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Bibliotherapy as an Intervention for Aggressive Elementary Children

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Bibliotherapy as an Intervention for Aggressive Elementary Children

Kari Newman

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Educational Specialist

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ABSTRACT

Bibliotherapy as an Intervention for Aggressive Elementary Children

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This study investigated the effect of bibliotherapy as an intervention for aggressive elementary children at a residential treatment center in the western United States. Bibliotherapy was provided for six children, three boys and three girls, ages 9 to 11, Caucasian and Hispanic, who took part in one of two groups. The study involved a multi-baseline design, beginning with a baseline phase, followed by two separate intervention phases comprised of eight sessions of bibliotherapy. Data gathered from almost daily observations along with pre- and post-intervention ratings of aggressive behaviors indicated that four of the six students demonstrated notable decreases in observed aggressive behaviors as well as decreases in teachers' ratings of aggression and/or social problems. Social validity for bibliotherapy as a viable and enjoyable intervention for aggressive behaviors was supported through interviews of students, teachers, and therapists. This study supports the potential for bibliotherapy to be a viable intervention to implement in the public school setting to decrease the observed aggressive behaviors of elementary school students.

Keywords: aggression, bibliotherapy, children, intervention

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Furthermore, I would like to thank the therapists, teachers, staff, and particularly the students who I worked with throughout the course of the study. Their real-world perspectives and ideas helped me to gain insight into the intersection of research and practice.

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DESCRIPTION OF THESIS STRUCTURE

This thesis, *Bibliotherapy as an Intervention for Aggressive Elementary Children*, is written in a hybrid format. The hybrid format brings together traditional thesis requirements with journal publication formats.

The preliminary pages of the thesis reflect requirements for submission to the university. The thesis report is presented as a journal article, and conforms to length and style requirements for submitting research reports to education journals.

The literature review is included in Appendix A. Examples of the observation form, the Achenbach System of Empirically Based Assessment Teacher's Report Form (TRF), and interview questions, respectively, are included in Appendices B, C, and D. The Parental Consent Form is included in Appendix E, while Appendices F and G include example lesson plans and the list of books used, respectively.

This thesis format contains two reference lists. The first reference list contains references included in the journal-ready article. The second list includes all citations used in the Appendix entitled "Review of the Literature."

Introduction

Schools across the nation continually deal with aggressive acts, with the most extreme cases, such as shootings, attracting attention from communities and the nation. However, less severe acts of aggression, such as bullying, teasing, name-calling, or hitting, commonly occur in the schools. A common response to aggression and violence is to adopt a zero-tolerance policy, with school officials thinking that the threat of punishment, or punishment itself, is powerful enough to address the problem (Shechtman, 2001). However, when school officials understand what aggression is and why it is occurring, other interventions may more effectively address the underlying issues.

Aggressive behavior is identified as any intentional act used to injure another, whether physically or psychologically, including a range of violent physical acts to verbal insults or name calling (Loeber & Hay, 1997; Moeller, 2001). Aggression is expressed in three different forms: physical, verbal, and relational (Shechtman, 2009). Physical aggression consists of any physical act to direct harm towards another person, animal, or object. Verbal aggression involves the use of words by the aggressor to injure another. Relational aggression is the intentional damaging of relationships, manipulating feelings of inclusion and acceptance within the friendship. Types of aggression can be either proactive or reactive, and are defined by the motive for the aggressive act. Pervasively aggressive youth often display both proactive and reactive aggression (Shechtman, 2009).

It is difficult to isolate the exact causes of aggression because the development of aggression is impacted by many risk factors (Shechtman, 2009). These risk factors have a complex interaction during a child's development; thus, it is not always *which* factor a child is experiencing, but *how many* factors he or she is experiencing that will establish the probability of

developing aggressive behaviors (Shechtman, 2009). Influences of aggression include genetic, biological, and temperamental factors that appear at birth or within the first few years of life; learning disabilities or other mental disabilities; social influences in the child's environment; and stage of development. Children seeking control or power are likely to engage in aggressive behaviors, particularly if they experience difficulty in verbalizing their own emotions, lack empathy for others, demonstrate deficits in social informational processing, or lack self-control (Shechtman, 2009). Children with these issues or influences in their lives can come to feel that acting aggressively is an appropriate way to gain control over their world.

To address the problem of aggression, schools have begun to proactively focus on prevention and intervention programs. Programs have included large-group, classroom, or systemic (e.g., whole school) interventions that focus on problem solving, conflict resolution skills, and changing attitudes and classroom environments (Shechtman, 2007). Other programs have recognized the effectiveness of small-group counseling of aggressive students when large-scale interventions are unable to reach students with aggressive behaviors (Shechtman, 2006, 2009). These large- or small-scale groups often use cognitive-behavioral approaches (Horne, Stoddard & Bell, 2007; Shechtman, 2006, 2009).

These large- and small-scale approaches tend to focus exclusively on either psychoeducation (e.g., teaching social or conflict resolution skills), or psychotherapy (e.g., the individual counseling of students to process their experiences and emotions). A more comprehensive approach includes both elements.

Bibliotherapy is one such approach, intending to not only help students learn and develop new social skills, but also to experience validation and insight into their own thought processes and emotions. The Greek root *biblio* means book, so bibliotherapy means to use books to help

individuals with problems (Pardeck, 1995; Pardeck & Pardeck, 1984; Shechtman, 2009). Books can be used to help people with broad range of personal problems, including emotional, physical, and developmental (Abdullah, 2002; Fincher, 1980). However, Franklin Berry's (1978) definition clarifies the roles of those who participate in the process of bibliotherapy, along with the literature used, stating, "Bibliotherapy is a family of techniques for structuring an interaction between a facilitator and a participant, an interaction which is in some way based on their mutual sharing of literature in the broadest sense possible" (p. 25).

Thus, bibliotherapy is not reserved only for mental health professionals with those who are viewed as very ill. Bibliotherapy is currently used by a variety of professionals in a variety of settings (Sullivan & Strang, 2003; Tews, 1970). Clinical psychologists and counselors, with the help of librarians, find and choose specific books to help individuals with psychological needs, while health professionals, such as doctors and nurses, provide pamphlets, brochures, and other information to educate and help their patients cope with the emotional stress of illness and medical procedures. Communities rely upon religious teachers and advisers to guide them in their spiritual and emotional progress by sharing sacred and religious texts (Sullivan & Strang, 2003). Teachers and librarians provide books to people of all ages and stages to help them with basic life problems by teaching them basic life skills (Catalano, 2008).

Those who use bibliotherapy understand and follow the theory that reading is able to impart information from a safe distance and/or arouse emotions within the reader, which then influences their thinking and behavior, especially when focused on their specific needs (Lenkowsky, 1987; Tews, 1970). In this way, bibliotherapy not only teaches basic skills, but also creates an emotional response that brings about change through a process of phases that parallels those in psychoanalysis: identification, catharsis, and insight (Fincher, 1980; Kramer &

Smith, 1998; Lenkowsky, 1987; Morawski, 1997; Pardeck & Pardeck, 1984; Riordan & Wilson, 1989; Tews, 1970). Pardeck and Pardeck (1984) advocate the use of bibliotherapy to specifically address children's issues, such as alcohol and drug addiction, divorce and separation of parents, emotional and behavioral problems, moving to a new home, physical disabilities, pregnancy and abortion, serious illness and death, sexual awareness, sibling relationships, and step-parents.

Only within the past 20 years has bibliotherapy been considered as a treatment for aggression. Zipora Shechtman has led out six research studies to discover the effectiveness of bibliotherapy in helping children with aggression (Shechtman, 1996; 1999; 2000; 2001; 2006; 2009). In her first study in 1996, Shechtman studied the use of bibliotherapy (15 short stories and films within a lesson plan for teachings to implement) to reduce (a) aggressive behavior, (b) endorsement of beliefs that support aggression, and (c) generally maladjusted behavior in 117 socially maladjusted adolescent males in three special education schools in Israel. The study took place over the course of two years with inconstant results; the second year of intervention showed to be much more effective than the first year in reduction of aggression and maladjusted behaviors. Interestingly, the control group showed an increase in the endorsement of beliefs that support aggression, along with increased aggression and acting out behaviors. The Peer Assessment Inventory, Attitudes Toward Aggression, and the Walker Problem Identification Checklist (WPBIC) measured results. Overall, the results of the study support the intervention of bibliotherapy in two ways: (a) they suggest some control over the increase of maladjusted behaviors with time, and (b) they indicate a reduction in aggressive behavior for most students.

In 1999, Shechtman conducted a single-case design study in Israel of five aggressive 8-year-old boys from the same fourth-grade class, utilizing bibliotherapy (ten 45-minute sessions that included short stories, poems, films, and pictures that focused on possible motifs that may

lead to aggression) as the primary mode of intervention in the group therapy with the goal to reduce aggression. A short version of the Achenbach Child Behavior Checklist (ACBC) self-report and teacher report of 15 items from the aggression and delinquent subscales were used, along with collecting and analyzing verbal responses representative of students' behaviors and attitudes in group therapy were used to measure results. Results suggested that aggression was reduced in all the five treatment students, compared with no change in the control children, by self- and teacher report. While Shechtman did not recommend that these results should be generalized, she did indicate that it does lend itself to a line of future research and promising results.

