

Child-Centered Play Therapists' Experiences of Conducting Group Play Therapy in Elementary
Schools

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Abstract

Child-Centered Group Play Therapy (CCGPT) is an effective, developmentally appropriate, and efficient mental health treatment for young children (Ray, 2011; Sweeney, Baggerly, & Ray, 2014). However, CCGPT is underutilized (Sweeney, Baggerly, & Ray, 2014), especially in elementary school settings. To investigate this underutilization, the researchers undertook this qualitative study to explore six play therapists' perceptions of conducting CCGPT in four elementary schools. Three overarching themes emerged from the data: *Internal Responses During Clinical Experiences*, *Perception of CCGPT*, and *Observed Change*. Results support the use of CCGPT in schools and highlight the need for counselor training in CCGPT.

Keywords: child-centered group play therapy, phenomenology, play therapist experiences, qualitative research, school-based mental health interventions

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Mental, social-emotional, and behavioral disorders among children are alarmingly high. However, very few children receive mental health treatment outside of the school setting (Center for School Mental Health [CSMH], 2012). Play therapy is a developmentally appropriate mental health intervention for young children, and child-centered play therapy (CCPT) is the most widely used approach (Bratton, Ray, Rhine, & Jones, 2005; Landreth, 2012; Ray, 2011). In the elementary school setting, where children with mental health needs far outnumber the available mental health providers (CSMH, 2012; U.S. Department of Education [DOE], 2017; Ray, 2011), child-centered group play therapy (CCGPT) has the potential to be an equally effective and more efficient approach than individual play therapy (Ray et al., 2014; Sweeney, Baggerly, & Ray, 2014; Sweeney & Homeyer, 1999). However, CCGPT is not often implemented in school or other settings (Sweeney et al., 2014). Most research into CCGPT is outcome-based and does not explain this discrepancy. The purpose of the current study is to investigate facilitator perceptions of implementing CCGPT in a school setting to uncover potential barriers to its use in elementary schools.

Mental Health Services in Schools

Schools are the most effective setting for delivering mental health services to children. Whereas about 20% of children and adolescents have mental, emotional, or behavioral disorders, as many as 70% of these children do not receive treatment (CSMH, 2012). Of the children who do receive treatment, 70-80% receive treatment in schools. Additionally, of those children referred to treatment outside the school, only 13% follow through on the referral as compared to 96% of students who follow through on referrals to in-school mental health services (CSMH,

2012). Clearly, a need exists for in-school mental health treatment (conducted by school counselors or other school-based mental health providers) in order to meet the widespread needs of children.

Child-Centered Play Therapy

Because children do not have fully developed verbal abilities and are better able to communicate through play, mental health providers should employ developmentally appropriate interventions, such as play therapy, to meet the critical need for services (Landreth, 2012; Ray, 2011). CCPT, the most widely used and researched play therapy approach, was developed specifically for young children, and is a developmentally appropriate and effective intervention (Bratton, Ray, Rhine, & Jones, 2005; Landreth, 2012; Ray, 2011). CCPT consists of both individual (CCIPT) and group (CCGPT) modalities and is effective for a multitude of problems (Ray, 2011).

CCPT has extensive support for its effectiveness both in and out of school settings (Bratton et al., 2005; Lin & Bratton, 2014; Ray, Armstrong, Balkin, & Jayne, 2014). Results of several metaanalyses support this conclusion. Bratton et al. (2005), completed a meta-analysis of 93 play therapy studies, using both individual and group modalities, and discovered an overall large treatment effect of .80 standard deviation, with humanistic play therapy modalities (such as CCPT) outperforming non-humanistic play therapy approaches. In 2013, Lin and Bratton conducted a meta-analysis of 53 studies based on a child-centered approach, and found a statistically significant, moderate effect size of .47. In 2014, Ray et al. conducted a meta-analysis evaluating the effectiveness of CCPT in 23 research studies, all of which were school-based, and concluded CCPT was effective (Cohen's $d = .21 - .38$) in addressing diverse issues, such as internalizing behaviors, externalizing behaviors, self-efficacy, academic issues, and other

problems. None of these meta-analyses reported any difference between the effectiveness of individual and group modalities (Bratton et al., 2005; Lin & Bratton, 2013; Ray et. al, 2014).

Individual Play Therapy vs. Group Play Therapy

In fact, four research studies specifically compared individual and group CCPT. These researchers also found no difference in the effectiveness of individual and group CCPT, with both treatments being effective (Blalock, Lindo, & Ray, in press; Pelham, 1971; Perez, 1988, Tyndall-Lind et al., 2001). Most recently, in a randomized controlled trial study, Blalock et al. (in press) found CCIPT and two-person CCGPT to be equally statistically significantly related to improvements in elementary school children's social and emotional assets, according to parent report on the Social Emotional Assets and Resilience Scale – Parent (SEARS-P; Merrell, 2011). Similarly, in a controlled trial study by Tyndall-Lind et al. (2001), children in a domestic violence shelter receiving either CCIPT or two-person CCGPT exhibited statistically significant improvement in behavior problems, with no statistically significant differences between CCIPT and CCGPT treatments. Therefore, evidence indicates practitioners can utilize CCGPT without concern that they will be less effective than with CCIPT.

The number of students needing mental health services is at a crisis level (CSMH, 2012), and school counselors have too much to do in too little time (Stone & Dahir, 2016). Although the American School Counselor Association recommends a school counselor to student ratio of 250 to 1 (ASCA, 2012), the current average ratio is 455 to 1 (U.S. DOE, 2017), almost twice the recommended level. CCGPT has the potential to address this concern because it is efficient as well as effective; mental health providers using a group approach can treat more than one child at a time (Ray et al., 2014; Sweeney et al., 2014; Sweeney & Homeyer, 1999).

