among pairs of observers was determined by dividing the number of recording intervals on which there was complete agreement by the total number of intervals recorded and multiplying by 100. Interrater agreement for the PSB scale consistently averaged 85% and has ranged between 80 and 90%.
Validity of the SSBD

Discriminant validity. Walker and Severson (1992) have conducted numerous studies, along with their colleagues to investigate the discriminant validity of the SSBD. Discriminant validity found supports the use of the SSBD in areas such as classifying group membership assignments and discriminating between externalizers and internalizers.

Criterion related validity. Criterion-related validity of the SSBD was investigated by examining the relationships between selected SSBD Stage One, Two, and Three measures and factorial dimensions derived from the School Archival Records Search (SARS) variables. Walker, Block-Pedego, Todis, and Severson (1991, as cited in Walker & Severson, 1992) factor analyzed the 10 SARS variables using a sample of 307 externalizers, internalizers, and normal comparison subjects enrolled in grades 1-5. This procedure expended three factors (i.e., needs assistance, disruptive, and low achievement) with eigen values of 3.34, 1.54, and 1.21. The cumulative percent of variance for these three factors was 61%. The multiple correlations between the SSBD predictor variables and status on the three factorial criterion variables were .43 for needs assistance, .50 for disruption, and .54 for low achievement. The respective R squares for these correlations were .19, .25, and .29. Overall, the multiple correlations provide moderate evidence of the SSBD measures' ability to predict subjects' status on independently recorded criterion variables derived from archival school records.

Predictive validity. The SSBD Stage Three observational measures were recorded in the follow-up year (1987-1988). The measures were entered into a
discriminant function analysis procedure in order to test their accuracy in classifying the subjects’ group membership in the previous year (1986-87). A total of 12 observation code categories and combinations were used as predictors in this analysis. Overall, these variables correctly classified 53% of subjects in the three student groups with 44%, 43%, and 60% of externalizers, internalizers, and non-ranked students (Walker & Severson, 1992). This demonstrates the classification efficiency as in the moderate range. These results suggest relatively modest levels of predictive validity for the SSBD measures as recorded over a 1-year follow-up period.

Research on the SSBD

A one-year field trial conducted by Walker et al. (1990) looked at validation of the SSBD in a suburban school district. All three stages were assessed. In stage three, four students were selected from each of the 97 participating classrooms for observations using the Peer Social Behavior scale. In addition to the SSBD, Systematic Archival School Record Searches (SARS) were conducted for each observed student.

In stage one, the gender ratio of students assigned to externalizing and internalizing behavior lists greatly differed (Walker et al., 1990). For externalizing behaviors, the group consisted of 256 males and 59 females (81% vs. 19%), whereas, for internalizing behaviors the group consisted of 149 males and 157 females (49% vs. 51%).

In stage two, children with externalizing behaviors registered the lowest scores for adaptive behavior and the highest scores for maladaptive behaviors. Children with internalizing behaviors ranked in the middle (between comparison children and
externalizing children) for adaptive behaviors and also in the middle for maladaptive behaviors.

In stage three, statistically significant differences were obtained on 9 of the 11 PSB variables (Walker et al., 1990). No significant differences were found on the social interaction and no codeable response variables. Significant gender differences were found on social engagement, participation, total social interaction, positive interaction, and total negative behavior. Walker et al. stated that “Girls were socially engaged more often than boys, participated in structured games and activities at recess, interacted more, engaged in more positive social behavior and less total negative behavior, and were rated more positively than boys by teachers in their adaptive behavior” (p. 36).

For the SARS, significant differences were found among the three groups (externalizers, internalizers, and comparison; Walker et al., 1990). The SARS profile was most problematic for the externalizers, indicating adjustment problems as well as academic performance problems. Overall, the profiles for the internalizers and externalizers showed significantly lower total achievement levels than the comparison students.

Three forms of construct validity were investigated by Walker et al. (1990): factorial, criterion-related, and discriminant. For factorial validity, two factors emerged. Factor one consisted of scale items that defined school adjustment according to adult expectations, while the content of Factor two focused on peer relations. For criterion-related validity the researchers found that the multiple correlations provided some evidence for the ability of the SSBD measures to predict subject’ status on independently
recorded criterion variables derived from archival school records. Discriminant validity was proven to highly occur in the SSBD with the ability of all stages to correctly classify the subjects.

Another field study conducted by Walker et al. (1990) looked at the validity of the SSBD in a metropolitan school district. Only stage one and two were assessed, while also utilizing a SARS. Four objectives were looked at during the assessment. The first objective looked at the sensitivity of the SSBD stage one screening procedures in identifying the SED (severely emotionally disturbed) students. From the teacher's rankings, 39 of 45 externalizers were ranked by their teachers as among the top 3 students on the externalizing list. All nine of the internalizing students appeared among the top three highest ranked students on the internalizing list. This demonstrates good sensitivity for the SSBD.

The second objective looked at in the Walker et al. (1990) study was the temporal stability of the SSBD stage one and two measures. The mean test-retest rank order correlations on the externalizing and internalizing teacher rank lists for a one-month interval were .79 and .72 respectively. The overall results suggest that teachers are capable of making relatively stable judgments regarding child behavioral attributes using the SSBD. The third objective looked at the replication of normative levels on the SSBD stage two instruments for the 3 subject groups. Results indicated that all mean differences for the 3 subject groups exceeded chance expectations (p<.05) on each of the stage two instruments (Critical Events Checklist, Adaptive Behavior Rating Scale, and Maladaptive Behavior Rating Scale). Objective four focused on establishing normative
levels on SSBD stage two for students considered as severely behaviorally disordered (SBD). Normative levels indicated relatively more problematic adjustment status for the SBD students than for either the externalizing or internalizing subject groups.

