Individual and Group Child-Centered Play Therapy: Impact on Social-Emotional Competencies

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Abstract

The researchers conducted a randomized controlled trial study with 56 elementary school participants to test the effectiveness of 16 sessions of the modalities of individual and group child-centered play therapy (CCPT) on improving social-emotional assets, including self-regulation/responsibility, social competence, and empathy. Parent report indicated treatment in both individual and group treatment conditions was correlated with substantial gains in overall social-emotional assets and in the constructs of self-regulation/responsibility and social competence.

Keywords: child-centered play therapy, group play therapy, empathy, self-regulation, social competence

INDIVIDUAL AND GROUP CHILD-CENTERED PLAY THERAPY: IMPACT ON SOCIAL-EMOTIONAL COMPETENCIES

A critical need for children's mental health services in schools currently exists. Young children's social-emotional skills are foundational to and predictive of their academic and social success (Denham et al., 2012). Unfortunately, approximately 14-20% of school-aged children experience social-emotional, behavioral, or mental disorders severe enough to impact their functioning (Center for School Mental Health (CSMH), 2013; Merikangas et al., 2010; National Academy of Sciences, 2009) and many of these children do not receive any treatment either in or outside of school (Adelman & Taylor, 2010). In fact, according to the CSMH (2013), approximately 50-70% of children and adolescents exhibiting mental, emotional, and behavioral disorders each year, do not receive treatment. Of the children who do receive treatment, 70-80% receive treatment in schools (CSMH, 2013). Additionally, whereas about 96% of children who receive services in schools follow through with treatment, only 13% of children who receive services through community mental health centers follow through (CSMH, 2013), indicating a need for in-school mental health treatment. In order to meet the demand of services, responsive counselors treating children clearly identify core social-emotional needs and the effective and efficient treatments to impact these elements.

Social-Emotional Competencies

According to Merrill (2011), social and emotional assets and resiliencies are "a set of adaptive characteristics that are important for success at school, with peers, and in the outside world. They include facets such as friendship skills, empathy, interpersonal skills, social support, problem solving, emotional competence, social maturity, self-concept, self-management, social independence, cognitive strategies, and resilience" (p. 3). In developing

their Social and Emotional Assets and Resilience Scale - Parent (SEARS-P), Merrell, Felver-Gant, & Tom (2011) performed factor analysis of parent perceptions of social and emotional assets, yielding the three constructs of empathy, self-regulation and social competence. Empathy can be defined as "Level of emotional warmth" (Ray, Stulmaker, Lee, & Silverman, 2013, p. 14), and includes both affective empathy, "…tendency to feel and care about what other people feel" (Dadds et al., 2009, p. 599) and cognitive empathy, the ability "to describe what and why other people feel, even if he does not share or care about those feelings" (Dadds et al., 2009, p. 599). Self-regulation involves the inhibition of emotional and behavioral reaction (Batum & Yagmurlu, 2007), and includes emotional regulation, "the inhibition of emotional reaction….and the maintenance and enhancement of emotions" (Batum & Yagmurlu, 2007, p. 273) and behavioral regulation, "low inhibitory control and high impulsivity" (Batum & Yagurlu, 2007, p. 290). Social competence includes the "ability to maintain friendships with peers, engage in effective verbal communication, and feel comfortable around groups of peers" (Merrell, 2011, p. 3). Empathy, self-regulation, and social competence appear to be the most meaningful, consistent, and robust constructs summarizing parent perceptions of their children's social-emotional assets (Merrell, Felver-Gant, & Tom, 2011).

Children's social-emotional competencies are related to their ability to succeed and thrive. Social-emotional assets are related to academic success (Denham et al., 2012). Additionally, the social-emotional assets of empathy, self-regulation, and social competence appear to be protective factors against behavioral problems such as violence and aggression (Caspi, Henry, McGee, Moffitt & Silva, 1995; Dodge, Coie, & Lynam, 2006; Eisenberg, Fabes, & Spinrad, 2006; Garner & Hinton, 2010; Henry, Caspi, Moffitt, and Silva,1996; Jolliffe & Farrington, 2006; Mofitt and Caspi, 2001; Payton et al., 2008; Valiente et al., 2003) and

protective factors against overall functional impairment (Cheng & Ray, 2016; Ray et al., 2013). Functional impairment refers to the inability of a child to function in a developmentally expected manner. It includes child behaviors that are problematic to adult authority figures, such as withdrawal, refusal to participate, having poor relationships with adults in authority, having poor relationships with peers, not achieving academically, engaging in criminal activity, or engaging in violence (Ray et al., 2013). Children's impaired ability to function appropriately can be problematic to teachers, caregivers, peers, and the children themselves; and is the primary reason most adults seek mental health services for children (Angold, Costello, Farmer, Burns, & Erkanli, 1999; Ray et al., 2013).