Child-Centered Group Play Therapy

CCGPT is a non-directive approach in which the group play therapist employs the same techniques as in CCIPT. The primary difference between CCIPT and CCGPT is that the presence of another child or children provides a variety of different opportunities for growth, and allows children to act as therapeutic agents for one another (Ray, 2011). Ray (2011) recommends that CCGPT groups consist of only two to three children so that the therapist can stay fully attuned to all group members and manage logistical concerns that arise with more group members.

As with CCIPT, CCGPT is broadly applicable to different children in different situations (Ray, 2011). Treatment in CCGPT is related to improvement in various childhood problems, such as anxiety, depression, negative self-esteem, and complex psychological trauma (Baggerly, 2004; Danger & Landreth, 2005; Kwon & Lee, 2018). CCGPT is also related to improvements in children's functioning, including social skills, self-control, competence, self-confidence, self-acceptance, and affection (Baggerly, 2004; Cheng & Ray, 2016; Su & Tsai, 2016; Trostle, 1988). The approach is effective with a broad range of children from a variety of cultures and at different ages: 4- to 5-year-old children with speech impairment (Danger & Landreth, 2005), 5- to 11-year-old homeless children (Baggerly, 2004), 8- to 9-year-old North Korean refugee girls (Kwon & Lee, 2018), 4- to 5-year-old bilingual Puerto Rican boys (Trostle, 1988), and second- and third-grade immigrants to Taiwan (Su & Tsai, 2016).

Problematic behaviors are often an area of concern in school settings. Several recent research studies support the use of CCGPT with problematic behaviors. Specifically, children living in a domestic violence shelter who received sibling CCGPT had statistically significantly improved scores for total behavior problems, externalizing behavior problems, internalizing problems, depression, anxiety, self-esteem, and aggression (Tyndall-Lind et al., 2001).

Preadolescents with learning disabilities and behavior problems who received CCGPT experienced statistically significant improvement in externalizing behavior problem and total problem scores (Packman & Bratton, 2003). CCGPT was related to greater decreases in total problem behaviors than a psychoeducation group and a waitlist group of 6- and 7-year-olds in a single case design study (Swank, Cheung, & Williams, 2018). Additionally, two- to three-person CCGPT in 43 kindergarten students was related to a statistically significant increase in empathy in a randomized controlled trial by Cheng and Ray (2016). In another randomized controlled trial study, of which this study's participants were a part, parents of 56 elementary participants with problematic behavior reported statistically significant increases in self-regulation/responsibility and social competence (Blalock et al., in press). Finally, in a metaanalysis evaluating the effectiveness of 23 school-based CCPT research studies, including CCGPT studies, Ray et al. (2014) concluded "CCPT may produce effects in externalizing problem behaviors and academic gains beyond those interventions typically accepted in schools, such as solution-focused therapy" (p. 121). Despite its effectiveness and efficiency, however, CCGPT is generally underutilized (Sweeney et al., 2014), including in elementary school settings.

Facilitator Perceptions of Group Play Therapy

There is little research that provides insight into why CCGPT is underutilized. To date, research in group play therapy has predominantly been outcome research rather than qualitative inquiry. Of the qualitative and mixed method research studies on group play therapy that do exist, most also focused on outcomes for the children who participated, albeit in the form of qualitative data (Danger & Landreth, 2005; Hillman, Penczar, & Barr, 1975; Hunt, 2010; Kwon & Lee, 2018; Packman & Bratton, 2003; Perryman, Moss, & Cochran, 2015; Su & Tsai, 2016). The positive outcomes reported in these studies belie the lack of implementation of CCGPT.

More information about the group facilitators is needed to understand how to increase the use of CCGPT.

In conducting a literature search, the researchers in the current study found only three qualitative studies that explored facilitator perceptions of group play therapy interventions (Parker & Nicol, 1981; Siu, 2014; Tucker, Schieffer, Wills, Hull, & Murphy, 2017). Two of these involved classroom-based Theraplay® interventions performed by teachers (Siu, 2014; Tucker et al., 2017), which are quite different from CCGPT performed by clinically trained child-centered play therapists. Siu (2014) trained teachers in Theraplay and Group Theraplay, which they then used with groups of students with developmental disabilities and low social skills. The teachers reported that they struggled to learn how to implement the intervention and found it to be tiring during the learning process, but had a positive view of the intervention overall (Siu, 2014). Tucker et al. (2017) trained preschool teachers in the Sunshine Circles model of Theraplay® who then implemented this in their classroom settings during the course of the school year. The preschool teachers reported improvements in their relationships with the students and an overall reduction in their stress due to decreased behavior problems. However, they also discussed logistical challenges, such as the difficulty of training teacher's assistants in a setting with high turnover and having access to the trainer for supervision, as well as the time it took teachers to develop confidence in their new skills (Tucker et al., 2017). The third study, conducted by Parker and Nicol (1981), used a non-directive approach based on Virginia Axline's work, which, while similar to, is not the same as CCGPT. Although the group facilitators indicated an intention to continue to use play therapy techniques, some expressed reservations, specifically noting experiencing stress regarding conducting play groups in schools versus clinic settings (Parker & Nicol, 1981). While these three studies hint at some of the possible barriers to implementing CCGPT in schools, no study has specifically explored facilitator perceptions of CCGPT in the school setting.