The results of the two field studies conducted by Walker et al. (1990) were encouraging. The psychometric properties of the SSBD appeared to be adequate. Acceptable levels of validity were presented. The SSBD was proven to be highly sensitive in discriminating externalizing, internalizing, comparison, and SBD students from each other.

Research studies looking at the utilization of the SSBD are extremely limited. The field studies presented above helped define the normative quality of the SSBD. However, very few actual studies have been written that have used and assessed the SSBD. One study conducted by Feil and Becker (1993) looked at the effectiveness and reliability of the SSBD for preschool children. The researchers revised the SSBD to be appropriate for the preschool population. Subjects were 121 children aged 3 to 6 who were enrolled in preschool. The results show significant reliability and validity and were able to correctly identify those children with emotional behavioral problems accurately.

Another study conducted by Sinclair, Del'Homme, and Gonzalez (1993) looked at the effectiveness of the SSBD for preschoolers. The researcher modified the SSBD to be appropriate for the preschool population. The results showed a significant potential for the SSBD to provide regular and mass screening of preschool children who may be at risk for behavioral disorders. This study, along with the study by Feil and Becker (1993), shows the usefulness of the SSBD, and that it is being used with various populations.
The study presented in this paper will not be looking at preschool children, rather first-graders. However, it is important to be aware of a variety of studies using the SSBD.

**Summary of the SSBD**

The SSBD is a multiple-gate screening device for the identification of children with behavior problems (Witt et al., 1994). The multiple-gates include; teacher nominations, teacher rating scales, and direct observations. The SSBD should be used along with other assessment devices to determine the particular needs of children.

Walker et al. (1990) conducted a one-year field trial that looked at the validation of the SSBD. All three stages were assessed and found to be significant. Another field study conducted by Walker et al. also looked at the validity of the SSBD. In this study, only stage one and two were assessed. The SSBD proved to be sensitive in discriminating externalizing, internalizing, and comparison SBD students from each other. Acceptable levels of validity were presented along with adequate psychometric properties.

A study conducted by Feil and Becker (1993) looked at the effectiveness and reliability of the SSBD for preschool children. The results show significant reliability and validity and were able to correctly identify those children with emotional behavioral problems accurately. Another study conducted by Sinclair et al. (1993) also looked at the effectiveness of the SSBD for preschool children. The results showed a significant potential for the SSBD to provide regular and mass screening of preschool children who may be at risk for behavioral disorders.
The SSBD is appropriate for the study presented in the following chapters since it is developed for young children in elementary school. In addition, significant reliability and validity coefficients were presented in the SSBD Manual. It demonstrates sensitivity to differentiating between the different behaviors of children within the various environments they are involved in.
CHAPTER THREE
METHODOLOGY

Setting

The two cooperating school districts were located in a city, in northern Iowa, which has a population of 30,000. One of the schools has a k-12 population of approximately 550 students. The group play treatment and control group were located at this school. The other school has a K-6 population of approximately 425 students. The group counseling treatment was located there. Enrollment in both schools is primarily Caucasian students with a small population of minority students. Socioeconomic status levels primarily range from middle-class to upper-middle-class.

Subjects

Due to research participation requirements for the two schools, the school counselors running the treatment groups selected the children who were chosen to take part in this study. The group play counselor selected the children to participate in the control group, but the author conducted the control group treatment. The target children were referred by their teachers for aggressive behavioral problems, and thus chosen by the counselors. The children were in the first-grade and their ages ranged from 6 to 7. There were 3 treatment groups (i.e., group play, group counseling, and a control group). A total of 15 students were selected. Five students were assigned to a group play treatment, five were assigned to a group counseling treatment, and five were placed in a control group. In each group two of the children had behavioral problems, while the other three children had no recognized behavior problems (n = 5, target = 2, model peers = 3).
Counselors and Control Group Leader

The counselor who ran the group play treatment used a non-directive approach in which she allowed the children to play amongst themselves in the play room and interacted when asked by the children. The counselor also interacted when situations arose that were conducive to group problem-solving and skill building. During these times the counselor would tap one of the model children and had them be teachers for the targeted students. While the children played, the counselor took notes on behaviors she observed in the play room.

The typical procedure of the group play treatment was to start with a feelings circle. Each child who wished to share something about a particular feeling was allowed. Then they dispersed and began playing freely. After approximately 20 minutes of playing, the children picked up and put away the toys they were using. The counselor had them pick up their toys to see if any developmental issues arose such as aggression, noncompliance, or ignorance. To close the group play session, the counselor had the children sit in a closing circle to process what occurred during the play time. Feelings, problems, and choices were discussed.

The counselor that ran the group counseling followed a more traditional counseling approach that also utilized some play due to the young ages of the children. She began each session with a review of the previous week. Then a discussion of what the children were doing and how they were behaving during recess was pursued. This was followed by the counselor reading the children a book or playing a game. Books used included; Tattlin Madeline, by Carol Cummings (1991b); I'm Always in Trouble, by
Carol Cummings (1991a); and Sharing is Caring, by Carol Cummings (1992). Games played were Candyland and Chutes and Ladders. When inappropriate behaviors were evident during the activities, the counselor would have a discussion with the group to see what feelings were present and how the behavior could be improved. After the book or game was complete, the counselor would develop a discussion on what was learned during that group session and how the children could practice that skill throughout the week.

The author conducted the control group. Each week a different book was read to the children. The children were allowed to read along with the researcher, or allowed to read aloud together. All of the books dealt with anger. The books included: When Sophie Gets Angry-Really, Really Angry, by Molly Bang (1999); The Very Angry Day that Amy Didn’t Have, by Lawrence Shapiro (1994); I Want What I Want When I Want It, by Arden Martenz (1995); Don’t Rant and Rave on Wednesdays- The Children’s Anger-Control Book, by Adolph Moser (1994); and Let’s Talk About Feeling Angry, by Joy Berry (1995). Upon completion of reading the books, and having brief discussion about the books relating to the children’s personal experiences, the children were allowed to draw pictures. Topics were not assigned for what to draw in order to allow the children free expression and creativity.