Lack of treatment for children's impairment in social-emotional competencies has serious consequences. Counseling interventions not only need to be effective and efficient, but also to be implemented early, as the level of social-emotional competencies children possess can set children on a trajectory toward success or failure both in school and out (Denham et al, 2012; CSMH, 2013). Social and emotional deficits are evident at an early age, are likely to worsen without treatment (Costello, Angold, & Keeler, 1999; CSMH, 2013; Dodge et al., 2006), and result in difficulties with aggression, relationships, academics, violence, risky sexual behavior, mental illness, and criminality. Early intervention for children with lack of adequate social-emotional competencies, is preferable to delaying treatment until adolescence or adulthood when problematic behaviors, legal issues, academic concerns, and substance abuse problems are likely to have already significantly affected their lives and the lives of others. With the importance of these competencies established in the literature, finding effective treatment is essential.

Play Therapy

When treating young children, counselors are most effective when they adopt developmentally appropriate interventions (Ray, 2011). Children naturally learn through play. As children's verbal abilities are not fully developed, they are better able to communicate complicated issues through play than words. Play therapy is a counseling intervention developmentally appropriate for young children (Landreth, 2012; Ray, 2011). Child-Centered Play Therapy (CCPT), specifically, is designed for use with younger children, making it a particularly promising intervention for pre-school and primary grade children (Ray et al., 2015). Although many play therapy interventions exist, CCPT is the most widely used and researched approach to play therapy (Bratton, Ray, Rhine, & Jones, 2005). CCPT is a manualized treatment with formalized treatment protocols and skills checklists to insure treatment fidelity (Ray, 2011; Ray, Purswell, Haas, & Aldrete, 2017). Additionally, CCPT is a nondirective play therapy modality, demonstrating higher levels of effects for young children than directive modalities (Bratton et al., 2015).

Research supports the choice of CCPT as an intervention for use with young children in schools for the purpose of improving social-emotional competencies. Plentiful research, including several meta-analyses, supports the effectiveness of both individual and group CCPT with a wide-range of impairments (Bratton, et al., 2005; Le Blanc & Ritchie, 2001; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015). Regarding the school population, specifically, research supports individual and group play therapy as both effective and practical treatment options in schools (Ray et al., 2015). Regarding children's social-emotional competencies, Landreth (2012) asserted CCPT is impactful in facilitating improvement in children's social-emotional competencies, and, indeed, research backs Landreth's assertions

(Fall, Navelski, & Welch; 2002, Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Ray & Bratton, 2010).

In applying CCPT to a group modality using a randomized controlled trial design, Cheng & Ray (2016) reported a statistically significant increase in empathy with a medium effect size for kindergarten children who participated in Child-Centered Group Play Therapy (CCGPT) as compared to children in a waitlist control group. Additionally, in the area of social competence, Cheng and Ray found children who participated in CCGPT demonstrated a statistically significant improvement over children in the control group with a medium effect size. However, results yielded no difference for self-regulation between treatment and control groups. Cheng and Ray is the only study to date that addressed the use of CCGPT specifically focused on social-emotional competencies. Therefore, a need exists for more research on the topic of CCGPT and social emotional competencies.

This current study builds on previous studies, in that it investigates the impact of both CCIPT and CCGPT on social emotional competencies. Four previous studies have compared the effectiveness of CCIPT and CCGPT on various aspects of social-emotional competencies (Pelham, 1972; Perez, 1988; Renee, 2003; Tyndall-Lind, Landreth, & Giordanno, 2001), but none of these studies focused specifically on the overall construct of social-emotional competencies. Additionally, results are mixed and inconclusive. As researchers conducted these studies 17-47 years ago, the studies suffer from design limitations when compared to current standards of methodological rigor. Pelham (1971) was the only study to utilize random assignment, yet measurements for this study lacked adequate reliability and validity support. Perez (1988) used a comparison design, but did not assign participants randomly, casting doubt on the equality of the three groups. Two studies (Rennie, 2003; Tyndall-Lind et al., 2001)

compared participants from two different non-simultaneous studies. Rennie compared her sample of 14 kindergarten children receiving CCIPT with an earlier sample from McGuire's (2001) study of 15 kindergarten children receiving CCGPT. Similarly, Tyndall-Lind et al. (2001) compared 10 children in sibling groups with participants from another study in which 11 children received CCIPT and 11 children were wait-listed (Kot, Landreth, & Giordano, 1998). Additionally, Tyndall-Lind et al. (2001) investigated specifically sibling groups, and their findings may not be applicable to non-sibling groups. Furthermore, the most recent of these four studies is 17 years old, indicating the need for a more current study.