Purpose of the Study

Because CCGPT is underutilized (Sweeney, Baggerly, & Ray, 2014), especially in elementary school settings, an exploration of mental health professionals' reluctance to utilize CCGPT is warranted. Additionally, as qualitative research appears to be underutilized in play therapy research, and as the researchers desired an in-depth exploration of the phenomenon of conducting CCGPT in elementary schools, we investigated counselors' perceptions of conducting CCGPT in elementary schools, gathering in-depth data on the group facilitators' perspectives. We believe researching group facilitators' perspectives on the benefits and challenges to conducting group play therapy might shed some light on the underutilization of CCGPT in the school setting. Ultimately, we hoped our results might encourage mental health providers, including school counselors, to conduct CCGPT in schools, and might encourage counselor educators and supervisors to provide CCGPT group training and supervision.

Therefore, the researchers in the current study sought to qualitatively examine the lived experiences of six play therapists conducting CCGPT in a school-based setting. Utilizing semi-structured individual interviews, this study addressed the following guiding research questions: (1) What are group play therapists' perceptions of the process and structure of group child-centered play therapy? (2) What are group play therapists' perceptions of the impact of group child-centered play therapy on children's behavior? (3) What are group play therapists' perceptions of the role of relationships in group play therapy?

Method

Research Design

The aim of the current study was to learn about therapists' experiences conducting group play therapy in elementary schools. Thus, a phenomenological approach was fitting for the

investigation. Phenomenology is a qualitative research method used when researchers seek to better understand the meaning of an experience or a phenomenon for a group or individual (Patton, 2002). The research team utilized a transcendental phenomenological approach to reveal the essence of the therapists' experiences and to allow the researchers "to see (the experiences of the phenomenon)...as if for the first time" (Moustakas, 1994, p. 85). Moustakas (1994) listed the core components of transcendental phenomenology when applied to human science research: (1) a scientific study of the appearance of things; (2) concerned with wholeness but uses a multi-faceted lens to reach the essence of a phenomenon; (3) seeks meanings from appearances using intuition and reflection to arrive at ideas and understandings; (4) committed to description rather than analysis; (5) connected to the researcher who is passionate about the subject matter under inquiry; (6) interweaves subjectivity with objectivity; (7) requires a sense of what the experience means; (8) includes the researcher's experience as fundamental information of scientific investigation; and (9) carefully crafted so that every statement, method, and research question guides a phenomenological process.

Participants

The current study was part of a larger study (Blalock et al., in press) which explored the impact of both individual and group play therapy on the social-emotional competencies of elementary school children with problematic behavior. Participants of the current study include the six play therapists who conducted group child-centered play therapy for the larger study. Participants conducted CCGPT in four elementary schools located in two cities in a southwestern state of the United States (US). One play therapist was a university professor, researcher, and author. The remaining five therapists were in the process of earning their doctoral degree. All play therapists had taken at least one class in play therapy, one in advanced play therapy, one in

group and activity play therapy, and one class in child-parent relationship therapy. All participants had experience in conducting child-centered individual play therapy (CCIPT) and CCGPT, although all but two of the participants had limited group experience – typically experience in leading one group. All participants were female, five were Caucasian, and one was African American. Participants ranged in age from 26 to 56. Two participants were experienced certified school counselors who were also Licensed Professional Counselor Supervisors (LPC-S) and Registered Play Therapist Supervisors (RPT-S), and four participants held provisional license as Professional Counselors (LPC-I). Each play therapist participant conducted between one and six groups for this study, each group consisting of 16 bi-weekly 30- minute sessions of 2-member CCGPT. All participants were given pseudonyms: Kate, Olivia, Jamie, Mariella, Sophia, and Deja.

All therapists conducted sessions with children in grades K-4 (aged 5-11 years). Group membership was decided based on age, with children in each two-person group being within 12 months of the same age. Children were not grouped according to presenting problem, as is consistent with CCPT (Landreth, 2012; Ray, 2011). Twenty-four children (16 males and 8 females) from four different schools in the Southwest US participated in two- member group sessions. Children were fairly evenly distributed between ages 5 – 9, with five children each being 6, 7, and 8 years old. Three children were 5 years old, and six children were 9 years of age. The participating children came from a variety of racial backgrounds: 1 child was identified as Asian, 2 as African-American, 5 as White, 10 as Hispanic, 2 as multiracial, and 4 as unspecified. All children exhibited problematic behaviors, as reported by teachers.

Blalock et al. (in press) elected to use 2-member groups for several reasons. Unlike many other interventions, such as psychoeducation, CCGPT is an unstructured intervention. As

some playrooms were located next to classrooms and offices, researchers were concerned about the level of noise and mess that would be created by larger groups. Space and scheduling were other logistical issues. Ray (2011) recommends 2-3 group members, as it is important for the mental health provider to be attuned to all children and to be able to provide the conditions of empathy, unconditional positive regard, and genuineness. Further, Cheng and Ray (2016) found two and three-person CCGPT to be equally effective.

Research Team

The research team comprised the first, second, and third authors, as well as two masters level counseling students, working as graduate research assistants. The first, second and third authors had training and experience in qualitative research methodology. The first author was an assistant professor and play therapy course instructor at a large university in the Southern US. She also led and participated in the Blalock et al. (in press) intervention study in which all participants conducted CCGPT. She conducted all the individual interviews for the current study, and provided written responses to the interview protocol based on her participation as a CCGPT play therapist. The second author was an associate professor at another large suburban university in the Southern US. She was also a play therapy course instructor, an expert in qualitative research methodology, and served as the data analysis consultant for the current study. The third author was an assistant professor and play therapy course instructor at a large university in the Southern US, the same university as the first author. She coordinated and participated in the data analysis and coding procedures. The two master's level counseling students assisted in data analysis under the direct supervision of the third author.