One year later in 2000, Shechtman conducted a larger study testing the effectiveness of a multidimensional program utilizing bibliotherapy and clarifying processes for 70 special education children and adolescents, grades 5-9, in 10 different schools in Israel. Ten weekly 45-minute sessions included children's short stories, poems, and films, followed by suggested activities for 10 counseling and special education graduate students who conducted the intervention with the students. Groups, pairs, or individual students, (dependent upon the choice of the therapist) took part in the intervention during the school day outside of the classroom. Pre- and post-treatment measurements of the Achenbach Child Behavior Checklist (CBCL) Self-Report and Teacher Report Form (TRF) scales were administered, and results were considerably different between the self- and teacher reports regarding the progress made in reducing aggression and maladjusted behaviors. Overall, both students and teachers reported a decrease in maladjusted behaviors, with students identifying within themselves a decrease in aggressive behaviors.

Shechtman engaged in a case study the following year, 2001, to study the results of a counseling prevention group for elementary school children who show a tendency to respond aggressively in peer interaction. The small group consisted of 4 fourth-grade students, 2 boy and 2 girls from the same classroom in a low-class, neighborhood school in Israel, while another aggressive boy from the same class who did not participate in the group served as a control. Five counseling group sessions were comprised of bibliotherapy, films, and the sharing of personal experiences. The CBCL and TRF, along with process measures of the stages of change, measured results. When compared with the control who had no change in aggressive behavior or empathy by teacher or self-report, all four children either showed a significant or small decrease in aggressive behaviors, and all showed a significant increase in empathy.

In 2006, Shechtman focused in on the effectiveness of bibliotherapy and counseling of 61 aggressive Israeli boys, ages 8 to 16 years, comparing its effectiveness to counseling alone, and control group of boys with no counseling. Boys who received counseling or counseling and bibliotherapy received the treatment in ten 45-minute sessions over the course of 4 months by 48 counseling students. Results, as measured by the pre- and post-treatment ratings from the CBCL and TRF and the Index of Empathy for Children and Adolescents were used to measure aggression and empathy, respectively. While the control group did not experience a significant change in aggression or empathy, both treatment groups decreased in aggression and increased in empathy, especially the groups that received bibliotherapy.

Finally, in 2009, Shechtman's study focused on an classroom (integrated) intervention and a small group (segregated) intervention for highly aggressive children to determine which was more efficacious in reducing aggression, lessening internalizing and externalizing behavior, and increasing positive classroom relationships. The study included 904 Israeli students in 5th to

8th grades from 13 schools, with students randomly assigned to either treatment group or a control group. The Peer Nomination Instrument, The Aggression Questionnaire, and the Illinois Aggression Scale gathered pre- and post-treatment measurements of aggression, while the TRF measured pre- and post-treatment internalizing and externalizing behavior. Finally, the Classroom Environment Scale measured class relations pre- and post-treatment. Both interventions were comprised of 12 sessions of a period of four months. Results showed similar positive outcomes on all variables in both treatment groups, and higher compared to the control group.

Statement of the Problem

Further research is needed to investigate the impact of bibliotherapy on aggressive children, as there have only been a few studies completed on this topic. While those studies showed promising results, they primarily took place outside the United States. Furthermore, the studies used global scales of behavior, which did not directly measure the frequency of observed aggressive behaviors. Finally, those studies only examined the effects of bibliotherapy on aggressive children in public schools; they did not study the effects of bibliotherapy on highly aggressive children in residential treatment centers, where more intense physical and verbal aggressive behaviors are observed in children, and thus sensitivities to interventions may be detected. Additionally, bibliotherapy in Shechtman's studies included children's books, poems, short stories, and films, instead of focusing principally on children's books.

Statement of Purpose

The purpose of this research is to examine the impact of bibliotherapy on highly aggressive children in a residential treatment center. Children in residential treatment centers often exhibit higher levels of aggression, allowing for more insight into the possible influence

bibliotherapy has upon aggressive behaviors. It is expected that once students take part in bibliotherapy, their aggressive behaviors will decrease.

Research Question

This study will address the following research question: To what extent does bibliotherapy reduce physically and verbally aggressive behaviors and social problems in elementary students who are being served in a residential treatment facility?

Method

This section will discuss the method used to undertake and complete the research study. The research design will be described, followed by a description of the participants in the study. Next, a report will be given of the setting where the study was conducted, as well as the instruments used to measure the dependent variable. Then, an explanation of the procedure followed to conduct the study will be given, followed by a description of the independent variable, treatment fidelity procedures, and the dependent variable. Finally, the data analysis section will describe the method used to analyze the quantitative and social validity data.

Research Design

This study involved a single-case design in which individual students' behavior was observed using a multiple baseline design. Two groups of participants were simultaneously observed while gathering baseline data. After two weeks of observations, the first group (hereafter called "group one") participated in the bibliotherapy intervention. One week later, the second group (hereafter called "group two") began participating in the bibliotherapy intervention. Once a group had completed all 16 interventions sessions, the maintenance phase began for that group.

Quantitative information was gathered through observations of participants' behavior throughout the intervention using observation recording forms along with teachers' pre- and post-ratings of ratings of participants' behavior according to a behavior checklist. Social validity information was gathered through the interviews at the conclusion of the intervention.

For the purpose of this study, the independent variable, bibliotherapy, is defined as the intentional use of literature shared by a facilitator with a participant to bring about an emotional response that brings about change. Thus, the primary use of literature in the form of picture books was read and shared with the group, with intervention lesson plans including pre- and post-reading activities.

The dependent variable included direct physically or verbally aggressive behaviors that were observed. Because the primary focus of this research was not necessarily on which specific acts of verbal or physical aggression were observed, a strict definition of these acts was not generated. However, the observation form used (Appendix B) helped to define the parameters of verbal and physical aggression to assist the observers in more readily determining which behaviors should be recorded as aggressive acts.

Participants

This study included eight children from two elementary classrooms at a residential treatment center in a mid-size city in the mountain west of the United States. The residential treatment center admits and treats approximately 50 youth, ages 7 to 15 years of age, from across the United States. These youth come from differing socioeconomic statuses and ethnic backgrounds, with each student experiencing different mental illnesses or disabilities. A primary concern for these elementary students was their disruptive behavior in the classroom, aggression being especially problematic. Consequently, all 18 students in the elementary classrooms were

specifically selected as potential participants in this study. The students selected for the study all had diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiance Disorder (ODD).

While at the treatment center, students receive the following services: individual, family, and group therapy at least once a week by a licensed Marriage and Family Therapist (MFT), and recreation therapy once a week by a licensed Therapeutic Recreation Specialist (TRS). The students attend school year round, taught by licensed elementary teachers with special education training. Psychiatrists, medical doctors, and nurses provide routine services, while speech language pathologists and occupational therapists provide as needed services.

The students included in the study were 3 girls and 5 boys between the ages of 9 and 11, representing third to sixth grades. All 18 students in the two elementary classes at the treatment center were deemed eligible for the study; however, only those whose parents gave permission were included in the study. Consent forms were given to all eighteen students' parents/guardians, and signed consent forms were returned for eight students. These eight students were evenly divided into two small groups of four each for implementation of the study. However, two male participants were discharged from the treatment center and were unable to continue as participants during the baseline phase, thus leaving six participants, which were evenly divided into two groups of three. As part of one of the two groups, each student participated in the bibliotherapy intervention and had quantitative and social validity data collected. Classroom teachers determined the composition of each group. This was done as a convenience for the teachers so as to interfere with the learning environment as little as possible.

Group one. Group one consisted of three students, two boys and one girl, ages 9 to 11, all of whom reported Caucasian ethnicity. Each student was identified with multiple diagnoses

according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). All three students in this group had been diagnosed as having ADHD and ODD. Students in this group had been admitted to the treatment center and receiving treatment from two to nine months. Following the multiple baseline design of the study, group one received the bibliotherapy intervention one week prior to group two.

Group two. Group two consisted of three students, two girls and one boy, ages nine to ten, with reported ethnicities of Caucasian, African American, and Hispanic. All three students in this group had been diagnosed ADHD, ODD, and Conduct Disorder (CD) according to DSM-IV criteria. Students in this group had been admitted to the treatment center and receiving treatment from two months to sixteen months. Group two received the bibliotherapy intervention beginning one week after group one began receiving the bibliotherapy intervention.

Settings

The study took place within the residential treatment center. Behavioral observations were completed while observing children in their home classroom. The bibliotherapy intervention was conducted in a visit room made available for the bibliotherapy groups.