Materials

The dependent variable measure was the scores on the SSBD, which is a multigate process that looks at students who may be, or are at risk for developing
behavior disorders. In this study, only one of the gates, direct observation, was used since the target children were already identified as having behavior problems.

The Peer Social Behavior Code (PSB) of the SSBD was conducted. It measured the quality, level, and distribution of each target student’s social behavior during free-play settings (Witt et al., 1994). The observations occurred during the children’s recesses. Five categories of behavior were observed and coded: (a) Social Engagement, (b) Participation, (c) Parallel Play, (d) Alone, and (e) No Codeable Response. The PSB intervals were 10 seconds in length. A behavior was recorded if it occurred at any time during the 10-second interval.

Reliability and Validity

Interrater reliability was the primary criterion used to develop, evaluate, and revise the Stage Three observation codes of the PSB subtest. Interrater agreement for the PSB scale consistently averaged 85% and has ranged between 80% and 90%. Walker and Severson (1992) conducted numerous studies, along with their colleagues to investigate the discriminant, criterion-related, and predictive validity of the SSBD. Discriminant validity found supports the use of the SSBD in areas such as classifying group membership assignments and discriminating between externalizers and internalizers.

The criterion-related validity procedure expended three factors (i.e., needs assistance, disruptive, and low achievement) with eigen values of 3.34, 1.54, and 1.21. The cumulative percent of variance for these three factors was 61%. The multiple correlations between the SSBD predictor variables and status on the three factorial
criterion variables were .43 for needs assistance, .50 for disruption, and .54 for low achievement. The respective R squares for these correlations were .19, .25, and .29. Finally, to determine predictive validity, the SSBD Stage Three observational measures were recorded in the follow-up year (1987-1988). Overall, the variables correctly classified 53% of subjects in the three student groups with 44%, 43%, and 60% of externalizers, internalizers, and non-ranked students. These results suggest relatively modest levels of predictive validity for the SSBD measures as recorded over a 1-year follow-up period.

Observers

One graduate student and one professor were trained to conduct observations using the PSB. The administration, training, and technical manuals, along with a video were studied as requirements for the training. Practice ratings were done using videotapes of classrooms other than those included in the study. Interobserver agreement during training sessions was 100%.

The trained researchers conducted observations during the recess periods of the fifteen children, where their problem behaviors were expected to be most prominent. The children were observed in 10-second intervals for a total of 7 minutes.

Procedure

The first set of data collection was gathered over five school days (observations during recess periods, once a day for five days) prior to treatment to obtain a baseline. The researchers observed the 15 children during their recess periods to gather behavioral baseline data. Treatment followed and lasted for 5 weeks. At this time, the children in
the group play and counseling group treatments met weekly for 30-minutes with a counselor to work on their behavior problems. The group play treatment and control group were situated at one school. The group counseling treatment was situated at a different school.

The group play treatment used only various play therapy approaches and techniques during the sessions. The group counseling treatment focused primarily on traditional counseling methods, but also utilized some play due to the young age of the children. The third set of subjects met in group for the same number of sessions as the treatment groups, but received only a reading from the author. After the treatment phase of the three groups, another set of data was collected to determine if the treatments had been effective in eliminating or decreasing the problem behaviors. Observations were once again collected on all 15 children over five school days during their recess periods.

To analyze the data, behavioral figures were constructed. Figures were made for each child during pre-treatment, treatment, and post-treatment. The frequencies were the observed frequencies on the PSB.
CHAPTER FOUR
RESULTS

Group Play Treatment

Child A

Child A was one of the target children in the group play treatment. Prior to treatment, Child A was positively socially engaged 49% and negatively socially engaged 18% of the time observed (a total of 126 intervals of 10-second duration). Child A never participated in a structured game and was always codeable. Child A was engaged in parallel play 23% and alone 10% of the time observed. Therefore, total social interaction was 67%, total negative interaction was 18%, total positive interaction was 49%, total positive behavior was 49%, and total negative behavior was 18% of time observed.

During treatment, Child A was positively socially engaged 65% and negatively socially engaged 11% of the time observed (a total of 210 intervals of 10-second duration). Child A never participated in a structured game and was not codeable 0.04% of time observed. Child A was engaged in parallel play 21% and was alone 2% of time observed. Therefore, total social interaction was 76%, total negative interaction was 11%, total positive interaction was 65%, total positive behavior was 65%, and total negative behavior was 11% of time observed.

After the termination of treatment, Child A was positively socially engaged 83% and negatively socially engaged 3% of the time observed (a total of 126 intervals of 10-second duration). Child A never participated in a structured game and was not codeable .07%. Child A was engaged in parallel play 13% and was never alone. Therefore, total social interaction was 87%, total negative interaction was 3%, total positive interaction
was 83%, total positive behavior was 83%, and total negative behavior was 3% of time observed. See Figure 1 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Figure 1. Child A. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

Child B

Child B was the other target child in the group play treatment. Prior to treatment, Child B was positively socially engaged 29% and negatively socially engaged 17% of the time observed (a total of 126 intervals of 10-second duration). Child B positively participated in a structured game 14% and negatively participated 5% of the time
observed. Child B was always codeable. Child B was engaged in parallel play 13% and alone 21% of the time observed. Therefore, total social interaction was 66%, total negative interaction was 17%, total positive interaction was 29%, total positive behavior was 44%, and total negative behavior was 22% of time observed.

During treatment, Child B was positively socially engaged 35% and negatively socially engaged 2% of the time observed (a total of 210 intervals of 10-second duration). Child B positively participated in a structured game 44%, negatively participated 5%, and was always codeable. Child B was engaged in parallel play 10% and was alone 4% of time observed. Therefore, total social interaction was 86%, total negative interaction was 2%, total positive interaction was 35%, total positive behavior was 79%, and total negative behavior was 7% of time observed.