CCGPT Intervention

As previously mentioned, the current qualitative study is part of a larger quantitative study. Blalock et al. (in press) conducted a randomized controlled trial study of 56 elementary aged participants (aged 5-11) with problematic behavior. Prior to recruitment, the researchers obtained approval from the institutional review board of the participating university as well as from the participating school districts. Participants were randomly assigned to 16 sessions of CCIPT, 16 sessions of two-person CCGPT, or to a waitlist group. Participants in both the CCGPT and CCIPT groups participated in 16 sessions of school-based play therapy - eight weeks of biweekly 30-minute sessions. Play therapists utilized the nondirective protocol outlined in the CCPT treatment manual (Ray, 2011) with adaptations necessary to conducting CCPT in group format. Accordingly, therapists utilized responses such as tracking; reflection of content, feeling, and meaning; returning responsibility; facilitation of creative expression; and limit-setting. Therapists attempted to create a safe and permissive therapeutic environment by enacting the core conditions of empathy, congruence, and unconditional positive regard. Therapists conducted sessions in playrooms located on children's elementary school campuses and equipped with developmentally appropriate toys to facilitate the expression of mastery, aggression, creativity, nurturance, and control, as recommended in Ray (2011).

Individual Interviews

All six play therapists who conducted both CCIPT and CCGPT as part of the larger study agreed to participate in an individual semi-structured interview to describe their experiences with CCGPT as compared to their experiences with CCIPT. As mentioned, the first author conducted all the semi-structured individual interviews and provided written responses to the interview questions based on her participation as a CCGPT play therapist. The individual interview protocol consisted of 13 questions including, "Tell me about your experience of conducting two

member group play therapy”, “Tell me about your relationship with each group member,” “Tell me about the relationship between group members,” and “In what ways, if any, did the presence of another group member affect each child’s progress?” We included other questions or prompts regarding improvement of group members’ presenting issues, play therapists’ differing experiences of conducting individual play therapy versus group play therapy, therapists’ level of confidence and comfort in conducting group play therapy, and therapists’ perceptions of the advantages and drawbacks of conducting group play therapy in the school setting as compared to the clinical setting. The researchers chose semi-structured interviews because of their usefulness with small samples (Laforest, 2009). The interviewer conducted four face-to-face individual interviews. Although the original plan was to conduct all interviews face-to-face, the interviewer conducted one interview over the telephone, due to extenuating circumstances. As the interviewer was also one of the participants, she responded to all interview questions in writing and provided the transcript to the three -person team conducting coding and analysis. Verbal interviews lasted approximately one hour each; all were audio recorded and transcribed.

Trustworthiness

Trustworthiness indicates the strength of a study (Patton, 2002) and indicates the quality of the research methodology. To enhance the trustworthiness of the current study the researchers used: (a) an audit trail, a detailed record of all steps in data collection and analysis (Hays & Singh, 2012), including informed consent documents, development of interviews, and the coding manual; (b) analyst triangulation, in which the research team employed three independent coders; and (c) peer debriefing among the research team members. Consistent with analyst triangulation, the aim of peer debriefing was to enhance accountability and limit potential researcher bias during data collection and analysis.

The first author was one of the group counselors and the lead investigator in the Blalock et al. (in press) study. Her interview responses were included in the current study, but she was not involved in data analysis. The second author, an associate professor, supervised the group play therapists in the Blalock et al. (in press) study. She was not directly involved in conducting CCGPT groups or data analysis. However, she served as data analysis consultant for the current study. The third author was not involved in the CCGPT intervention or the Blalock et al. (in press) study. She coordinated and participated in the data analysis for the current study, with the help of two Graduate Research Assistants who were enrolled in a counseling masters program.

Data Analysis

The researchers followed an adapted data analysis plan based on Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method. For each interview transcript the members of the coding team completed the same steps.

First, using a phenomenological approach, the coding team obtained a full description of each member's experience of the phenomenon under investigation. In the current study, the phenomenon under inquiry was the lived experiences of therapists conducting CCGPT in a school-based setting. Before examining the transcribed interviews, members of the coding team bracketed their biases and previous knowledge regarding CCGPT and play therapy in school-based settings. As such, the coding team was dedicated to staying open to what emerged in the data and continued to examine assumptions related to the phenomenon.

Secondly, the coding team considered each statement of each verbatim transcript. Each person on the coding team examined participants' statements and practiced horizontalization (i.e., viewed each line in the transcript with equal value). Each person on the coding team noted all relevant statements. Each individual transcript was examined line by line

and margin notes were created for each transcript. Team members recorded each nonrepetitive, nonoverlapping statement. These were examined and meaning units or codes were derived.

Then, team members clustered invariant meaning units into themes. Preliminary themes were created for each individual interview. Through a series of meetings, the team discussed each code and created a code book of what the participants experienced (i.e., textural descriptions; Patton, 2002). Next, members synthesized the invariant meaning units and themes into textural descriptions, including verbatim quotes. Members then reflected on these textural descriptions and identified the various potential meanings, conditions, and contexts within the descriptions (i.e., structural description). Finally, members constructed a description of what and how (i.e., textural and structural) the participants experienced the phenomenon. Team members completed all the above steps for each transcribed interview.

Next, team members integrated all individual descriptions into a composite description of the experience representing the group of participants (Moustakas, 1994). Synthesis was achieved when descriptions were combined to convey the essence of the experiences (Moustakas, 1994) and when the authors reached agreement on themes and subthemes.

Team members then developed a preliminary coding manual. Creswell and Poth (2017) noted the importance of reducing the data to eliminate redundancy. The coding team continued to merge categories, refine codes, and develop preliminary themes based on the data (Miles, Huberman, & Saldaña, 2014). Then, team members conducted initial coding. The coding team established inter-coder agreement (Marques & McCall, 2005) by independently applying the preliminary coding manual to a subset of the data (e.g., three of six interviews). During weekly coding meetings, the coding team adjusted the preliminary coding manual and re-applied it to the data subset. The coders continued this process until they reached a mean agreement that

approached or exceeded 90% (Miles, Huberman, & Saldaña, 2014) and finalized the coding manual.