Purpose

The purpose of this randomized controlled trial was to test the comparative effectiveness of CCIPT and CCGPT for improving social and emotional assets and resiliencies. Specifically, the research questions were: (a) Do children who participate in CCIPT and CCGPT improve in overall social-emotional assets (i.e., Self-Regulation/Responsibility, Social Competence, and Empathy) over children who do not participate in CCPT as measured by parents? (b) Do children who participate in CCIPT and CCGPT improve in overall social-emotional assets (i.e., Self-Regulation, Responsibility, Social Competence, and Empathy) over children who do not participate in CCPT as measured by teachers?

Methodology

Participants

Participants were 56 children recruited from four Title 1 elementary schools --schools with large concentrations of low-income students-- in a southwestern state. Inclusion criteria were that: (a) teachers, parents, or the school counselor referred children who were exhibiting problematic or disruptive behaviors, including difficulty with empathy, self-regulation, and peer

relationships; (b) children were at least 5 years old and in Grades K-4; (c) parents and teachers were willing to complete instruments; (d) participants did not receive play therapy or counseling from another source during the study; and (e) children understood and spoke English. In a priori power analysis using repeated measures within-between ANOVA, a medium effect size of .25, a probability of .05, power of .80, 3 groups, and 2 measures, G Power indicated a needed total sample size of 42 participants or 14 in each group, indicating the current study had an adequate number of participants.

Of the 56 participants, 14 were enrolled in kindergarten, 11 in first grade, 11 in second grade, 7 in third grade, and 13 in fourth grade. At the beginning of the study, 11 participants were 5 years old, 12 participants were 6 years old, 11 participants were 7 years old, 7 participants were 8 years old, 12 participants were 9 years old, and 3 participants were 10 years old. Most participants were male (46), and 10 were female. One participant identified as Asian, 17 as White, 21 as Hispanic, 8 as multiracial, and 9 did not identify an ethnicity.

Instruments

The Social and Emotional Assets and Resilience Scale (SEARS; Merrell, 2011) is a strength–based assessment tool measuring social and emotional competencies of children aged 5-18. Higher scores indicate higher levels of perceived functioning (Merrell, 2011). For the purpose of this study, researchers used both the SEARS-Parent (SEARS-P) and SEARS-Teacher (SEARS-T) to get a holistic perspective on each child (Merrill, 2011).

The SEARS-P has strong psychometric properties. Strong Cronbach's alpha coefficients indicate validity for the three subscales and total score as follows: Self-regulation/Responsibility (.95), Social Competence (.89), Empathy (.87), and Total (.96). Test-retest reliability coefficients for all three subscales and total score are strong: Self-regulation/Responsibility

(.92), Social Competence (.88), Empathy (.90), and Total (.93). To confirm convergent validity, researchers compared the SEARS-P with two strength-based assessments that had strong psychometric properties, were standardized, and were widely used: the Social Skills Rating System-parent rating form (SSRS-P; Gresham & Elliott, 1990) and the Home and Community Social Behavior Scales (HCSBS; Merrell & Caldarella, 2002). The Pearson product-moment correlations between the SEARS-P and both the SSRS-P and the HCSBS were statistically significantly positive, with coefficients ranging from .22-.75 and .38-.87, respectively, and with a correlation between total scores of .74 and .87, respectively (Merrell, 2011). For the current study, Cronbach's alpha for the total scale was .96 for the SEARS-P.