After the termination of treatment, Child B was positively socially engaged 40% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child B never participated in a structured game and was always codeable. Child B was engaged in parallel play 56% and was alone 4% of time observed. Therefore, total social interaction was 40%, total negative interaction was 0%, total positive interaction was 40%, total positive behavior was 40%, and total negative behavior was 0% of time observed. See Figure 2 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Child C

Child C was one of the comparison children in the group play treatment. Prior to treatment, Child C was positively socially engaged 68% and negatively socially engaged
Figure 2. Child B. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

16% of the time observed (a total of 126 intervals of 10-second duration). Child C never participated in a structured game and was always codeable. Child C was engaged in parallel play 9% and alone 7% of the time observed. Therefore, total social interaction was 84%, total negative interaction was 16%, total positive interaction was 68%, total positive behavior was 68%, and total negative behavior was 16% of time observed.

During treatment, Child C was positively socially engaged 92% and never negatively socially engaged during the time observed (a total of 210 intervals of 10-second duration). Child C never participated in a structured game and was not codeable 1% of time observed. Child C was engaged in parallel play 7% and was never alone.
Therefore, total social interaction was 92%, total negative interaction was 0%, total positive interaction was 92%, total positive behavior was 92%, and total negative behavior was 0% of time observed.

After the termination of treatment, Child C was positively socially engaged 87% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child C never participated in a structured game and was always codeable. Child C was engaged in parallel play 9% and was never alone. Therefore, total social interaction was 87%, total negative interaction was 0%, total positive interaction was 87%, total positive behavior was 87%, and total negative behavior was 0% of time observed. See Figure 3 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Child D

Child D was one of the comparison children in the group play treatment. Prior to treatment, Child D was positively socially engaged 40% and negatively socially engaged 9% of the time observed (a total of 126 intervals of 10-second duration). Child D never participated in a structured game and was not codeable 0.07%. Child D was engaged in parallel play 43% and alone 8% of the time observed. Therefore, total social interaction was 48%, total negative interaction was 9%, total positive interaction was 40%, total positive behavior was 40%, and total negative behavior was 9% of time observed.

During treatment, Child D was positively socially engaged 86% and negatively socially engaged 2% of the time observed (a total of 210 intervals of 10-second duration). Child D never participated in a structured game and was always codeable. Child D was
Figure 3. Child C. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

engaged in parallel play 10% and was alone 2% of time observed. Therefore, total social interaction was 70%, total negative interaction was 2%, total positive interaction was 71%, total positive behavior was 71%, and total negative behavior was 2% of time observed.

After the termination of treatment, Child D was positively socially engaged 67% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child D never participated in a structured game and was always codeable. Child D was engaged in parallel play 25% and was alone 9% of time observed. Therefore, total social interaction was 67%, total negative interaction was
0%, total positive interaction was 67%, total positive behavior was 67%, and total negative behavior was 0% of time observed. See Figure 4 for a graphic representation of pre-treatment, treatment, and post-treatment data.

![Behavior Codes Chart]

**Figure 4.** Child D. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

**Child E**

Child E was another comparison child in the group play treatment. Prior to treatment, Child E was positively socially engaged 29% and negatively socially engaged 10% of the time observed (a total of 126 intervals of 10-second duration). Child E never participated in a structured game and was always codeable. Child E was engaged in
parallel play 32% and alone 29% of the time observed. Therefore, total social interaction was 39%, total negative interaction was 10%, total positive interaction was 29%, total positive behavior was 29%, and total negative behavior was 10% of time observed.

During treatment, Child E was positively socially engaged 29% and never negatively socially engaged during the time observed (a total of 210 intervals of 10-second duration). Child E never participated in a structured game and was not codeable 1% of time observed. Child E was engaged in parallel play 39% and was alone 32% of time observed. Therefore, total social interaction was 29%, total negative interaction was 0%, total positive interaction was 29%, total positive behavior was 29%, and total negative behavior was 0% of time observed.

After the termination of treatment, Child E was positively socially engaged 17% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child E never participated in a structured game and was always codeable. Child E was engaged in parallel play 44% and was alone 39% of time observed. Therefore, total social interaction was 17%, total negative interaction was 0%, total positive interaction was 17%, total positive behavior was 17%, and total negative behavior was 0% of time observed. See Figure 5 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Group Counseling Treatment

Child F

Child F was one of the target children in the group counseling treatment. Prior to treatment, Child F was positively socially engaged 51% and negatively socially engaged
Figure 5. Child E. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

13% of the time observed (a total of 126 intervals of 10-second duration). Child F positively participated in a structured game 0.07% and was not codeable 0.07% of time observed. Child F was engaged in parallel play 24% and alone 10% of the time observed. Therefore, total social interaction was 64%, total negative interaction was 13%, total positive interaction was 51%, total positive behavior was 52%, and total negative behavior was 13% of time observed.

During treatment, Child F was positively socially engaged 86% and negatively socially engaged 4% of the time observed (a total of 210 intervals of 10-second duration). Child F never participated in a structured game and was always codeable. Child F was
engaged in parallel play 2% and was alone 8% of time observed. Therefore, total social interaction was 90%, total negative interaction was 4%, total positive interaction was 86%, total positive behavior was 86%, and total negative behavior was 4% of time observed.