For the final step, team members conducted final coding; they applied the final coding manual to each of the interviews. During weekly coding meetings, they continued to discuss discrepant codes. A mean intercoder agreement of 90% was met throughout the final coding period.

Results

Three overarching themes emerged from the data: *Internal Responses During Clinical Experiences*, (subthemes: Connection in Relationship and Emotional Responses in Therapist), *Perception of CCGPT* (subthemes: Benefits of Using CCGPT, Challenges of Using CCGPT, and CCGPT Compared to Individual PT), and *Observed Change* (subthemes: Observed Change in Clients and Shift in Therapist Perception of Conducting CCGPT).

Internal Responses During Clinical Experiences

The *Internal Responses During Clinical Experiences* theme arose as participants described their experiences working with children in CCGPT. Participants discussed their internal responses that surfaced over the course of their experiences with their CCGPT clients. Internal responses were commonly related to the connection they experienced or noticed in the relationships with the children and to their emotional responses to the work.

Connection in relationship. Several participants reported feeling connected with clients and enjoying the level of closeness. For Olivia, her connection notably increased after overcoming challenges in session. Olivia shared, "...the ones that gave me the most trouble, I feel like are the ones I have the relationship with...there's something very validating about what we're doing when I work with [kids who are struggling]." Some discussed feeling closer to

clients when they expressed concern or were protective of the participants. For example, Jamie shared that this was how she knew that she had established a bond with her clients. In discussing a 4th grader referred for aggression and disruptive behavior, she stated:

As sessions progressed, he showed empathy to me by letting me know that he was just “playing” when he was doing aggressive play. He told the other child to be sure and not hurt me – several times – although that never really seemed a danger at all.

Kate believed that the relationship became more connected with exchanges that involved her as the testing ground for interaction. Kate described one of the children in her group reaching out to the other child with a stethoscope. After several sessions of only applying the stethoscope to Kate, the child “ventured into putting the stethoscope on the other child. And so you could see (the other child) jump when the kid put his stethoscope on him...” The child who initiated contact with the stethoscope was a second grade child diagnosed with autism, and making this type of physical contact with the participant and the other child was indicative of significant progress. Although the other child was initially hesitant, he accepted the physical contact, which was marked progress for this child, who struggled with attachment. Kate noted how this became a regular occurrence in therapy, and the relationship between the children and between the children and the therapists were more cohesive from that point forward.

Similarly, Mariella recalled that one client would make a concerted effort to connect with her and build their connection, because the child could not easily achieve connection with the other child in the group. She shared, “He'd always find some way to try to include me into the play...we had a strong bond...and [he] apparently felt very accepted by me to continue to have one-on-ones with me when feeling rejected by the other child.” The connections formed in the therapeutic relationship led to better connections with the other children in the group.

Emotional responses in therapists. One participant, Kate, enjoyed the influence of one child on another, describing it as “really neat, the whole group thing was really neat.” Deja discussed feeling moved that her client was “concerned about her,” exhibited by his offering her suggestions for how to and how not to respond to the children in the playroom. Mariella stated that she experienced joy and will “...forever do group play. Because I love it, I love to see the benefits of it.” Other common statements from participants included “I felt close to (the child),” I missed (a child), “I loved being with (a child, group), and “I loved (a child, doing group work).” Yet, several respondents also noted feeling “outside” of the children’s learning and feeling as though they were “not enough” when compared to what one child could gain from the other child, and thus, the dynamics of the group. Sophie recalled, “I had a very strong relationship with both of them. But they also had a really strong relationship with each other.” Additionally, some reported feeling “frustration” during moments of conflict and “tired” by the end of session. Indeed, CCIPT is often fast-paced with a lot of activity, and CCGPT is even faster.

As such, participants reportedly had to balance their emotional reactions toward the children, particularly when they experienced differing emotions regarding each child. For example, Olivia noted that that one child felt rejected by the other during sessions. It was challenging to hold sadness for one child while respecting and empowering the other child to decide who and what to engage in play. Similarly, Jamie shared that she struggled to navigate acceptance for both children in her group of first graders with defiant and attention seeking behaviors when she felt compelled to protect one from the other.

Participants were aware of the internal responses to their work with children in CCGPT. They were attuned to their clients’ connectedness in session as the relationship developed as well

as attentive to their own emotions in response to their interactions in group. Respondents further described their experiences beyond their internal responses to include witnessing benefits, challenges, and distinctions of using CCGPT in schools.

Perception of CCGPT

The theme “Perception of CCGPT” emerged as participants described experiencing the benefits and challenges of CCGPT with children in elementary schools. In addition, participants discussed distinctions between individual and group play therapy. Specifically, participants discussed the dynamic between group members versus that which occurs in individual sessions, as well as the utility of and demands on the therapist.

Benefits of using CCGPT. Respondents discussed benefits of CCGPT, including general benefits for children that may not be available in individual settings. They described how group play therapy provided unique opportunities to address relational concerns. As Jamie related (specifically regarding the progress of a child with selective mutism paired with a child who demanded attention),

This child could never have made the same progress in the absence of the other child. She was able to initiate play (and play with) another child at school for the first time. This ability generalized to the playground and she began to play with other girls on the playground for the first time. She gained courage and confidence in the playroom (a relatively low risk environment with adult support) to take a risk to initiate play with the other child. She developed her play themes by watching the other child. She went from no play, to imitation play, to parallel play, to playing together. She had the opportunity to go through all the developmental play milestones in the sessions.