The SEARS-T also has strong psychometric properties. Cronbach's alpha coefficients are high and range from .91-.98 for the four scales and total score. Test-retest reliability coefficients are strong (ranging from .84-.94). To confirm convergent validity, researchers compared the SEARS-T with two strength-based assessments that are standardized, widely used, and have strong psychometric properties: the Social Skills Rating System (SSRS; Gresham & Elliott, 1990) and the School Social Behavior Scales (SSBA-2; Merrell & Caldarella, 2002). The Pearson product-moment correlations between the SEARS-T and the SSRS (teacher version) were statistically significantly positive, yielding coefficients ranging from .39-.82, a median of .70, and a correlation between total scores of .82. The Pearson product-moment correlation between the SEARS-T and the SSBS-2 Peer Relations scale was positive as well, with coefficients ranging from .76-.90, with a median of .80 (Merrell, 2011). For the current study, Cronbach's alpha for the total scale was .94 for the SEARS-T.

The purpose of the SEARS is not to provide a diagnosis. Rather, score interpretation involves placement of scores into one of three Tiers. Tier 1 indicates "Average to High" (p. 34)

functioning and includes children scoring from the 21st to the 99th percentile. Children in Tier 1 appear to be functioning within the "normal" range, and probably do not have need of intervention. Tier 2 indicates "At Risk" (p. 34) functioning. Tier 2 includes children scoring from the 6th to the 20th percentile, which is approximately one standard deviation below the mean. Children scoring in this range may have "emerging social-emotional deficits" (p. 35) and may benefit from intervention. Tier 3 indicates "High Risk" (p. 35) functioning. About 5% of children score in the Tier 3 range, indicating a high risk for serious impairment and a probable need for intervention (Merrill, 2011).

Procedures

The researchers received approval from the university Institutional Review Board and from participating school districts prior to recruitment. We recruited participants by talking to administrators, teachers, school counselors, and parents in person. Additionally, we sent a recruitment letter to all teachers in the four selected schools, informing them of the study and asking them to refer children with disruptive or problematic behaviors to the school counselor. Once a participant was referred, we contacted parents/guardians through information letters regarding the study and collected parent and teacher permission forms and completed pre-test assessments. The current study was a smaller exploration of play therapy effectiveness within a larger study. As a result, all African American child participants were selected to be part of another study and did not participate in the current study. For all other children identified for the study, researchers used block randomization, stratified first by school, to randomly assign children into one of three groups: (a) CCIPT treatment group, (b) CCGPT treatment group, and (c) waitlist control group. We placed children participating in CCGPT in two-person CCGPT groups, pairing children who were within 12 months of age, according to best practice (Sweeney

et al., 2014). As researchers did not stratify children by grade (age and development are better criteria for grouping), researchers continued to recruit participants until we could pair all children with group treatment modality assignment with a group member of an appropriate age.

Standard practice in CCGPT (Ray, 2011) provided the rationale for two-member groups, as did, in part, the referral criteria. A play therapy group with more than two children with problematic or disruptive behavior could prove to be difficult for the therapist and unhelpful to the children. Limited playroom space also impacted the decision to have two participants per group. Additionally, some playrooms were in close proximity to classrooms, and researchers were concerned about the possibility of noise disrupting these classrooms.

Children in both the CCIPT and CCGPT groups participated in bi-weekly 30-minute sessions of CCPT for eight weeks, for a total of 16 sessions. Therapists provided treatment in accordance with the protocol outlined in the CCPT treatment manual (Ray, 2011), with modifications enacted as necessary and appropriate for CCGPT. In accordance with client-centered principles, therapists sought to be non-directive, genuine, non-judgmental, and empathetic. Therapists created a safe, warm, and permissive therapeutic environment. Therapists used responses such as tracking, reflection of content, reflection of feeling, reflection of meaning, limit-setting, returning responsibility, and facilitation of emotional expression (Landreth, 2012; Ray, 2011). Children participated in CCPT in playrooms on their elementary school campuses. In accordance with recommendations by Ray (2011), we equipped playrooms with developmentally appropriate toys and materials selected to encourage maximum emotional expression and communication. Researchers selected toys and materials intended to facilitate expression of nurturance, aggression, mastery, control, imagination, and creativity.

To ensure uniformity and integrity of treatment, all therapists were doctoral-level counseling students with a master's degree in counseling and at least one year of experience in providing play therapy. All therapists had completed at least two 3-hour master's level university courses in play therapy, including a course dedicated to CCGPT. Most therapists (six of 10) provided both group and individual sessions. To further ensure integrity and uniformity of treatment, all therapists participated in a two-hour training on the protocols for conducting CCPIT and CCGPT in schools.