Instruments

Observations. Observations were conducted in the students' home classroom, four times a week for 30 minutes at a specified time prior to or after lunch, according to the researcher's schedule and the students' class schedule. Observations began two weeks before the bibliotherapy intervention phase, and continued on throughout the intervention phases of the study. Observations were initially planned to take place five days a week for one hour, but were reduced to four times a week for 30 minutes to accommodate the time constraints of the two observers. Observations continued through the maintenance phase of the study, but only took

place once a week for 30 minutes during this three-week phase. Observations began approximately in October and concluded in February.

Two observers carried out the observations, with the experimenter being the primary observer, and another staff member taking part in observations throughout the baseline and intervention phases to provide inter-rater reliability. During the training of the two observers, the observation form was created to list the most commonly observed forms of physical or verbal aggressive behaviors of the student participants. Because aggressive acts, physical or verbal, were observed taking place in as little as a matter of seconds of each other, the preferred observation technique was a frequency count of the behaviors. The observation form is presented in Appendix B.

Behavior ratings. In addition to the behavioral observations of aggression, a measure of overall behavioral ratings was administered to capture the broad context and frequency of the students' behaviors as a supplement to the sampling of the observations conducted. The Achenbach System of Empirically Based Assessment Teacher's Report Form (TRF) (Achenbach, 1991) for Ages 6-18 was used for pre- and post-measurement of the overall behavior of each student. Ratings of the students were completed pre- and post-intervention during both the baseline and maintenance periods. Response choices include: "Not True" (0), "Somewhat or Sometimes True" (1), and "Very True or Often True" (2) for 112 items that measure anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. While the entire 112 items were completed for each student's pre- and post-measurement of behavior, only the items related to aggressive behaviors (21 items) and social problems (11 items) were scored. Example items for aggression include: "screams a lot," "mean to others," and "destroys others'

things.” Example items for social problems include: “doesn’t get along,” “feels as those others are out to get him/her,” and “not liked.”

When measuring aggression, for children ages 6-11 years old, a total score of 0-11 identifies them within the normal range (below the 92nd percentile when compared to the normative sample), while scores of 12-16 identifies them in the borderline clinical range (the between 93rd and 97th percentiles when compared to the normative sample), and scores of 17-42 identifies them in the clinical range (above the 98th percentile when compared to the normative sample).

When measuring social problems for children ages 6-11 years old, a total score of 0-6 identifies them within the normal range (below the 92nd percentile when compared to the normative sample), while scores of 7-9 identifies them in the borderline clinical range (between the 93rd and 97th percentiles when compared to the normative sample), and scores of 10-22 identifies them within the clinical range (above the 98th percentile when compared to the normative sample). The measure of social problems was included because aggressive behaviors are known to cause social problems. Thus, a decrease in social problems would be related to a decrease in aggression.

The reliability coefficients using the test-retest method (16 days) averaged at 0.85, and the inter-rater (between teachers) reliability coefficient was 0.51 (Achenbach, 1991). Regarding content validity, the TRF has been widely used and continually refined over many years, with new items replacing older items that failed to discriminate significantly. Regarding criterion validity, the items are able to discriminate between demographically similar children who were either referred or nonreferred ($p < 0.01$) for clinically significant behaviors (Achenbach, 1991). An example of the TRF questionnaire is given in Appendix C.

Interviews. To determine social validity of the bibliotherapy intervention, interviews of the participants, the teachers, and therapists involved in the treatment of the children were conducted at the end of the intervention. Each interview was given in an open-ended format, one-on-one with the examiner, lasting about 5 to 15 minutes in length. The examiner asked questions and recorded answers as the respondent gave them, clarifying responses along the way. Each student participant (6 total), each teacher of the student participants (3 total), and each Marriage and Family Therapist (M.F.T.), or primary therapist, of the student participants (3 total) were interviewed. Student participants were asked what they liked or disliked about the bibliotherapy intervention, along with what they felt that they learned or improved upon by taking part. The teacher and therapists were asked what they thought about the bibliotherapy intervention, its effectiveness in decreasing aggressive behaviors in the children, and what suggestions they had for improving the intervention. Interview questions were created by the experimenter specifically for this study and are of a qualitative nature. Thus, there are no reliability or validity measurements involved. Interview questions are presented in Appendix D.

Procedure

Prior to beginning the study, Institutional Review Board (IRB) approval was obtained from Brigham Young University, as well as permission obtained from the Chief Executive Officer, clinical director, and academic team of the treatment center where the study was conducted. Once the classrooms of elementary children were chosen, informed consent of parents for all children in the classrooms was solicited (18 potential student participants). The informed consent form is presented in Appendix E. Students' whose parents/legal guardians returned the informed consent were then divided into two equal groups of students, as determined by their teachers. The rehabilitation center acted "in loco parentis" to include the

intervention as part of the treatment that the children received, such that child assent was not obtained.

Initially, eight students had informed consents returned and permission granted to participate in the study. However, two of these students were unable to continue due to discharging from the treatment center during the baseline phase, leaving six students to participate in the study.

Baseline. Prior to the intervention taking place, baseline data of observed verbal and physical aggressive acts were taken for each student. To collect an adequate baseline measurement, all students were observed for two weeks prior to group one beginning the bibliotherapy intervention. Group two continued to be observed for one additional week, for a total of three weeks, until their intervention started one week following group one. Frequency counts of observed aggressive acts were recorded. Additionally, the students' teachers completed a TRF form for each student, rating their behavior and social skills as a pre-intervention measurement of their overall behavior.

Once baseline data through observations and behavior ratings were collected, the bibliotherapy intervention was introduced to the students, informing them that they would be in one of two groups that would meet together and take part in reading and discussing picture books, along with taking part in some additional activities, 2 times a week for 8 weeks, for a total of 16 sessions. They were also informed that one group would begin taking part in these sessions prior to the second group, but that all students would participate in the same number of groups and experience the same books and activities.

It was during this baseline phase that two male student participants discontinued taking part in the study due to being discharged from the treatment center. Accordingly, six student participants (three girls and three boys) remained and continued on with the study.

Interventions. The intervention was first introduced to students in group one, one week prior to introducing the intervention to students in group two. The bibliotherapy intervention was divided into two phases. Phase one of the intervention consisted of reading and discussing picture books with various follow-up activities, such as discussion of ideas, games, and writing new endings to the stories. Phase two of the intervention consisted of reading and discussing picture books with follow-up activities that focused on role-play situations to practice skills learned in place of the previous post-reading activities of discussions, games, and writing. Thus, the primary difference between phase one and phase two was the role-play and practice of the skills learned. Each session was led and carried by the researcher with the three group members, lasted 30 minutes, and followed the same structure, which consisted of: 1) reviewing the group rules, 2) introducing the book and the concepts covered, 3) reading the book, 4) post-reading activities, and then, 5) self-ratings of how well each student followed the group rules and participated in the group. Phase one lasted for the first eight sessions, and phase two lasted for the last eight sessions. Examples of lessons plans for each phase of the intervention can be found in Appendix F, with a complete list of the books used throughout the two intervention phases in Appendix G. Throughout the intervention phases students' verbal and physical aggressive behaviors were observed in the classroom and recorded by one observer at the same time each

day, with another observer taking part on eleven different observation periods to provide inter-rater reliability of the observations.

Maintenance. Once the intervention concluded, a maintenance period of three weeks ensued for final observations to be conducted once a week for a post-intervention measurement of behaviors. Additionally, teachers filled out the TRF rating form for each student during the maintenance period for a post-intervention measurement of overall observations of aggressive behavior and social skills.

Interviews. Once the intervention and maintenance period observations concluded, the children were individually interviewed to determine what they thought about bibliotherapy in terms of what they liked and did not like, along with what they felt they learned or improved on from taking part in the group. Finally, interviews of the teacher and therapists of the participants were conducted to establish the social validity of bibliotherapy as a treatment of physical and verbal aggression in children. These interview data represent the only contribution of the therapists to this study.

Interviewees' responses were typed immediately as they were given during the interview process. The interview transcripts were reviewed for errors. In a few instances the examiner confirmed the content of the typed responses. The transcripts were verified for accurate representation of interviewees' responses.

Independent Variable

For the purpose of this study, bibliotherapy is the intentional use of literature shared by a facilitator with a participant to bring about an emotional response that brings about change. Thus, literature in the form of picture books were considered for use, with a primary focus on using picture books as the main medium for bibliotherapy, along with other follow-up activities.

The books used in this experiment were specifically chosen because of the subject matter they covered as picture books. As such, they easily lent themselves to being easily understood because they were engaging with pictures and easily readable for students. Subjects covered included: feelings, anger, how we handle our feelings, books with frustrating situations at home or at school, how to make and keep friends, how to reconcile disagreements, and how to befriend those who hurt or bully us. The experimenter reviewed dozens of books and sought consultation from three experts in bibliotherapy during the process of selection. The books finally selected directly address the problems that the students faced. These books also dealt with their problems in realistic ways, had characters that the students could identify with, and took into account the participants' age, reading level, emotional development, gender, backgrounds, interests and cultural perspectives (Pardeck, 1995; Sullivan & Strang, 2003).