As Olivia further explained when discussing a boy-girl kindergarten group, “I think, that power and control need that he had was addressed a little bit more...he got to work through that a little bit more, I don't think he would have been able to do that in individual [play therapy].” She went on to report, “I think (the child) was impacted because she was able to stand up for herself a little bit later on. Just developing that self-concept...I don't think she would have gotten that in individual [play therapy], or maybe not as much.” Benefits related to school settings specifically included having consistent attendance and accessibility to children. Sophia noted, “... I think that's such a great way to get as many kids possible seen.” Further, feedback from teachers and parents’ reports as told to teachers, was useful in learning about ongoing concerns and in assessing progress. Although the study results revealed benefits of CCGPT, there were innate challenges as well.

Challenges in using CCGPT. Participants discussed various challenges that arose in CCGPT. Deja described group play therapy as “a lot more work just in general” (as compared to individual play therapy). Kate discussed CCGPT as requiring “more of my energy to conduct. It felt like there was more risk and more to gain.”

Additionally, the school setting contributed to challenges in using CCGPT. Some participants reported that even though they believed their clients made progress, there would have been more progress if they would have had more time in the playroom (beyond the 30 minutes allowed) and more sessions overall (beyond the 16 sessions provided to all groups). Time constraints were related to conducting groups in a school setting and to being part of a research study. The number of sessions each group would receive was determined ahead of time, in order to be completed in one semester, with the caveat that therapists would continue counseling with any children still in crisis.

Other concerns were related to limited space and inconsistent space as participants reported that they were asked to switch rooms when their previously used room was scheduled for another meeting. For some children, the lack of consistency in space created an issue. For example, Olivia described the experience of a kindergarten boy with aggressive behaviors, “It felt like he was almost being set up for failure a little bit. Because there were so many distractions, and he already had difficulty like just with concentration and stuff.” Participants were also concerned about maintaining an appropriate noise level to avoid disrupting instruction in neighboring classrooms, but they wanted to allow children to play freely. Other barriers in treatment included not having parents present to provide relevant history and lacking information from assessments, as would typically be available in a clinic setting.

CCGPT compared to CCIPT. Participants indicated that individual and group CCPT both have utility with children in schools. However, participants noted that group CCPT was faster paced than individual, and the dynamics of group impact the role of the therapist. Participants shared that having two children in the room created opportunities for each to play out whatever they needed to work out, particularly social and behavioral issues that only arise in the presence of another child. Mariella, whose group consisted of a boy experiencing attachment issues and separation anxiety, and a boy experiencing grief and depressed mood, stated it this way, “....you have some additional little therapists in there in a sense... you have other little helpers and you don’t realize how much they’re helping you when they’re in the room with you.” About her group consisting of a neurotypical first grade boy and a second grade boy with autism, Kate stated, “...I think they were both getting something really different though from each other.” Speaking of her group consisting of a second grade gifted boy without friends and a third

grade girl who was struggling academically and behaviorally, Sophia shared, “I mean like I was included, but I still felt more like a facilitator, like it was really the relationship between them.”

The engagement of the play therapist varied depending on the needs of the group. Olivia shared that she served as a “safe base” for a child who often included her in the play when feeling rejected by the other child in session. Other respondents discussed that the group approach was not completely suitable for some children, and this made attending to both children in the group even more difficult. For example, Deja who conducted a boy-girl group with two aggressive eight-year-olds, compared the manner in which a child, who she perceived as negatively impacted by the other child, presented in the group sessions compared to how this child had presented in previous individual interactions. She stated, “he felt much more regulated to me when it was just the two of us. It almost felt like dysregulated play when he was with the other kiddo.” Sophia similarly shared about a third grade girl struggling academically who was paired with a gifted second grade boy, “I don't think that she felt the safety in the room with another child...Where in our individual relationship, she went right into that and played out a lot of those things.”

Overall, participants discussed CCGPT as a beneficial approach for children in schools despite limitations of the setting. Furthermore, participants' responses demonstrated that CCGPT offered unique opportunities for children to work collaboratively on their individual presenting concerns; yet circumstances may keep CCGPT from being a good fit for some children.

Observed Change

Observed change in clients. Some participants observed change in their clients' display of empathy, self-regulation, and social engagement. Regarding a second grade boy on the autism spectrum paired with a neurotypical first grade boy, Kate stated,

So, it didn't take long at all, a couple sessions for him, to get more empathic. And that I thought was really cool that that's what he was getting from it, is to get more empathic and in tune with the other child. ...he was initially kind of, not aggressive, but definitely more assertive than he needed to be, like trying to get what he wanted. And then you saw him kind of figure out, oh there's another way I need to go in and it needs to be softer. And you could see him figure that out. I thought that was really cool.

Kate discussed seeing changes in social engagement and getting this feedback from others. She stated, "it was a huge difference between allowing somebody to be with him, around him, interact with him. That was way, way, way more open. And then, him reaching out initiating contact." Speaking of a third grade girl struggling with behavior and academic problems paired with a gifted second grade boy without peer connections, Sophia shared, "After group play, I would say that her ability, her ability to control herself within the playroom, like to regulate had changed." However, she went on to describe that it was hard for the child to regulate herself in the classroom. Similarly, Olivia noted that a first grader with aggressive behavior "had very low level of self-control and then it improved. And then it crashed. And it was like a roller coaster." As previously stated, many participants believed that despite making progress, their clients could have made greater gains if there were an increase in the number of available sessions.