All therapists participated in weekly group supervision by a faculty member with advanced experience in play therapy. Additionally, researchers assessed protocol adherence by randomly reviewing one session per child using the CCPT Research Integrity Checklist (CCPT RIC; Ray et al, 2017) when the treatment was CCIPT or using the revised Group Play Therapy Skills Checklist (Cheng & Ray, 2016) when the treatment was CCGPT. Sessions adhered to CCPT protocol with an average of 97.53% adherence to protocol per session.

Children in the waitlist control group remained in the classroom during the fall semester when the intervention took place. Therapists provided the children on the waitlist group with individual or group CCPT in the spring, in accordance with ethical standards. Although researchers did not inform either parents or teachers as to whether a child was in the experimental or waitlist group, teachers, in particular, were likely aware.

After the eight-week intervention period, parents completed the SEARS-P, and teachers completed the SEARS-T. Participants in the waitlist control group did not participate in treatment until after data collection was completed, when they received the same intervention (either CCIPT or CCGPT). Therapists used their therapeutic judgment to determine whether children on the wait list received CCIPT or CCGPT.

Results

In order to address the research question exploring the impact of CCIPT and CCGPT on children's social and emotional assets, researchers conducted two mixed between-within analysis of variance (ANOVA) tests with the pre- and post-test Total Scores on the SEARS-P and SEARS-T as the within-subject factor, and treatment groups (CCIPT, CCGPT, and waitlist control group) as the between-subject factor. We tested and adequately met the assumptions necessary to conduct mixed between-within ANOVA, including independence of observations, normal distribution, homogeneity of variance, and homogeneity of intercorrelations (Pallant, 2013). We set the criterion for statistical significance at $p \leq .05$ and used Cohen's (1988) cautious thresholds for practical significance of η^2: .01 for small, .06 for medium, and .14 for large effect.

Parent Results

Results of the mixed between-within ANOVA on the Total score of the SEARS-P indicated a statistically significant interaction effect between treatment group and time, F (2,53) = 3.15, p = .05, η^2 = .11 (a moderate to large effect; Cohen, 1988). Table 1 presents the means and standard deviations. Results indicated that, following the intervention, parents of children in CCIPT and CCGPT reported statistically significant improvement in Total Social and Emotional Competencies Scores with a medium to large effect, compared to parents of children in the waitlist group. Exploration of means reveals that children in the CCIPT and CCGPT groups were reported to have improved social-emotional competencies while children in the control group experienced negligible improvement. Figure 1 provides a visual depiction of the improvement in scores from pre-test to post-test for all three groups. According to the graph, it

appears that both CCIPT and CCGPT are equally impactful in facilitating development of children's social-emotional competencies.

Although researchers utilized random assignment for group placement, we noted the difference in pretest social-emotional competency scores between groups. Upon statistical comparison of pretest scores using ANOVA, results revealed no statistically significant difference between groups at pretest. Researchers also noted all three groups were comparable in age, with mean age in years being 7.07, 6.86, and 6.72 for the CCITP, CCGPT, and the wait list groups, respectively.

Because SEARS-P Total scores yielded a statistically significant interaction effect with moderate to large practical significance, researchers conducted further analysis on SEARS-P scores to specifically examine the differences in the subscales comprising the Total score. In order to explore the differential impact of Self-Regulation/Responsibility, Social Competence, and Empathy on statistically significant findings on the total Social and Emotional Competencies score, we conducted three ANOVAs using the gain scores on each subscale (Self-Regulation/Responsibility, Social Competence, and Empathy) as dependent variables and assignment to play therapy or control group as the independent variable (Dimitrov, 2013). Because there was little difference in outcome regarding the group or individual CCPT assignment, the play therapy groups were collapsed into one for the analyses.

For Self-Regulation/Responsibility, there was a statistically significant difference between the CCPT group and control group (F (1,54) = 4.03, p = .05) with moderate effect size of η^2 = .07. For Social Competence, there was a statistically significant difference between CCPT group and control group (F (1,54) = 4.07, p = .05) with moderate effect size of η^2 = .07. For the Empathy subscale, results indicated no statistically significant difference between the

CCPT group and the control group (F (1,54) = .53, p = .47) with a negligible effect size of η^2 = .01.

Additionally, in terms of clinical significance, parents of children in the CCIPT and CCGPT groups noted more improvement than parents of children in the waitlist group. Specifically, the number of children in the High-Risk category decreased by 50% for children in CCIPT and CCGPT, as compared to 16.6% of children in the waitlist group. This finding suggests CCPT may be helpful for children at high risk for serious impairment. Table 2 presents the number of children scoring in the High-Risk Tier level for the intervention group (both CCIPT and CCGPT) and control group at pre-test and post-test.