The experimenter facilitated bibliotherapy sessions. As a school psychology graduate student, the experimenter learned bibliotherapy therapy techniques through graduate level courses and additional readings. She has also received training in a group counseling graduate course, which assisted her in better understanding and utilizing group processing mechanisms.

As the study took place at a residential treatment center, the bibliotherapy intervention was projected to be the only significant variable introduced to the students. Throughout the duration of the intervention all other aspects of their treatment, schooling, and residency were kept constant, as dictated by the therapeutic program design at the residential treatment center.

Dependent Variable

For the purpose of this study, direct physically or verbally aggressive behaviors were observed. These behaviors were determined during the training of the observers, using an observation form to list the various verbal and physical aggression acts observed. This

observation form was used to guide the observers in their measurement of aggressive act occurrences, helping to delineate what could be considered a physically or verbally aggressive act versus those that were defiant or non-compliant. Physically aggressive acts included any of these actions directed toward an object or a person: hitting, kicking, pushing, throwing an object, slamming an object, spitting, biting, or pulling hair. Verbally aggressive acts included any of these actions directed toward an object or a person: screaming, swearing, put downs, or unkind words. Defiant or non-compliant behavior would include an action of not complying with adult or peer requests, such as: ignoring, non-responses, or arguing about the request. Physical and verbal aggressive acts were combined for purposes of this study because although both were observable, they often occurred simultaneously. Hence, to increase reliability of rating any verbal or physical act of aggression was recorded. Relational aggression was not specifically coded because it is often not displayed in the presence of adults and is difficult to observe, and thus would be unreliably coded. Nevertheless, the combination of physical and verbal aggression would likely be indicative of overall aggressive patterns.

The experimenter and a direct care staff member at the treatment center were the observers of this study. Observers were trained in how to observe and record observations of physically or verbally aggressive behaviors of each student participant by practicing observing and recording observations prior to the implementation of the study. Concerns and questions about observations were discussed after each of the six training sessions. Observations took place four times a week for 30 minutes through the baseline and intervention phases, and once a week for 30 minutes during the maintenance phase.

Two observers recorded behavioral observations at the same time for 22% of the observations. Inter-rater reliability was 87.9% throughout the six training sessions, and 78.2 percent for the eight observation periods (see Tables 1 and 2).

Table 1
Inter-Rater Reliability During Training Sessions

| Session | Experimenter | Staff Member | Agreement |
|---------------------------------------|--------------|--------------|-----------|
| 1 | 8 | 7 | 87.5% |
| 2 | 8 | 10 | 80% |
| 3 | 6 | 6 | 100% |
| 4 | 15 | 14 | 93.3% |
| 5 | 2 | 3 | 66.7% |
| 6 | 6 | 6 | 100% |
| Total Inter-Rater Reliability Average | | | 87.9% |

Table 2
Inter-Rater Reliability During Study Observations

| Session | Experimenter | Staff Member | Agreement |
|---------------------------------------|--------------|--------------|-----------|
| 1 | 8 | 7 | 87.5% |
| 2 | 20 | 14 | 70.0% |
| 3 | 9 | 7 | 77.8% |
| 4 | 7 | 4 | 57.1% |
| 5 | 6 | 5 | 83.3% |
| 6 | 4 | 2 | 50.0% |
| 7 | 2 | 2 | 100% |
| 8 | 3 | 3 | 100% |
| Total Inter-Rater Reliability Average | | | 78.2% |

Data Analysis

Observation frequency counts of aggressive behavior were converted into line graphs. To determine the impact that the intervention had upon students' aggressive behavior, within-phase and between-phase visual analyses were used. Within-phase analysis includes consideration of levels, trends, and variability in the data points, thus helping the experimenter to identify students' patterns of aggressive behavior prior to, during, and after taking part in the bibliotherapy intervention. Between-phase analysis included analyzing the immediacy of the effect on behavior due to the intervention, as measured by the percent of data exceeding the median of baseline.

Additionally, to further determine the impact of the bibliotherapy intervention on students' aggressive behavior, analysis of the TRF ratings was conducted. Comparisons of pre- and post-intervention ratings of students' behavior using the TRF checklist was used to identify increases or decreases in pre- and post-scores in aggressive behavior and social problems.

Qualitative data received in interviews via open-ended questions were analyzed by discovering trends and themes in the responses given. This qualitative data helped to establish the social validity of bibliotherapy as an intervention according to the perceptions of children involved in the treatment, along with the professionals' views towards bibliotherapy's effectiveness as a treatment for aggression.

Results

This research study was designed to measure the impact of bibliotherapy as an intervention for physically and verbally aggressive behaviors of elementary students. To do this, the study used a single-case, multiple baseline design that was conducted with six students divided into two groups. Each group received the bibliotherapy intervention at staggered start

times. To determine the impact that the bibliotherapy had upon the students' aggressive behaviors, data were gathered in the form of frequency counts of observed aggressive acts pre-, during, and post-intervention. Visual analyses of within- and between-phase data and comparison of pre- and post-intervention ratings of individual student's behaviors were conducted. Individual student data is reported using pseudonyms. Finally, the social validity of bibliotherapy as an intervention was determined through trends and themes in answers to open-ended questions about bibliotherapy itself and as an intervention for aggressive behaviors.

The Impact of Bibliotherapy

The impact of bibliotherapy on the aggressive behaviors of individual elementary students was evaluated using a multiple-baseline design across six participants in baseline, intervention, and maintenance phases, along with pre- and post-intervention ratings of aggressive behaviors and social problems using the TRF checklist. Figure 1 shows the change in the frequency of aggressive acts observed across these phases. Figure 2 shows the change in the teacher ratings of aggressive behaviors and social problems. Table 3 presents the same data in numerical format. As can be seen in both Figure 2 and Table 3, all participants began the study with aggression and social problems rated to be in the clinical range. Scores exhibited variability and by the end of the study all but one participant remained in the clinical range.

Results for Brandon

Behavioral observations. Brandon was a member of group one. During the baseline phase, Brandon averaged 3.13 aggressive acts per observation session, and had a range of aggressive acts from 0 to 11. Throughout this phase, there was some variability in Brandon's aggressive behaviors, with one day of excessive aggressive acts relative to other baseline days. While it is understandable for a child under these circumstances to have one day of excessive

behaviors and stable trends are desired to compare results between the baseline and treatments phases, we moved forward with the phase of study as it would have been difficult to have matching trends of behavior of all students included in the study; thus, despite the trends of each individual student in the baseline phase, the study continued on to the treatment phase. During the first treatment phase, Brandon's behaviors began to stabilize, as there was a decrease in the average aggressive acts to 1.44 per observation session, and the range of aggressive acts was from 0 to 4. Throughout this phase there was a stable trend and only moderate variability in his aggressive behaviors. During the second treatment phase, Brandon's aggressive acts continued to decline in frequency to an average of 0.90 aggressive acts per observation session, and the range of aggressive acts was from 0 to 3. Throughout this phase, however, there was a moderate upward trend and moderate variability. During the maintenance phase no data were collected on Brandon due to him discharging from the treatment center after the last observation of the second treatment phase.