After the termination of treatment, Child F was positively socially engaged 49% and negatively socially engaged 6% of the time observed (a total of 126 intervals of 10-second duration). Child F positively participated in a structured game 12% and was not codeable 2%. Child F was engaged in parallel play 27% and was alone 4% of time observed. Therefore, total social interaction was 67%, total negative interaction was 6%, total positive interaction was 33%, total positive behavior was 33%, and total negative behavior was 6% of time observed. See Figure 6 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Child G

Child G was the other target child in the group counseling treatment. Prior to treatment, Child G was positively socially engaged 98% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child G never participated in a structured game and was always codeable. Child G was engaged in parallel play 2% and was never alone. Therefore, total social interaction was 98%, total negative interaction was 0%, total positive interaction was 98%, total positive behavior was 98%, and total negative behavior was 0% of time observed.
Figure 6. Child F. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

During treatment, Child G was positively socially engaged 80% and negatively socially engaged 3% of the time observed (a total of 210 intervals of 10-second duration). Child G positively participated in a structured game 9%, negatively participated 0.04%, and was always codeable. Child G was engaged in parallel play 7% and was never alone. Therefore, total social interaction was 92%, total negative interaction was 3%, total positive interaction was 80%, total positive behavior was 89%, and total negative behavior was 3% of time observed.

After the termination of treatment, Child G was positively socially engaged 87% and negatively socially engaged 2% of the time observed (a total of 126 intervals of 10-
second duration). Child G positively participated in a structured game 8% and was always codeable. Child G was engaged in parallel play 2% and was never alone. Therefore, total social interaction was 98%, total negative interaction was 2%, total positive interaction was 87%, total positive behavior was 95%, and total negative behavior was 2% of time observed. See Figure 7 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Figure 7. Child G. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.
Child H

Child H was one of the comparison children in the group counseling treatment. Prior to treatment, Child H was positively socially engaged 48% and negatively socially engaged 25% of the time observed (a total of 126 intervals of 10-second duration). Child H never participated in a structured game and was not codeable 0.07% of time observed. Child H was engaged in parallel play 21% and alone 13% of the time observed. Therefore, total social interaction was 74%, total negative interaction was 25%, total positive interaction was 48%, total positive behavior was 48%, and total negative behavior was 25% of time observed.

During treatment, Child H was positively socially engaged 35% and never negatively socially engaged during the time observed (a total of 210 intervals of 10-second duration). Child H never participated in a structured game and was always codeable. Child H was engaged in parallel play 39% and was alone 26% of time observed. Therefore, total social interaction was 35%, total negative interaction was 0%, total positive interaction was 35%, total positive behavior was 35%, and total negative behavior was 0% of time observed.

After the termination of treatment, Child H was positively socially engaged 44% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child H positively participated in a structured game 2% and was always codeable. Child H was engaged in parallel play 43% and was alone 4% of time observed. Therefore, total social interaction was 45%, total negative interaction was 0%, total positive interaction was 44%, total positive behavior was 45%, and total
negative behavior was 0% of time observed. See Figure 8 for a graphic representation of pre-treatment, treatment, and post-treatment data.

![Behavior Codes](image)

**Figure 8.** Child H. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

**Child I**

Child I was another comparison child in the group counseling treatment. Prior to treatment, Child I was positively socially engaged 97% and negatively socially engaged 2% of the time observed (a total of 126 intervals of 10-second duration). Child I never participated in a structured game and was always codeable. Child I was never engaged in parallel play and was alone 2% of the time observed. Therefore, total social interaction
was 98%, total negative interaction was 2%, total positive interaction was 97%, total positive behavior was 97%, and total negative behavior was 2% of time observed.

During treatment, Child I was positively socially engaged 67% and negatively socially engaged 4% of the time observed (a total of 210 intervals of 10-second duration). Child I never participated in a structured game and was always codeable. Child I was engaged in parallel play 24% and was alone 5% of time observed. Therefore, total social interaction was 71%, total negative interaction was 4%, total positive interaction was 67%, total positive behavior was 67%, and total negative behavior was 4% of time observed.

After the termination of treatment, Child I was positively socially engaged 86% and negatively socially engaged 2% of the time observed (a total of 126 intervals of 10-second duration). Child I never participated in a structured game and was always codeable. Child I was engaged in parallel play 4% and was alone 8% of time observed. Therefore, total social interaction was 88%, total negative interaction was 2%, total positive interaction was 86%, total positive behavior was 86%, and total negative behavior was 2% of time observed. See Figure 9 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Child J

Child J was one of the comparison children in the group counseling treatment. Prior to treatment, Child J was positively socially engaged 73% and negatively socially engaged 10% of the time observed (a total of 126 intervals of 10-second duration). Child J positively participated in a structured game 6% and was not codeable 0.07%. Child J
Behavior Codes

Figure 9. Child I. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

was engaged in parallel play 9% and alone 0.07% of the time observed. Therefore, total social interaction was 90%, total negative interaction was 10%, total positive interaction was 73%, total positive behavior was 79%, and total negative behavior was 10% of time observed.

During treatment, Child J was positively socially engaged 50% and negatively socially engaged 0.04% of the time observed (a total of 210 intervals of 10-second duration). Child J never participated in a structured game and was always codeable. Child J was engaged in parallel play 43% and was alone 6% of time observed. Therefore, total social interaction was 50%, total negative interaction was .04%, total positive
interaction was 50%, total positive behavior was 50%, and total negative behavior was .04% of time observed.

Data were not gathered after the termination of treatment for Child J due to her being ill that week. It was not deemed necessary to gather data at a later date since the effectiveness of treatment was not evident. See Figure 10 for a graphic representation of pre-treatment and treatment data.

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**Figure 10.** Child J. The results of observations taken during pre-treatment and treatment weeks.
Control Group

Child K

Child K was one of the target children in the control group. Prior to group gatherings, Child K was positively socially engaged 74% and negatively socially engaged 6% of the time observed (a total of 126 intervals of 10-second duration). Child K never participated in a structured game and was always codeable. Child K was engaged in parallel play 13% and was alone 7% of the time observed. Therefore, total social interaction was 80%, total negative interaction was 6%, total positive interaction was 74%, total positive behavior was 74%, and total negative behavior was 6% of time observed.