Teacher Results

Results of the mixed between-within ANOVA on the Total score of the SEARS-T indicated no statistically significant interaction between treatment group and time, F(2,52) = .76, p = .47, η^2= .03 (a small effect). Results indicated that teachers did not report statistically significant improvement after intervention for children in the CCIPT and CCGPT group as compared to children in the waitlist control group. The small effect size indicated only a small practical difference attributed to group assignment. Table 3 presents the means and standard deviations. Figure 2 provides a visual depiction of the improvement in scores from pre-test to post-test for all three groups. Given that the ANOVA results indicated no statistically significant difference with small effect between the individual, group, and control conditions, researchers conducted no further investigation.

Discussion

Summary of results of the current study indicated that parents of children in CCIPT and CCGPT reported significantly greater improvement in overall social-emotional competencies

compared to parents of children in the waitlist group. Parents of children in CCIPT and CCGPT reported significantly greater improvement in self-regulation and responsibility, as well as social competence, when compared to parents of children in the waitlist group. Teachers of children in CCIPT and CCGPT did not report statistically significant improvement in overall social-emotional competencies compared to teachers of children in the waitlist group. Therefore, parents, but not teachers, reported a significant improvement in the social emotional competencies of children receiving CCIPT and CCGPT.

Parents of children in CCIPT and CCGPT reported statistically, practically, and clinically significant improvement with medium to large effect in overall social and emotional competencies when compared to parents of children in the waitlist group, indicating the positive impact of school-based CCPT with elementary students who display emerging or serious impairment in social-emotional development. The findings indicate that both CCIPT and CCGPT may be viable interventions for facilitating children's overall social-emotional development. Specifically, parents of children in the play therapy experimental groups reported significant improvement in self-regulation/responsibility and social competence. Social competencies appeared to improve equally with play therapy, regardless of whether the modality was individual or group. Therefore, it could be suggested that counselors may maximize their time and resources by using the group modality, without concern that group intervention will result in less improvement than individual intervention. However, group CCPT involves therapeutic judgment, ethical decision making, and complex counseling skills in order to select appropriate group members, match group members therapeutically, and facilitate a self-directed environment.

Parents of children in all three groups reported no statistically significant improvement in Empathy subscale scores. Several possible explanations exist for the lack of results for development of empathy. Whether in group or individual format, empathy may be more difficult to impact with therapy than other constructs, and may require more long-term therapy, as indicated by Cheng & Ray (2016). Just as internalizing behaviors are harder to observe or measure than externalizing behaviors, empathy may be harder to observe or measure than either self-regulation/responsibility or social competence. Additionally, the Empathy subscale may be less sensitive than the Self-Regulation/Responsibility subscale as the Empathy subscale consists of one-third the number of items.

Teacher Perceptions

According to teachers, all three groups of children improved from pre- to post-test. Unlike parents, however, teachers of children in CCIPT and CCGPT did not report statistically significant improvement when compared to teachers of children in the waitlist group on overall social-emotional assets. Both the control and CCIPT groups improved an average of 1.3 points per participant, whereas participants in CCGPT improved 3.9 points on average--3 times the amount of improvement in either CCIPT or control groups, but not large enough to result in statistical significance.

Lack of statistically significant results based on teacher reports is consistent with previous research (Cheng & Ray, 2016; Garza & Bratton, 2005). Historical research on teacher perceptions indicates variability in teacher versus parent report on childhood behavior and emotional well-being (Achenbach, McConaughy, & Howell, 1987; Epkins & Meyers, 1994). In addition to unique perceptions of teachers, teacher report in the current study may have been influenced by failure to provide a controlled environment for teacher evaluation (Cheng & Ray,

2016; Garza & Bratton, 2005). Also, factors relating to the time of year may have affected results (Cheng & Ray, 2016; Garza & Bratton, 2005; Helker & Ray, 2009), specifically asking teachers to complete pre-testing before they have had time to know children well, and asking teachers to complete post-testing during the holiday season when they are busy, schedules are disrupted, and children are distracted. Additionally, teachers may not notice some differences in student behavior, particularly internalizing behavior (Helker & Ray, 2009). Finally, the SEARS-T may not be a sensitive enough instrument for measurement of teacher perceptions.