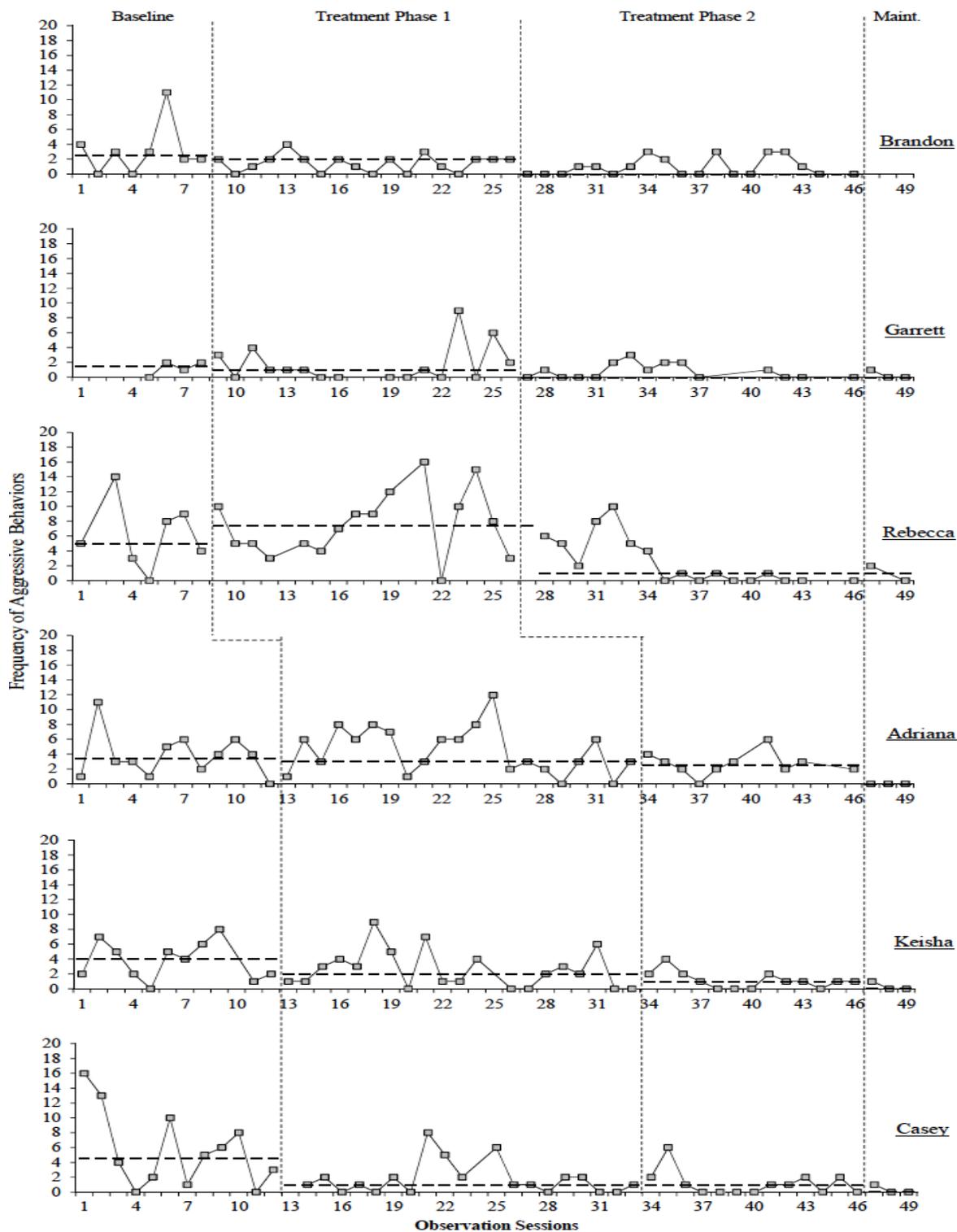


Figure 1. Frequency of observed aggressive acts of six students during baseline, treatment, and maintenance phases.

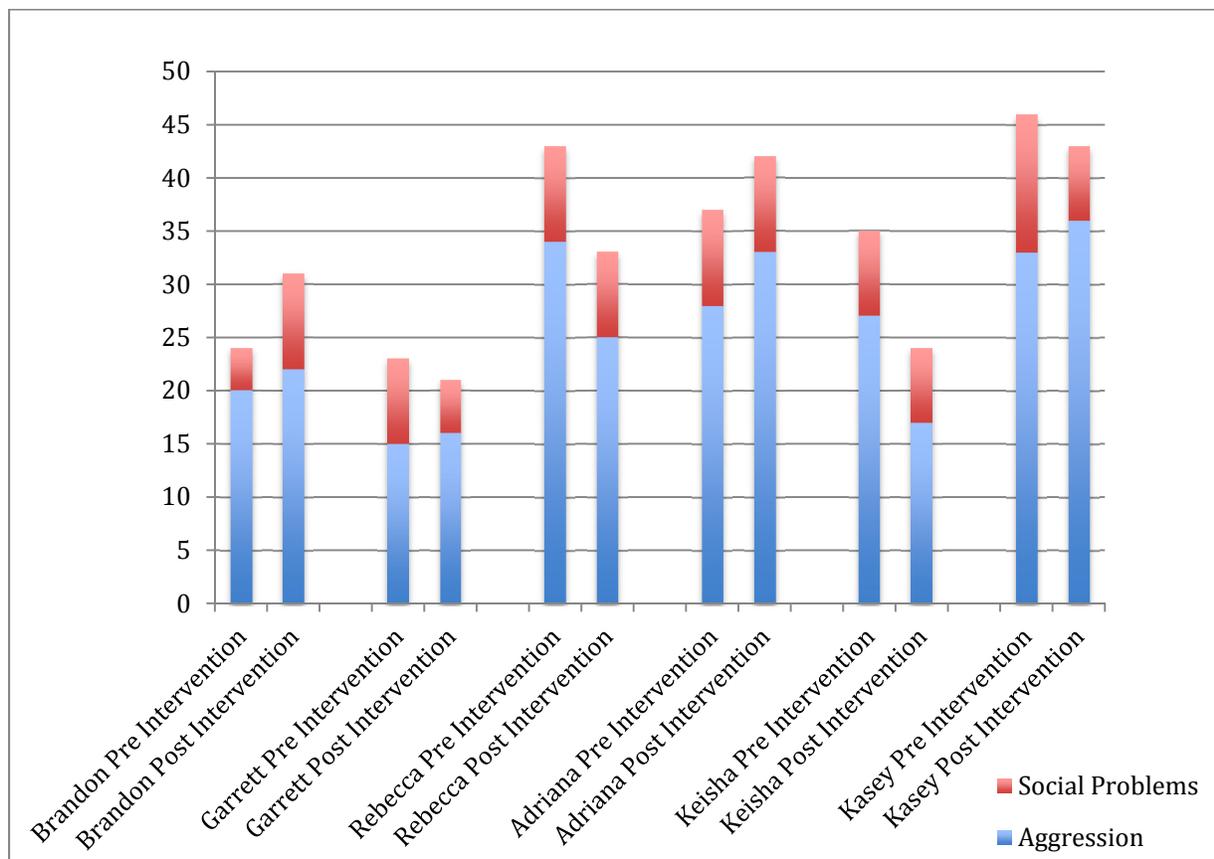


Figure 2. *Teacher Report Form (TRF) ratings of aggressive acts and social problems of six students before and after receiving bibliotherapy.*

Table 3
TRF Teacher Report Form (TRF) Ratings

| | Aggression | | | Social Problems | | | Total | | |
|---------|------------|------|----------|-----------------|------|----------|-------|------|----------|
| | Pre | Post | (change) | Pre | Post | (change) | Pre | Post | (change) |
| Brandon | 20 | 22 | (+2) | 4 | 9 | (+5) | 24 | 31 | (+7) |
| Garrett | 15 | 16 | (+1) | 8 | 5 | (-3) | 23 | 21 | (-2) |
| Rebecca | 34 | 25 | (-9) | 9 | 8 | (-1) | 43 | 33 | (-10) |
| Adriana | 28 | 33 | (+5) | 9 | 9 | (0) | 37 | 42 | (+5) |
| Keisha | 27 | 17 | (-10) | 8 | 7 | (-1) | 35 | 24 | (-11) |
| Casey | 33 | 36 | (+3) | 13 | 7 | (-6) | 46 | 43 | (-3) |

Note: Lower ratings are more desirable, as they indicate little to no observations of aggression or social problems, respectively. For aggression, scores of 0-11 are observed to be within the normal range (below the 92nd percentile when compared to the normative sample), scores of 12-16 identifies them in the borderline clinical range (the between 93rd and 97th percentiles when compared to the normative sample), and scores of 17-42 identifies them in the clinical range (above the 98th percentile when compared to the normative sample). For social problems, scores of 0-6 are observed to be in the normal range (0 to 92nd percentile of the normative sample scores), scores of 7-9 are observed to be in the borderline clinical range (93rd to 97th percentile of the normative sample scores), and scores of 10-22 are observed to be in the clinical range (98th percentile or above of the normative sample scores).

Between phase visual analysis. Calculations of percentages exceeding the median (PEM) were performed, following the recommendations of Ma (2006) to help make sense of trends in the data. As there are moving data points with outliers for this study, the PEM was used as Ma proposed the use of PEM in order to reduce the impact of data outliers on the calculation of the effect size. In this study, aggressive behaviors below the median were desirable, so the PEM was the percentage of data points *less than* the baseline median of aggressive acts. Brandon's baseline median of aggressive behaviors was 2.5. During the first treatment phase, Brandon's aggressive acts were observed to be less than the baseline median 88.9% of the time, and during the second treatment phase his aggressive acts were observed to be less than the baseline median 78.9% of the time. Together, Brandon's aggressive acts were observed to be less than the baseline median 83.8% of the time.

Table 4
Brandon's Observed Frequency of Aggressive Behaviors

| | Baseline | Treatment 1 | Treatment 2 | Maintenance |
|-------------|----------|-------------|-------------|-------------|
| Average | 3.13 | 1.44 | 0.90 | --- |
| Median | 2.50 | 2.00 | 0.00 | --- |
| Range | 11.00 | 4.00 | 3.00 | --- |
| Trend | Steep Up | Stable | Moderate Up | --- |
| Variability | High | Moderate | Moderate | --- |

Note: No maintenance data were collected on Brandon due to his discharge from the treatment center just after the intervention ended.