During the non-treatment weeks, Child K was positively socially engaged 41% and negatively socially engaged 9% of the time observed (a total of 210 intervals of 10-second duration). Child K never participated in a structured game and was not codeable 2% of time observed. Child K was engaged in parallel play 34% and was alone 15% of time observed. Therefore, total social interaction was 50%, total negative interaction was 6%, total positive interaction was 41%, total positive behavior was 41%, and total negative behavior was 6% of time observed.

After the non-treatment weeks, Child K was positively socially engaged 90% and negatively socially engaged 2% of the time observed (a total of 126 intervals of 10-second duration). Child K never participated in a structured game and was always codeable. Child K never engaged in parallel play and was alone 7% of time observed. Therefore, total social interaction was 93%, total negative interaction was 2%, total
positive interaction was 90%, total positive behavior was 90%, and total negative behavior was 2% of time observed. See Figure 11 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Figure 11. Child K. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

Child L

Child L was the other target child in the control group. Prior to group gatherings, Child L was positively socially engaged 60% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child L never participated in a structured game and was always codeable. Child L was engaged in
parallel play 27% and alone 13% of the time observed. Therefore, total social interaction was 60%, total negative interaction was 0%, total positive interaction was 60%, total positive behavior was 60%, and total negative behavior was 0% of time observed.

During the non-treatment weeks, Child L was positively socially engaged 93% and negatively socially engaged 3% of the time observed (a total of 210 intervals of 10-second duration). Child L never participated in a structured game and was always codeable. Child L was never engaged in parallel play and was alone 4%. Therefore, total social interaction was 96%, total negative interaction was 3%, total positive interaction was 93%, total positive behavior was 93%, and total negative behavior was 3% of time observed.

Data were not gathered after the non-treatment weeks for Child L due to her being ill that week. It was not deemed necessary to gather data at a later date since the effectiveness of treatment was not evident. See Figure 12 for a graphic representation of pre-treatment and treatment data.

Child M

Child M was one of the comparison children in the control group. Prior to group gatherings, Child M was positively socially engaged 80% and was never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child M never participated in a structured game and was always codeable. Child M never engaged in parallel play and was alone 20% of the time observed. Therefore, total social interaction was 80%, total negative interaction was 0%, total
Figure 12. Child L. The results of observations taken during pre-treatment and treatment weeks.

Positive interaction was 80%, total positive behavior was 80%, and total negative behavior was 0% of time observed.

During the non-treatment weeks, Child M was positively socially engaged 75% and negatively socially engaged 4% of the time observed (a total of 210 intervals of 10-second duration). Child M never participated in a structured game and was always codeable. Child M was engaged in parallel play 2% and was alone 19% of time observed. Therefore, total social interaction was 79%, total negative interaction was 4%, total positive interaction was 75%, total positive behavior was 75%, and total negative behavior was 4% of time observed.
After the non-treatment weeks, Child M was positively socially engaged 82% and negatively socially engaged 2% of the time observed (a total of 126 intervals of 10-second duration). Child M never participated in a structured game and was always codeable. Child M was engaged in parallel play 0.07% and was alone 16% of time observed. Therefore, total social interaction was 83%, total negative interaction was 2%, total positive interaction was 82%, total positive behavior was 82%, and total negative behavior was 2% of time observed. See Figure 13 for a graphic representation of pre-treatment, treatment, and post-treatment data.

Figure 13. Child M. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.
Child N

Child N was one of the comparison children in the control group. Prior to group gatherings, Child N was positively socially engaged 79% and never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child N never participated in a structured game and was always codeable. Child N never engaged in parallel play and was alone 21% of the time observed. Therefore, total social interaction was 79%, total negative interaction was 0%, total positive interaction was 79%, total positive behavior was 79%, and total negative behavior was 0% of time observed.

During the non-treatment weeks, Child N was positively socially engaged 55% and negatively socially engaged 5% of the time observed (a total of 210 intervals of 10-second duration). Child N never participated in a structured game and was always codeable. Child N was engaged in parallel play 38% and was alone 3% of time observed. Therefore, total social interaction was 99%, total negative interaction was 8%, total positive interaction was 91%, total positive behavior was 91%, and total negative behavior was 8% of time observed.

After the non-treatment weeks, Child N was positively socially engaged 56% and never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child N never participated in a structured game and was always codeable. Child N was engaged in parallel play 5% and was alone 40% of time observed. Therefore, total social interaction was 56%, total negative interaction was 0%, total positive interaction was 56%, total positive behavior was 56%, and total negative
behavior was 0% of time observed. See Figure 14 for a graphic representation of pre-treatment, treatment, and post-treatment data.

![Graph showing behavior codes](image)

**Figure 14.** Child N. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

**Child O**

Child O was one of the comparison children in the control group. Prior to group gatherings, Child O was positively socially engaged 63% and never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child O positively participated in a structured game 2% and was not codeable 0.07% of time observed. Child O was engaged in parallel play 19% and alone 15% of the time.
observed. Therefore, total social interaction was 65%, total negative interaction was 0%, total positive interaction was 63%, total positive behavior was 65%, and total negative behavior was 0% of time observed.

During the non-treatment weeks, Child O was positively socially engaged 60% and negatively socially engaged 0.04% of the time observed (a total of 210 intervals of 10-second duration). Child O positively participated in a structured game 2% and was always codeable. Child O was engaged in parallel play 30% and was alone 3% of time observed. Therefore, total social interaction was 62%, total negative interaction was 0.04%, total positive interaction was 60%, total positive behavior was 62%, and total negative behavior was 0.04% of time observed.

After the non-treatment weeks, Child O was positively socially engaged 67% and never negatively socially engaged during the time observed (a total of 126 intervals of 10-second duration). Child O never participated in a structured game and was always codeable. Child O was engaged in parallel play 11% and was alone 22% of time observed. Therefore, total social interaction was 67%, total negative interaction was 0%, total positive interaction was 67%, total positive behavior was 67%, and total negative behavior was 0% of time observed. See Figure 15 for a graphic representation of pre-treatment, treatment, and post-treatment data.