Shift in therapist perception of conducting CCGPT. Participants indicated a shift in perception of CCGPT. Some were initially "worried," "anxious," and "uncertain". Some had preconceived notions based on stories they heard or what they learned about group, including how groups should be selected and who was suitable for CCGPT. By the end of CCGPT with their clients, some reported having a revived passion for group and intentions of continuing

groups in practice. Mariella shared, “I didn't realize how much I actually love group. I knew I did, but after, it was like yeah, I forgot how much I really do love group work. It's so rewarding, it's so fulfilling.” Kate remarked on how much she has learned in this experience not only for clinical use but also for training others. In describing her group, she shared that her clients had different intellectual disabilities, and she did not initially believe the pair of children would be a good match to participate in group play sessions together, as one of the children was on the autism spectrum and the other was not, Kate shared,

...now I gotta throw out all my rules. So, I don't know, I'm glad I'm not teaching it (soon) because I don't know how I'm gonna teach it. I'm gonna have to really, I need more time to process through all of it. Because we have all these rules about “how do you match kids,” and “these kids are good candidates for group, and these kids aren't”. I was just, these two kids I know would have been ruled out if you'd just followed the rules that I usually share.

Over time, all participants reported that their comfort level in conducting CCGPT increased.

Discussion

In this study, the researchers explored facilitator perceptions of implementing two-person CCGPT in an elementary school setting. Three major themes emerged from the interviews with the participating play therapists: *Internal Responses During Clinical Experiences*, *Perception of CCGPT*, and *Observed Change*. Falling under the *Internal Responses During Clinical Experiences* theme, participants reported growth in their relationships with the children through the group intervention, as well as experiencing emotions such as joy, connectedness, inadequacy and disconnection, frustration, and fatigue at varying points during the group sessions. The facilitators also discussed general and school-specific advantages and limitations in utilizing

CCGPT with children, which formed the *Perception of CCGPT* theme. Benefits specific to CCGPT in schools included teacher feedback, access to children, and more consistent attendance. Participants reported challenges of the school setting included limited time with children, limited or inconsistent space, missing relevant information from assessments and/or parent report, and noise-level concerns. Within the *Observed Change* theme, the group play therapists explained changes that occurred in both their clients and themselves. There was observed progress in some children over the course of therapy (i.e., more awareness, empathy, collaboration, problem-solving), and participants overall deemed CCGPT an effective and fitting approach for children in schools. Participants noted an increased level of comfort and sense of competence in using CCGPT with children in schools.

Benefits and Challenges of Practicing CCGPT

Participants had varying reactions to the impact of the group condition on their feelings of “connectedness” to their child clients. The group modality requires the play therapist to divide attention between child clients, but also provides the opportunity for “connectedness” between children. Some participants reported enjoying witnessing the connectedness between children; in some cases, children were able to generalize their new found connection to other children outside of the group. Other group play therapists reported a sense of “loss” of the feeling of connectedness they typically experienced in CCIPT – a loss connected with not being the major source of connection for the child. They reported feeling “less included.” It is already well-documented that the quality of the therapeutic relationship predicts the outcome of therapy (Karver et al., 2006). The result of this loss of connection was beyond the scope of this study but may have had an impact on client outcomes.

Therapists in the current study acknowledged feeling frustrated when children were in conflict. Children's conflict with each other in session is unique to group counseling modalities such as CCGPT and can be considered a double-edged sword. On the one hand, child conflict caused anxiety and frustration for some participants and possibly anxiety or frustration to some of their child clients. On the other hand, participants reported that conflict helped to bring issues and opportunities into the playroom that would not have arisen otherwise. This observation is consistent with the documented benefits of group play therapy (Sweeney, Baggerly, & Ray, 2014; Sweeney & Homeyer, 1999), and is also a necessary component of adult group therapy (Berg, Landreth, & Fall, 2018). Conflict happens for children outside the playroom, so children benefit from having the opportunity to experience this conflict in a safe environment in the presence of a caring adult who can set limits when necessary. More than one therapist in the current study expressed belief that the child would not have been able to work through core issues without the presence of another child. As Jamie put it, "Children in group tend to push the limits more than in individual – which can be challenging, but not a measure of "not working well".

Additionally, therapists described feeling fatigue in relation to conducting CCGPT. Participants experienced CCGPT as more work than CCIPT, in general. Again, this is not surprising, as CCGPT is inherently faster paced than CCIPT. This is consistent with the perceptions of the teachers implementing Group Theraplay in Siu (2014). It is also similar to adult group therapy which can be more draining than individual adult therapy, as there is much more to attend to in the session (Berg, Landreth, & Fall, 2018).

Another interesting theme to come out of this study was therapist perception of which modality (individual or group) was more suitable for specific children. Some participants

expressed perceptions that some of their individual clients might have made more progress in the group modality and vice versa. One participant voiced a shift in her perception of which children could benefit from the group modality to include children which, previous to the experience of this study, she would not have thought of as a good fit for the group modality. Although her previous perceptions had aligned with the prevailing recommendations from the literature (Sweeney et al., 2014; Sweeney & Homeyer, 1999), her experience during the study included a student who would not have been recommended for group, according to the literature, but for whom she saw much progress in the group condition.

Sense of Competence with CCGPT

The interviewer noted all participants appeared forthcoming and eager to discuss their experiences conducting CCGPT, including their internal reactions. Some play therapists described initial anxiety at the prospect of conducting CCGPT, if they did not have extensive previous experience in conducting CCGPT. This is not surprising, particularly because CCGPT is a more advanced skill than CCIPT. This supports the finding in Tucker et al. (2017) that the time it took facilitators to develop confidence in their skills was a major challenge for them. The initial anxiety and the advanced level of skill required is also an issue for the leaders of adult groups (Berg, Landreth, & Fall, 2018). One encouraging finding is that participants were generally positive about the experience of conducting CCGPT once they had completed their sessions. They reported feeling less anxious and more confident.