Table 5
Brandon's Percentage Exceeding the Median (PEM)

| Baseline Median | Treatment 1 | Treatment 2 | Treatments 1 and 2 | Maintenance |
|-----------------|-------------|-------------|--------------------|-------------|
| 2.5 | 88.90% | 78.90% | 83.80% | --- |

Behavior ratings. Brandon's behavior ratings completed by his teacher showed a reported increase in ratings of aggressive behaviors and social problems. Brandon's aggression ratings increased from 20 to 22, and his social problems increased from 4 to 9. Overall, his total ratings increased from 24 to 31. These scores represent ratings in a clinical range that increased substantively to be even more problematic over time.

Results for Garrett

Behavioral observations. Garrett was also a member of group one. During the baseline phase, Garrett averaged 0.63 aggressive acts per observation session, and had a range of aggressive acts from 0 to 2. Throughout this phase, there was moderate variability in Garrett's aggressive behaviors, and his behaviors were moving in a steep upward trend. During the first treatment phase, Garrett's average aggressive acts increased to 1.56 per observation session, and the range of aggressive acts was from 0 to 9. Throughout this phase there was a moderate upward trend and high variability in his aggressive behaviors. Days that Garrett was absent were not depicted in Figure 1. During the second treatment phase, Garrett's aggressive acts began to stabilize and decline in frequency to an average of 0.60 aggressive acts per observation session, and the range of aggressive acts was from 0 to 3. Throughout this phase, there was a slight upward trend and moderate variability. During the maintenance phase there was a continued decrease in aggressive behaviors, as Garrett's aggressive acts averaged at 0.33 per observation session, and ranged from 0 to 1. Throughout this phase there was a moderate downward trend and low variability.

Table 6
Garrett's Observed Frequency of Aggressive Behaviors

| Descriptive statistic | Baseline | Treatment 1 | Treatment 2 | Maintenance |
|-----------------------|----------|-------------|-------------|---------------|
| Average | 0.63 | 1.56 | 0.60 | 0.33 |
| Median | 1.50 | 0.50 | 0.00 | 0.00 |
| Range | 2.00 | 9.00 | 3.00 | 1.00 |
| Trend | Steep Up | Moderate Up | Slight Up | Moderate Down |
| Variability | Moderate | High | Moderate | Low |

Between phase visual analysis. Garrett's baseline median of aggressive behaviors was 1.5. During the first treatment phase, Garrett's aggressive acts were observed to be less than the baseline median 68.75% of the time, and during the second treatment phase his aggressive acts were observed to be less than the baseline median 73.33% of the time. Together, Garrett's aggressive acts were observed to be less than the baseline median 70.97% of the time. During the maintenance phase, Garrett's aggressive acts were observed to be less than the baseline median 100% of the time, as can be seen in Table 7.

Table 7
Garrett's Percentage Exceeding the Median (PEM)

| Baseline Median | Treatment 1 | Treatment 2 | Treatments 1 and 2 | Maintenance |
|-----------------|-------------|-------------|--------------------|-------------|
| 1.50 | 68.75% | 73.33% | 70.97% | 100% |

Behavior ratings. Garrett's behavior ratings completed by his teacher showed an overall decrease in aggressive behaviors and social problems. While Garrett's aggression ratings

increased from 15 to 16, his social problems decreased from 8 to 5. Overall, his total ratings decreased from 23 to 21.

Results for Rebecca

Behavioral observations. During the baseline phase, Rebecca, also a member of group one, averaged 5.38 aggressive acts per observation session, and had a range of aggressive acts from 0 to 14. Throughout this phase there was high variability in Rebecca's aggressive behaviors, and her behaviors were moving in a steep upward trend. During the first treatment phase, Rebecca's behaviors showed an increase in frequency, because there was an increase in the average aggressive acts to 6.72 per observation session, and the range of aggressive acts was from 0 to 16. Throughout this phase there was a moderate upward trend and high variability in her aggressive behaviors. During the second treatment phase, Rebecca's aggressive acts began to stabilize and decline in frequency to an average of 2.15 aggressive acts per observation session, and the range of aggressive acts was from 0 to 10. Throughout this phase, there was a steep downward trend and high variability. During the maintenance phase there was a continued decrease in aggressive behaviors, as Rebecca's aggressive acts averaged at 0.67 per observation session, and ranged from 0 to 2. Throughout this phase there was a moderate downward trend and low variability.

Between phase visual analysis. Rebecca's baseline median of aggressive behaviors was 4.0. During the first treatment phase, Rebecca's aggressive acts were observed to be less than the baseline median 25%, and during the second treatment phase her aggressive acts were observed to be less than the baseline median 70.59%. Together, Rebecca's aggressive acts were observed to be less than the baseline median 48.48%. During the maintenance phase, Rebecca's aggressive acts were observed to be less than the baseline median 100%.

Table 8
Rebecca's Observed Frequency of Aggressive Behaviors

| Descriptive statistic | Baseline | Treatment 1 | Treatment 2 | Maintenance |
|-----------------------|----------|-------------|-------------|---------------|
| Average | 5.38 | 6.72 | 2.15 | 0.67 |
| Median | 4.50 | 6.00 | 0.50 | 0.00 |
| Range | 14.00 | 16.00 | 10.00 | 2.00 |
| Trend | Steep Up | Moderate Up | Steep Down | Moderate Down |
| Variability | High | High | High | Low |

Behavior ratings. Rebecca's behavior ratings completed by her teacher showed an overall decrease in aggressive behaviors and social problems. Rebecca's aggression ratings decreased from 34 to 25, and her social problems decreased from 9 to 8. Overall, her total ratings decreased from 43 to 33.

Table 9
Rebecca's Percentage Exceeding the Median (PEM)

| Baseline Median | Treatment 1 | Treatment 2 | Treatment 1 and 2 | Maintenance |
|-----------------|-------------|-------------|-------------------|-------------|
| 4.00 | 25.00% | 70.59% | 48.48% | 100% |

Results for Adriana

Behavioral observations. Adriana, a member of group two, averaged 3.83 aggressive acts during baseline. During this phase, her range of aggressive acts was from 0 to 11. Throughout this phase there was high variability in Rebecca's aggressive behaviors, and her behaviors were moving in a moderate downward trend. During the first treatment phase, Adriana's behaviors showed an increase in frequency, as there was an increase in the average aggressive acts to 4.48 per observation session, and the range of aggressive acts was from 0 to 12. Throughout this phase there was a moderate downward trend and high variability in her aggressive behaviors. During the second treatment phase, Adriana's aggressive acts began to stabilize and decline in frequency to an average of 2.08 aggressive acts per observation session, and the range of aggressive acts was from 0 to 6. Throughout this phase, there was a slight upward trend and high variability. During the maintenance phase there was a continued decrease in aggressive behaviors, as Rebecca's aggressive acts averaged at 0.0 per observation session, and had a range of 0. Throughout this phase there was a stable trend and low variability.

Table 10
Adriana's Observed Frequency of Aggressive Behaviors

| | Baseline | Treatment 1 | Treatment 2 | Maintenance |
|-------------|---------------|---------------|-------------|-------------|
| Average | 3.83 | 4.48 | 2.08 | 0.00 |
| Median | 3.50 | 3.00 | 2.00 | 0.00 |
| Range | 11.00 | 12.00 | 6.00 | 0.00 |
| Trend | Moderate Down | Moderate Down | Slight Up | Stable |
| Variability | High | High | High | Low |

Between phase visual analysis. Adriana's baseline median of aggressive behaviors was 3.5. During the first treatment phase, Adriana's aggressive acts were observed to be less than the baseline median 52.30%, and during the second treatment phase her aggressive acts were observed to be less than the baseline median 80%. Together, Adriana's aggressive acts were observed to be less than the baseline median 61.30%. During the maintenance phase, Adriana's aggressive acts were observed to be less than the baseline median 100%.

Table 11
Adriana's Percentage Exceeding the Median (PEM)

| Baseline Median | Treatment 1 | Treatment 2 | Treatment 1 and 2 | Maintenance |
|-----------------|-------------|-------------|-------------------|-------------|
| 3.50 | 52.30% | 80.00% | 61.30% | 100% |

Behavior ratings. Adriana's behavior ratings completed by her teacher showed an overall increase in aggressive behaviors and social problems. Adriana's aggression ratings increased from 28 to 33, and her social problems did not change from a rating of 9 to 9. Overall, her total ratings increased from 37 to 42.

Results for Keisha

Behavioral observations. Keisha was also a member of group two. During the baseline phase, Keisha averaged 3.5 aggressive acts per observation session, and had a range of aggressive acts from 0 to 8. Throughout this phase, there was high variability in Keisha's aggressive behaviors, and her behaviors were moving in a slight downward trend. During the first treatment phase, Keisha's average aggressive acts decreased to 2.48 per observation session, and the range of aggressive acts was from 0 to 9. Throughout this phase there was a moderate downward trend and high variability in her aggressive behaviors. During the second treatment phase, Keisha's aggressive acts continued to stabilize and decline in frequency to an average of 1.15 aggressive acts per observation session, and the range of aggressive acts was from 0 to 4. Throughout this phase, there was a moderate downward trend and moderate variability. During the maintenance phase there was a continued decrease in aggressive behaviors, as Keisha's aggressive acts averaged at 0.33 per observation session, and ranged from 0 to 1. Throughout this phase there was a moderate downward trend and low variability.