**Comparison of Treatment Groups**

Prior to the implementation of treatment, all three subject groups predominantly exhibited positive social engagement behaviors. Parallel play was the second most frequent behavior exhibited for the group play treatment children. Negative social
Figure 15. Child O. The results of observations taken during pre-treatment, treatment, and post-treatment weeks.

engagement and parallel play were the second most frequent behavior exhibited for the group counseling treatment children. Alone was the second most common behavior for the control group children. Participation in structured games or activities was infrequent for all three groups. Negative social engagement was exhibited by the group play and group counseling children. The control group children rarely exhibited negative behaviors. Figure 16 shows a graphic representation of the results of pre-treatment between the three subject groups.

During treatment weeks, positive social engagement was still the most frequent behavior for all three subject groups. However, the frequency declined for the group
Figure 16. Pre-treatment. A comparison of the results of observations taken during the pre-treatment week of the three treatment groups of children.

counseling and control groups while the frequency increased for the group play treatment children. Negative social engagement decreased for the group play and group counseling children, but increased in frequency for the control group. Positive participation also increased for the group play and group counseling children. Parallel play decreased in frequency for the group play children and increased for the group counseling and control groups. Alone decreased for the group play and control groups and increased for the group counseling children. Figure 17 shows a graphic representation of the results of treatment between the three subject groups.
After the terminations of treatment, positive social engagement was still the predominant behavior for all three subject groups. Compared to pre-treatment, positive social engagement, positive participation, parallel play increased, while negative social engagement and alone decreased for the group play treatment children. Compared to pre-treatment, positive social engagement, negative social engagement, and alone frequencies decreased for the group counseling children, while positive participation and parallel play increased. Compared to pre-treatment, positive social engagement and alone behavior frequencies increased, while parallel play frequencies decreased for the control group.
Figure 18 shows a graphic representation of the results post-treatment between the three subject groups.

![Figure 18](image)

**Behavior Codes**

- **SE+**: play therapy
- **SE-**: counseling
- **P+**: control group
- **P-**: control group
- **N**: control group
- **PLP**: control group
- **A**: control group

**Figure 18.** Post-treatment. A comparison of the results of observations taken during the post-treatment week of the three treatment groups of children.

**Commentary from Group Leaders**

The author conducted interviews with each counselor. The counselors were informed at the beginning of the study to keep anecdotal notes of the treatment sessions to share with the author after treatment was terminated. A summary of the interviews is presented. The confidentiality commitment prohibited the author from including the raw notes in the study.
The counselor that ran the group play treatment made anecdotal notes throughout the play sessions. One thing she noticed was that all of the group members were happy to go to the play room and enjoyed group play. Child D actually made a comment to the children in the control group that she gets to go play instead of listening to books. In the group there were three girls and two boys. The counselor only had two dolls. The girls “fought” every week for who got to play with the dolls, particularly Child A and Child D. The counselor would intervene and help them see their competitiveness and teach negotiation skills. Child A would often pout when she didn’t get her way. When the other children did not pay attention to her pouting, she would come back to join the group and negotiate what she desired with the other children.

The counselor noted that a lot of pretend play occurred in the play room, particularly with the girls. Every week the girls would pretend that they were pregnant or were already mothers. The boys, Child B and Child E, primarily played basketball. The boys played cooperatively together and were very kind to one another. The counselor observed that the group play became gender play. Every week the girls would play with the dolls together and the boys would play basketball together. Every once in awhile, the two groups would intermingle.

The counselor mentioned that she saw the most growth in Child A. Her demanding attitude decreased and compromising increased. During the fourth week’s session, Child A stated to Child D, “We fight a lot. We are getting along today because we are sharing.” The counselor saw this as a major evolution for Child A. In the
beginning of treatment she always had to get her way, at the end of treatment she was willing to negotiate and compromise with her group members. The counselor stated that she did not see “improvement” in the children because “improvement” takes a lot of time. However, she noticed “growth” in the skills of negotiating and getting along in all of the children.

Group Counseling Leader

The counselor that ran the group counseling treatment made brief anecdotal notes throughout the counseling sessions. One thing she noticed was that all the children enjoyed attending group counseling. The children enjoyed listening to the books she read, but their favorite activities were playing Candyland and Chutes and Ladders. Child G was the only child that displayed competitive, aggressive behaviors during the counseling sessions. Child G was extremely competitive during the games. He would have a temper tantrum whenever he wasn’t winning. The counselor had a discussion with Child G, along with the rest of the group, concerning how to handle competitiveness. After that discussion, Child G handled the remaining group sessions better. He would compliment the other children when they did something well and did not throw temper tantrums when he lost.

The counselor also noticed that Child F was withdrawn and uninvolved during group counseling. When he did participate, he would display attention-seeking behaviors. His behavior and attitude would fluctuate up and down during each session. Overall, the counselor did not notice a lot of improvement in the children, except Child G. He overcame his competitiveness and learned how to be a team player. The
remaining children learned new ways of behaving appropriately during the group. However, great improvement was not noticed.

**Control Group Leader**

The leader that ran the control group treatment made anecdotal notes throughout the group sessions. One thing she noticed was that all the children enjoyed going to group every week. However, the children did not always want to listen to a book. They all preferred to draw during the group session. Therefore, a short book was read during the first half of the group time and the children were allowed to draw during the second half. Child K and Child O were very quiet and withdrawn during all of the group sessions. They would only participate when specifically asked to. They were unenthusiastic with the books and did not want to discuss anger situations.