Comparison of CCIPT and CCGPT: Existing Theory and Usage

Because researchers explored the use of both individual and group CCPT, it is helpful to consider whether the study confirms existing theory and current uses of both treatments. CCIPT is a more common modality, perhaps because CCGPT requires more advanced training and competence than CCIPT (Ray, 2011). Therapists are typically more hesitant to conduct CCGPT sessions than CCIPT sessions due to anxiety over the increased pace, limit setting opportunities, and opportunities for conflict between children (Ray, 2011). Additionally, CCGPT requires more space and creates more noise and mess than CCIPT (Ray, 2011), which is difficult for counselors whose office space is limited or located near other offices or classrooms. CCGPT is more complicated than CCIPT in that counselors must screen each group member for appropriateness of membership (Ray, 2011). Some children may not be appropriate for CCGPT, such as children who are acting out sexually or are violent towards other children (Ray, 2011). Additionally, scheduling is more complicated for CCGPT than CCIPT (Ray, 2011). Finding two or more children who are appropriate for group counseling, are within 12 months of age of each other, and are available at the same time can be challenging, but definitely more feasible for counselors in schools than in other locations. A therapeutic advantage of CCIPT

over CCGPT is that the child does not share the relationship with the counselor, an especially important consideration for children with attachment problems (Ray, 2011).

On the other hand, CCGPT provides some advantages beyond child-centered individual play therapy (CCIPT) in that the benefits of CCPT are joined with the benefits of the group process (Sweeney, Baggerly, & Ray, 2014). Some of the advantages of CCGPT include opportunity for children to learn from observing/modeling a peer, receiving feedback on the impact of their own behavior from a peer, and acting out social problems with a peer in the presence of a trained and caring adult. Due to the presence of another child, CCGPT sessions tend to be very "grounded in reality" and therefore theoretically more amenable to generalization outside the playroom (Sweeney, Baggerly, & Ray, 2014; Sweeney & Homeyer, 1999; Ray, 2011). Additionally, many children feel less anxious about therapy in the presence of another child, have many more opportunities to respond to limit setting in the presence of another child, and act more freely in the presence of another child, leading to quicker therapeutic movement (Sweeney, Baggerly, & Ray, 2014; Sweeney & Homeyer, 1999), an important consideration in light of managed care, lack of services, and large caseloads. Regarding the decision to use CCIPT or CCGPT, the current standard recommendation is that group play therapy is preferable to individual play therapy with children's social issues (Sweeney et al., 2014; Sweeney & Homeyer, 1999). This study indicates the current theory on the benefits of CCGPT may be valid, specifically with the constructs of self-regulation/responsibility and social competence.

Limitations and Recommendations

Some limitations in the current study existed: (a) The researchers selected participants from a convenience sample in local area schools, limiting generalizability (b) parent and teacher knowledge of whether or not a child was receiving treatment, could have possibly resulted in

rater bias or placebo effect (Bryman, 2008; Rubin & Bellamy, 2012) (c) as researchers used two forms of the same measurement, the possibility of mono-methods bias constituted a threat to construct validity (Trochim, 2006) (d) the current study lacked African American participants, due to all African American children participating in a separate part of the larger study.

Recommendations for future research include: (a) replicating the current study with the inclusion of African American participants (b) comparing CCIPT and CCGPT to an already existing evidence-based treatment rather than a control group (c) using a second measurement instrument in addition to the SEARS (d) using school counselors as treatment providers (e) providing a controlled environment for teachers to complete assessments (Garza & Bratton, 2005), by providing substitute personnel to relieve teachers of class, lunch and/or recess duty, giving teachers the opportunity to complete assessments in an unhurried manner (f) providing a more thorough explanation of the rationale for pre- and post-assessment to parents and teachers (g) continuing to collect data from both teachers and parents due to the inconsistent findings between parents and teachers (h) the addition of an independent rater for a relatively unbiased observation of children (i) comparing long-term CCIPT and CCGPT which might result in even more substantial findings and (j) the development of a formal CCGPT manual as CCGPT requires different skills, training, materials, and responses than does CCIPT. Finally, the result of random assignment for this study was that children in the group condition were of various ages and grades, making it necessary to continue to recruit participants in order to find appropriate matches. Future researchers might avoid the difficulty we had in matching appropriate group members for CCGPT by utilizing a narrower age range of participants or blocking by grade when randomizing.