Between phase visual analysis. Keisha's baseline median of aggressive behaviors was 4.0. During the first treatment phase, Keisha's aggressive acts were observed to be less than the baseline median 70%, and during the second treatment phase her aggressive acts were observed to be less than the baseline median 92.3%. Together, Keisha's aggressive acts were observed to be less than the baseline median 78.79%. During the maintenance phase, Keisha's aggressive acts were observed to be less than the baseline median 100%.

Table 12
Keisha's Observed Frequency of Aggressive Behaviors

| | Baseline | Treatment 1 | Treatment 2 | Maintenance |
|-------------|-------------|------------------|------------------|------------------|
| Average | 3.50 | 2.48 | 1.15 | 0.33 |
| Median | 3.00 | 2.00 | 1.00 | 0.00 |
| Range | 8.00 | 9.00 | 4.00 | 1.00 |
| Trend | Slight Down | Moderate Down | Moderate Down | Moderate Down |
| Variability | High | High | Moderate | Low |

Table 13
Keisha's Percentage Exceeding the Median (PEM)

| Baseline Median | Treatment 1 | Treatment 2 | Treatment 1 and 2 | Maintenance |
|--------------------|-------------|-------------|----------------------|-------------|
| 4.00 | 70.00% | 92.30% | 78.79% | 100% |

Behavior ratings. Keisha's behavior ratings completed by her teacher showed an overall decrease in aggressive behaviors and social problems. Rebecca's aggression ratings decreased from 27 to 17, and her social problems decreased from 8 to 7. Overall, her total ratings decreased from 35 to 24.

Results for Casey

Behavioral observations. During the baseline phase, Casey, also a member of group two, averaged 5.67 aggressive acts per observation session, and had a range of aggressive acts from 0 to 16. Throughout this phase there was high variability in Casey's aggressive behaviors, and her behaviors were moving in a steep downward trend. During the first treatment phase, Casey's behaviors showed a decrease in frequency, as there was a decrease in the average

aggressive acts to 1.62 per observation session, and the range of aggressive acts was from 0 to 8. Throughout this phase there was a moderate downward trend and high variability in his aggressive behaviors. During the second treatment phase, Casey's aggressive acts continued to decline in frequency to an average of 1.15 aggressive acts per observation session, and the range of aggressive acts was from 0 to 6. Throughout this phase, there was a moderate downward trend and high variability. During the maintenance phase there was a sustained decrease in aggressive behaviors, as Casey's aggressive acts averaged at 0.33 per observation session, and ranged from 0 to 1. Throughout this phase there was a moderate downward trend and low variability.

Table 14
Casey's Observed Frequency of Aggressive Behaviors

| Descriptive statistic | Baseline | Treatment 1 | Treatment 2 | Maintenance |
|-----------------------|---------------|------------------|------------------|------------------|
| Average | 5.67 | 1.62 | 1.15 | 0.33 |
| Median | 4.5 | 1 | 1 | 0 |
| Range | 16 | 8 | 6 | 1 |
| Trend | Steep Down | Moderate Down | Moderate Down | Moderate Down |
| Variability | High | High | High | Low |

Between phase visual analysis. Casey's baseline median of aggressive behaviors was 4.5. During the first treatment phase, Casey's aggressive acts were observed to be less than the baseline median 84.21%, and during the second treatment phase his aggressive acts were observed to be less than the baseline median 92.31%. Together, Casey's aggressive acts were

observed to be less than the baseline median 87.50%. During the maintenance phase, Casey's aggressive acts were observed to be less than the baseline median 100%.

Table 15
Casey's Percentage Exceeding the Median (PEM)

| Baseline Median | Treatment 1 | Treatment 2 | Treatment 1 and 2 | Maintenance |
|-----------------|-------------|-------------|-------------------|-------------|
| 4.50 | 84.21% | 92.31% | 87.50% | 100% |

Behavior ratings. Casey's behavior ratings completed by his teacher showed an increase in aggressive behaviors, but a decrease in social problems. Casey's aggression ratings increased from 33 to 36, while his social problems decreased from 13 to 7. Overall, his total ratings decreased from 46 to 43.

Social Validity Interviews

Social validity information was obtained from individual interviews of student participants, as well as interviews of the teachers and therapist of the student participants. Information gathered from the students indicated the things they most enjoyed about the group were being able to have time away from others in a smaller group, being able to be calm, being able to read, and being able to have fun. When asked what they disliked about the group, there was only one report by one student about being frustrated when peers were fighting during the group. Overall, students reported that they would enjoy being a part of a similar group in the future because it is "fun" to read and be engaged in different activities, and that they have the opportunity to learn new things as well as to express their feelings.

While students had a more difficult time identifying new things that they learned from the group, when asked what they learned to do better or that they are better at now from being in the group, they responded: “listening well and not disrupting everybody,” “smiling, having good language, and not yelling at my friends,” “controlling my anger,” “paying attention and kind of not arguing,” and “calming down and working in school.” Three of the five students indicated that they enjoyed writing their own story as one of the post-reading activities, and others also mentioned that they enjoyed drawing, playing charades, and taking part in role plays. A note of interest is that students were able to remember and identify books that they enjoyed reading, even from sessions that were from the beginning of the intervention a few months earlier.

The elementary school teachers both endorsed the fact that bibliotherapy is supporting reading skills, reading comprehension, analyzing skills, communication and listening skills, which they were excited to have supported by another activity outside of class. Furthermore, two teachers observed bibliotherapy validating the situations or emotions of the students, while also offering clues or ideas of how to deal with their issues. While two teachers were unclear of the impact that bibliotherapy had upon students and their behaviors, as there are many intervention variables involved in the residential treatment setting (e.g., medication, group therapy, family therapy, home visits), the other teacher did express that she saw the specific students who were in the group develop more of a camaraderie and better relationships with one another, working better together and arguing less. Overall, the group was enjoyed by the students and was an incentive to make sure that they were involved and participating in class so that they would be given the privilege to go when the time came for the bibliotherapy groups.

The teachers saw weakness in the possibility that it might not be the best intervention to treat aggression, or that it would be difficult for the students to generalize and apply what they

learned. Ultimately, all teachers concluded that that the students could use as much help as possible, and bibliotherapy was something that they saw as useful, even for the time that students were taken away from the classroom for the intervention sessions. The teachers indicated that scheduling and having the teacher be aware of the intervention were most important for it being worthwhile and feasible in conducting in small group or whole classroom settings.

Information gathered from the three marriage and family therapists who served the students participants indicated that they were unsure of the exact impact that bibliotherapy had on the students because of all the treatment variables to take into account, but one therapist indicated that he observed that it had a calming effect on the students that contributed to the success of students' response to other interventions utilized in therapy. Although all therapists agreed that bibliotherapy would not be recommended to be a stand-alone treatment for students in a residential treatment center, they did see it being an appropriate and useful treatment because of the perceived positive effect of being read to, and is a teaching and learning modality that could involve multiple senses and provide students with an internal narrative, or model, that would be accessible to them when handling situations.

While the therapists did not identify any specific weaknesses that they saw in bibliotherapy from what they observed in the students, a therapist did speculate that bibliotherapy might be too slow-paced for some students, and another therapist proposed that certain books or stories could provide the wrong characters for students to identify with and follow. Therapists did see value in the bibliotherapy as long as it was scheduled in such a way to support other learning activities or therapies available to the students, such as being a point of reference to use when students are debriefing and working to understand their frustrating situations and how they can guide their own behavior. The therapists particularly saw it as

valuable in being an individualized therapy in a small group setting where students would be engaged in the activity, feel comfortable, desire to open up, and develop connections with others in their group.

Overall, students, teachers, and therapists identified bibliotherapy as being a valuable intervention to support reading, communication, listening, and providing internal narratives to model choices and behaviors, all the while being engaging and enjoyable for the students to be involved in. While it was unclear from therapist or teacher observations how effective bibliotherapy was on student behavior, especially considering the many diverse interventions and therapies that students were involved in, the each individual student were able to identify something new they learned as well as something they had improved upon. Additionally, students were able to identify specific books or activities that they enjoyed and specific skills they learned from these books. Generally, the therapists and teachers supported the small group setting for the intervention rather than a whole classroom setting, but did acknowledge the value that it could have in both settings when appropriately scheduled and planned with other learning activities and therapies to coordinate, support, and reinforce student learning and application of knowledge. Ultimately all saw the value in bibliotherapy, with therapists and teachers supporting student involvement, and all student participants specifying that they would want to be involved in another bibliotherapy group because of what they learned and the fun they had in the process.