The leader noted that Child M was very loud and hyper during the group session. Child M would blurt out inappropriate comments and noises and interrupt other group members while they spoke. He often had to be reminded of the group rules. However, he was very excited about group every week and was willing to participate. Child L was also verbally aggressive. She would often blurt out inappropriate comments and interrupt other group members while they spoke. Child N acted the most appropriately during group. She participated often, was friendly to all group members, followed the rules, and was cooperative. She would often redirect the other group members when they became side tracked. Overall, the group leader did not notice improvements in the children’s behavior.
Conclusion

In this study the ability to determine the effectiveness of group play therapy and combined group counseling based on the SSBD observations of aggressive behaviors observed was not possible. Aggressive behaviors were infrequent and therefore not evident enough to determine effectiveness of the treatment groups. Many factors could have inhibited the aggressive behaviors, including cold weather, clothing restrictions, and limitations enforced by playground monitors.
Comparing the graphs of data, there does not appear to be a significant change in student behaviors. Some of the children exhibited improved behavior throughout and after treatment, but most were not significant improvements.

The counselor that ran the group play treatment stated that she did not see “improvement” in the children because “improvement” takes a lot of time. However, she noticed “growth” in the skills of negotiating and getting along in all of the children. The counselor that ran the group counseling treatment also did not notice a lot of improvement in the children. The children learned new ways of behaving appropriately during the group, and practiced those skills, however, great improvement was not noticed. The leader that ran the control group treatment did not notice improvement in the children’s behaviors. Each child’s behavior was consistent throughout all of the group sessions.

Strengths

The strength of the study was the researcher’s desire to observe behaviors of children in free-play settings. Many problems children have with their behavior occur during free-play settings. However, that is not typically the setting in which observations are conducted. Usually observations occur during class time. However, observations may need to be conducted in both settings to get the broad picture of the child’s behavior to see if certain situations are causing the behavior to flare up.
Limitations

Limitations of the study were a lack of trained observers and a longer time span for pre-treatment, treatment, and post-treatment observations. It was difficult to observe more than one child at a time, which was required due to time constraints. Ideally, five people should have been trained to observe the children. Also, with only one week to do pre- and post-treatment observations, frequency was dropped to three observations for 7-minute duration for pre- and post-treatment. Since treatment was 5 weeks, 5 observations of each child were attainable (one observation per week). Since observations were only conducted for 7 minutes, many changes in behavior were not recorded that the observers saw once the 7-minute interval was complete. However, with only two observers, and 15 children, 15-minute observations were not possible.

Another factor that reflected on fewer and shorter observations was due to many children being ill. If pre- and post-treatment data collection had been for two weeks, rather than one, it may have been possible to gather 5 days of observations for each child. Also due to illness, the researchers were unable to gather post-treatment data on two children.

Implications for Future Research

It is in this researcher’s opinion that this study was carried out in the least intrusive, well thought-out manner. Permission was obtained by school principals, parents, and counselors to carry out the study. To remain unobtrusive, the observers did not conduct file reviews on the children. Subjects were selected based on teacher and counselor opinions on children who displayed the most aggressive behaviors in the first
grade and would most likely show aggressive behaviors during free-play at recess. Parents obtained informed consent forms, therefore, acknowledging an understanding and acceptance of the procedure.

The observers found the behavior codes of the SSBD to be too broad to be used while observing multiple children at the same time. For example, Social Engagement is such a broad behavior code, that the majority of behaviors the children exhibited fell under that category. It was difficult to track each child since the children would sporadically change their locations on the playground and spread out. One possible remedy to the tracking and coding of children would be to have a camcorder on the playground videotaping the children during free-play. This would allow the observers to code the children’s behaviors while viewing the video, numerous times if necessary. However, this fails to remain unobtrusive. Parents and educators may not agree to participate in a study with this condition.

Other factors that may or may not have impacted the outcome of this study were cold weather, clothing restrictions, and playground monitors. Observations were conducted during the months of January, February, and March. Temperatures were frequently below twenty degrees. Therefore, children wore heavy clothing that may have restricted their mobility, in order to stay warm. Most of the time, the children were socially engaged rather than participating in a structured game. If observations were conducted during warmer months, this frequency in behavior may have been different. In addition, the playground monitors often stopped any aggressive behaviors from occurring.
or continuing (which is their job) when observed. This stopped the frequency of aggressive behaviors from escalating very high.

Even though the researcher knew from the first week of observations that aggressive behaviors in the children were not surfacing enough to show if group play or group counseling treatments were effective, the study continued. The reason for the continuance was based on agreements reached for permission to conduct the entire study from principals, teachers, counselors, and parents. In addition, continuance was needed to fulfill requirements for this thesis. In future studies, if aggressive behaviors are not evident, it is this researcher’s recommendation to terminate the study and modify it as needed.

**Reflections**

Currently, there are few effective and low-cost methods of screening for behavioral disorders in early childhood settings (Feil & Becker, 1993). Many require mass administration rather than small group or individual administration. Mass administration is difficult to do with young children due to their rapid fluctuation of attitudes, activities, and behaviors. Instruments must be more developmentally sensitive in order to be implemented.

Research on the SSBD must be expanded. There are few studies that demonstrate how the SSBD was implemented as an assessment tool, what the results were, and how effective the SSBD was found to be with that student population. Walker and Severson (1992) recommend that other assessment tools be used conjointly with the SSBD.
Therefore, it would be helpful if researchers would conduct studies with various similarly-related instruments to determine which correlate well with the SSBD.

Overall, more research studies need to be conducted of group play therapy and group counseling on young children. Professionals can help children reduce aggressive behavior and demonstrate more appropriate behaviors to help them achieve more success and happiness in their lives. Group play therapy and group counseling are two therapeutic techniques that may be effective in reducing aggression. However, research must be conducted to determine the effectiveness of group play therapy and group counseling for aggressive behaviors of children. Only then will group play therapy or group counseling become the interventions of choice.
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