Barriers Related to the School Setting

Several therapists in the current study discussed their perception that some of their child clients could have benefitted from more CCGPT sessions. As participants were providing CCGPT for a university research study, the number of sessions provided was limited to what

could be provided in one semester. As a condition of the larger randomized controlled trial study (Blalock et al.; in press), and to coincide with school district schedules, therapists provided CCGPT to children in the experimental group in the fall, and to children in the waitlist control group in the spring. According to Sweeney et al. (2014), school-based interventions are typically shorter than 8-10 weeks – the length of this intervention. However, school counselors and other school-based practitioners could choose to continue to treat children who, in their therapeutic judgement, continue to require services.

Participants in the current study perceived yet further disadvantages in school-based CCGPT in limited or inconsistent space, and noise-level concerns. Parker and Nicol (1981) also found that group play therapy facilitators reported the school setting to be more stressful than a clinic setting. Although disadvantages to school-based counseling exist, they are perhaps outweighed by the fact that most children will not receive mental health services unless they receive them at school (CSMH, 2012). Schools are the one environment where play therapists have access to all children needing services.

Limitations

One of the major limitations of any study with a small sample size is low generalizability. Another factor that limits generalizability is the fact that this study focused on CCGPT facilitators who came into the school to provide services, rather than on mental health providers already based within the school. School counselors and other in-school mental health providers may face fewer challenges such as unexpected room changes, and may be better situated to advocate for play therapy within their schools. Alternatively, school counselors may find that the amount of time they have to spend in group play therapy is even more limited than what our

participants reported, due to district policies, lack of time, assignment of non-counseling duties, and large number of students (Stone & Dahir, 2016).

Another limitation of this study was the incorporation of researcher bias when analyzing and interpreting the results. While the researchers attempted to minimize this as much as possible by bracketing biases before the data coding process, it is impossible to completely eliminate the inclusion of bias in the data. Future research is needed to confirm or contradict the current study's findings.

Implications for Research, Teaching, and Practice

This study raises many questions that could be explored in further research. Given the sense of loss participants felt around their individual connections with clients in a group setting, future researchers could explore how the therapist's desire for connectedness might affect the therapeutic relationship, client progress, and therapist wellness.

Many of the participating therapists reported frustration around conflict that arose naturally in the group play setting. Therefore, another interesting topic for future research would be CCGPT therapists' perceptions of the impact of conflict between child group members on their ability to provide "acceptance," one of the core therapeutic conditions (Rogers, 1957).

The surprising finding that children who would traditionally be deemed as unsuitable for a group intervention were able to make significant progress in CCGPT highlights a need for further research into which children are better served by group CCPT, and which are better served by individual. Thus far, researchers have found no difference in the effectiveness of each modality (Blalock et al., in press; Pelham, 1971; Perez, 1988, Tyndall-Lind et al., 2001), but research on how client conditions impact the outcome is still needed. Additionally, given the

lack of other research into facilitator perceptions of CCGPT, further research is needed to corroborate or contradict the findings of this study.

There are also many implications for the teaching and practice of CCGPT. Participants in this and another study (Siu, 2014) reported group play therapy to be particularly tiring. As a result, the authors recommend therapists not schedule too many group sessions back to back. Additionally, as it appears anxiety and lack of confidence might be a barrier to more play therapists conducting CCGPT, researchers' findings in this study can serve to encourage play therapists to receive training, supervision, and practice in CCGPT. This study may also serve to encourage training facilities to provide training in CCGPT to school counselors and other school-based mental health professionals. Supervisors should be aware of the possibility of supervisees feeling "less connected" while conducting CCGPT and address this topic in supervision.

While participants reported implementing CCGPT in a school setting was challenging due to limitations on time, space, and noise, there are multiple avenues that can be taken to surmount the obstacles inherent in this setting. Continued, clear communication with school personnel, especially principals, can be particularly helpful. Noting that Hunt (2010) concluded raising staff awareness of the therapeutic value of play was beneficial, we suggest communication to school staff regarding the therapeutic value of play.

Administrators are often resistant to students giving up instructional time to receive counseling services. School-based mental health professionals, including school counselors, will be more successful in advocating for school-based mental health services when they appeal to the priorities of school personnel – academic progress and improved behavior. Both of these priorities are consistent outcomes of counseling, as attending to children's underlying needs

results in children's increased ability to take advantage of the school environment (Stone & Dahir, 2016).

As the mental health needs in any elementary school are undoubtedly more than one person can contend with, we suggest school counselors welcome/seek other school-based mental health providers to work in the school. For practitioners who would like to do work with children in schools, we suggest partnering with the school counselor. The school counselor is in a position to know the needs of all the children in the school and can be the point of contact and coordination of all mental health services in a school, as was the case in this current study. Once the room and materials are in place, both school counselors and other mental health professionals (as long as they are trained in play therapy) can effectively deliver school-based CCGPT, as has been the experience of the researchers.

Conclusion

The literature supports the effectiveness of CCGPT in general (Bratton et al., 2005; Karcher & Lewis, 2002; Packman & Bratton, 2003; Tyndall-Lind, Landreth, & Giordano, 2001), and as a school-based intervention in particular (Blalock et al., in press; Cheng & Ray, 2016; Ray et al., 2014). The US is currently experiencing an urgent need for more mental health services in schools (CSMH, 2012), and CCGPT is a developmentally appropriate, effective, and efficient treatment (Landreth, 2012; Sweeney et al., 2014). CCGPT therapist perceptions in this study indicate that play therapists can gain confidence through experience in conducting CCGPT. Their perceptions also indicate that CCGPT therapists see the benefit to clients of conducting CCGPT, and, once they gain experience in the modality, they appear willing to use it again. This study highlights the need for more opportunities for training, for school counselors and other school-based mental health providers, in CCGPT than currently exist.

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