Implications

The results of the current study help to confirm the effectiveness of both CCIPT and CCGPT as viable interventions for the facilitation of children's social and emotional competencies. Specifically, this study indicates group and individual CCPT may be effective for the development of overall social-emotional assets, including self-regulation/responsibility and social competence. This result is important for many reasons, not the least of which is that CCPT is one of few models of therapy developmentally appropriate for young children. Additionally, this study indicates the current theory on the benefits of CCGPT may be valid, specifically with the constructs of self-regulation/responsibility and social competence. In terms of the comparative effectiveness of CCIPT and CCGPT, researchers found no statistically significant difference in overall social-emotional competencies. However, regarding the specific subcategories of social-emotional competence (empathy, self-regulation, and social competence), this study appears to indicate CCIPT may be more effective for increasing children's empathy, while CCGPT may be more effective for increasing children's self-regulation. Although CCIPT and CCGPT appeared to be equally effective for improvements in social-competence, CCGPT would be the more time-efficient, cost-effective intervention, yet involve more complexity for delivery.

In terms of interventions for use in schools, specifically, the results of this study help to confirm the viability of CCPT (both group and individual) as an appropriate and effective treatment for use in schools. It appears it could be valuable for university programs to train school counselors (and any counselor working with child populations) in CCIPT and CCGPT. As training is one of the major obstacles for CCGPT usage, universities already training counselors in CCIPT, could add further training in CCGPT to help counselors efficiently meet the growing need for services. Counselors who work with children and are concerned with social-emotional

competencies would appear to benefit from training in CCPT. Although further research is needed to be conclusive, it appears counselors may be effective when using CCGPT, specifically, with children needing improvement in self-regulation. School counselors, in particular, could maximize their impact by becoming comfortable with CCGPT, as it appears effective, when appropriate, and is a more efficient use of school counselors' time, and as school counselors have access to enough children to easily utilize group counseling. While it is important for school counselors to be able to meet the social-emotional needs of children, large case-loads make this challenging. Therefore, it behooves school counselors and other clinicians to work together to provide services in schools for children.

Conclusion

The current study was only the second randomized controlled study to compare CCIPT and CCGPT, the last one (Pelham, 1971) having been conducted 45 years ago. Clearly, more current research is needed comparing CCIPT and CCGPT. As the current study was the first to compare CCIPT and CCGPT in the development of overall social-emotional competencies, it is important that future researchers replicate this study. According to the results of this study, both CCIPT and CCGPT appear to be effective interventions for improving school children's social-emotional competencies. Until more research is completed on the use of CCGPT with empathy, authors recommend using CCIPT when treating children with obvious empathy deficits. However, it appears CCGPT would be the intervention of choice for those children needing treatment in self-regulation. Although CCIPT and CCGPT appear to be equally effective for social competence, CCGPT might be the more efficient treatment alternative.

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Table 1 *SEARS-P Total Scores: Pre- and Post-Test Scores by Group*

	CCIPT (*n* = 17)			CCGPT (*n* = 21)			Control (*n* = 18)		
Total Score	Pre-Test	Post-Test	Mean Difference	Pre-Test	Post-Test	Mean Difference	Pre-Test	Post-Test	Mean Difference
M	39.41	43.88	**4.47**	35.76	39.57	**3.81**	39.33	39.50	**0.17**
SD	7.13	7.94	6.36	8.47	10.43	4.97	12.91	10.29	5.36

Note: An increase in score indicates an improvement in social-emotional assets

Table 2

Number of Children Scoring in the High Risk Tier for Intervention and Control Groups

	Intervention Group		Waitlist Control Group	
Tier	Pre-Test (n = 38)	Post-Test (n = 38)	Pre-Test (n = 18)	Post-Test (n = 18)
High-Risk	16	8	6	5

Note: SEARS software converted scores based upon participants' raw score, T-score, and percentile.

Table 3

SEARS-T Total Scores: Pre- and Post-Test Scores by Group

	CCIPT (n = 16)			CCGPT (*n* = 21)			Control (*n* = 18)		
Total Score	Pre-Test	Post-Test	Mean Difference	Pre-Test	Post-Test	Mean Difference	Pre-Test	Post-Test	Mean Difference
M	41.44	43.31	**1.87**	36.14	39.57	**3.43**	37.22	38.56	**1.34**
SD	8.99	8.72	6.22	8.46	8.38	5.97	6.32	7.04	4.16

Note: An increase in score indicates an improvement in social-emotional assets