Discussion

In recent years, multiple interventions targeting proactive social skills have been recommended in the research literature, with a large amount of research support accruing for positive behavior supports (PBS; Sugai et al., 2000). As one of many components of PBS that

has been recommended in the literature, bibliotherapy has been shown to be an effective intervention for children and youth experiencing problematic behaviors. Traditionally, past efforts to decrease acts of aggression among students at schools have been zero tolerance policies, the threat of punishment, or punishment itself (Shechtman, 2001). Because these approaches do not address the underlying causes of the aggression or put into place mechanisms for the prevention of aggressive behaviors, other approaches have emerged. Many prevention and intervention methods for aggression either include psychoeducation or psychotherapy (Horne et al., 2007; Shechtman, 2007, 2009). The method of bibliotherapy seeks to provide both educational and therapeutic components.

Bibliotherapy imparts information while at the same time attempts to create an emotional response to bring about behavior change through a process of phases that parallels those in characteristic of psychotherapy, including identification, catharsis, and insight (Fincher, 1980; Kramer & Smith, 1998; Lenkowsky, 1987; Morawski, 1997; Pardeck & Pardeck, 1984; Riordan & Wilson, 1989; Tews, 1970).

Traditionally, bibliotherapy has focused on internal, emotional problems (e.g., distress resulting from divorce or separation of parents, moving, new or changing relationships) but not externalization of emotion, specifically aggression (Pardeck & Pardeck, 1984). Only within the past 15 years has bibliotherapy been considered a treatment for aggression. The present study sought to further understand and validate the influence that bibliotherapy has upon aggressive children. To extend previous research, this study was focused on a population within the United States, used instruments that directly measured aggressive acts or behaviors by observation, and specifically targeted interventions for highly aggressive children in a residential treatment center

to potentially capture more insight into the impact that bibliotherapy has upon aggressive behaviors in children.

The purpose of this study was to determine the relationship between bibliotherapy and aggressive acts in elementary aged children in a residential treatment center. The results showed that bibliotherapy, when combined with post-reading activities and role plays (purposefully used during treatment phase two), effectively decreased the number of observed aggressive acts for most of the students. This was demonstrated by decreases in frequency of aggressive acts throughout the treatment and maintenance phases of the study. Furthermore, teacher behavior ratings indicated general decreases in aggression and social problems. The results varied from individual to individual. Students demonstrated different levels of change in their aggression as a function of the intervention.

Specifically, the results showed that three of the students exhibited notable decreases in observed aggressive acts, two exhibited small decreases in aggressive acts, and one exhibited inconsistent behaviors without notable decreases in aggression. Ratings provided by the teachers on the TRF showed a similar pattern of different responses for each individual participant, with two demonstrating notable decreases in aggression and social problems overall, two remaining stable, and two demonstrating increases. For those students demonstrating consistent decreases in observed aggressive behaviors, these decreases were most significant in phase two of the intervention. Thus, it could be that role-plays were a particularly effective component of the intervention provided.

According to the observed number of aggressive acts in the single case design, five of the six students were on a stable, downward trend at the end of treatment phase two (the start of the maintenance phase). Brandon was the one student who began to show an increase in aggressive

behaviors at the end of the treatment phase two, even though his aggressive behaviors initially did decrease during treatment phase one. Additionally, Brandon's teacher indicated an increase in his aggression and social problems at that time. Brandon was unavailable during the maintenance phase of the study because he was discharged from the treatment center (due to an inability to pay for services) just prior to beginning of the maintenance phase. Teachers, therapists, and staff offered an explanation of this phenomenon, explaining that it is common for students who are leaving the treatment center display an increase in behaviors due to the uncertainty and anxiety that often accompanies this event. This appears to be a plausible reason why Brandon's aggressive behaviors increased at the end of the study, at a time when no other student demonstrated the same increase in aggressive behaviors. Nevertheless, it could also be that the intervention was less effective for Brandon at the end of his time in the center for reasons unknown.

Another student's data also demonstrated unexpected inconsistencies. In general, Garrett's behaviors were very stable because he displayed few aggressive behaviors. However, there was a large spike in Garrett's aggressive behaviors towards the end of treatment phase one, over about five sessions. This pattern was clearly inconsistent with his typical patterns of behavior. In consultation with staff at the treatment center, it was determined that at about that time, Garrett discontinued medication that had been prescribed for ADHD. It is possible that Garrett may have experienced more agitation and decreased impulse control during that period of time that may have related to his increased aggressive behavior. However, further inspection of the data indicated that four of the six students also displayed increased aggressive behavior during those same observation sessions at the end of treatment phase one. Interestingly, those sessions also preceded the Christmas holiday, when many students would have the possibility of

visiting with family members or caregivers at or away from the treatment center. The staff explained that that period of time often increased students' anxiety, and the students often appeared to be preoccupied with the impending visits with their family at the treatment center or back home at the end of the term. Although this explanation appears to be a plausible reason for the sudden, and simultaneous, increase in aggressive behavior, it could also be accounted for by other dynamics in the center or possibly in the intervention during that particular phase.

Taken as a whole, and assuming that the staff members' observations about increased student anxiety are correct, it could be that bibliotherapy is less effective than it otherwise would be in reducing the aggressive student behavior during times of greater anxiety. This explanation seems reasonable because the bibliotherapy intervention did address how to handle prolonged anxiety that could exacerbate aggressive behaviors. Rather, bibliotherapy sessions were designed to address aggression when encountering situational or relational frustrations that were typically short in their duration of time (e.g., having an argument with a friend, or the actions of another causing negative feelings).

Visual analysis of treatment phase two and the maintenance phase indicate that with the exception of one student, Brandon, all students demonstrated an overall decrease in aggressive behaviors at the conclusion of the maintenance phase. As such, it would be expected that teachers' ratings of aggressive behaviors and social problems of all students would likely coincide and be commensurate with these observed behaviors. However, this was not the case. Teachers' ratings of aggression decreased only for Rebecca and Keisha, but teachers' ratings of social problems decreased for Garrett, Rebecca, Keisha, and Casey. Brandon and Adriana were the only two students who teachers rated as either stable or increasing in their aggressive behaviors and social problems. It is interesting to note that these two were also the only students

who had unstable or increasing aggressive behavior during treatment phase two. The four students who demonstrated decreases in observed aggressive behaviors (Garrett, Rebecca, Keisha, and Casey) were also rated by their teachers to have decreases in their aggression and/or social problems.

The effectiveness of the intervention varied as a function of individual factors. Rebecca and Keisha, both girls, one Caucasian and one African American, appeared to experience the greatest decrease in aggressive acts by observation and/or by teacher ratings. Brandon and Adriana, a Caucasian male and a Hispanic female, experienced the opposite effect. Two other males, both Caucasian, both positively but moderately responded to the bibliotherapy. Given the limited information available about the participants and their circumstances, no conclusions can be drawn from this study about the differences in findings among students.

Overall, four of the six students had consistent data indicating that their observed aggressive behaviors decreased. Thus, the bibliotherapy intervention appeared to be modestly effective in decreasing aggression in this sample of elementary-aged children in the treatment center, children who are more highly aggressive than those typically found in the public school system.

Limitations

This study has multiple limitations in terms of both internal validity and external validity. These include limitations of the population sampled, selection and equivalency of groups, possible simultaneous interventions (history effects), participant maturation, participant attrition, knowledge of the participants about the purpose and aims of the study, possible cooperation of the participants across groups, and integrity of implementation of the intervention and completion of observations and rating scales.

The sample of participants was dependent upon those which parents or guardians completed and returned the consent form, creating a biased sample. It could be that children whose parents or guardians completed the form systematically differed from the other children (e.g., parental support/involvement).

Furthermore, children were not randomly assigned to groups, so there could have been systematic differences in several variables unmeasured in this study, such as willingness to change. Students were placed in one of two groups by convenience, according to which teacher was working with them at the beginning of the study. However, all potential participants were deemed to display moderate to high amounts of aggressive behaviors, and there was no known reason to suspect that one group was more likely to respond to treatment than another. So although the lack of random assignment to groups increased was less than optimal, this study could not have been conducted without scheduling participation according to the existing conditions at the center.

Originally, eight students were identified for participation, but two dropped out due to being discharged from the treatment center. This problem had been foreseen, and the researcher was prepared to conduct the study with as few as six students. Nevertheless, it is plausible that the two students who did not participate in the study differed from the other students who remained in the study, such as being generally less responsive to treatment, and this could have impacted the overall findings had they participated.

Students at the center receive multiple treatments, with all aspects of their living conditions dictated by the therapeutic program at the center. Thus it is plausible that some of the reductions in students' aggression and social problems were attributable to other interventions provided at the center at the same time. Nevertheless, the baseline data were intended to control

for those existing conditions, and no other intervention was known to have changed or been implemented during the timeframe of this particular study.

A related concern involves the effects of participant maturation. Children tend to improve in their self-regulation, emotional awareness, and other adaptive skills over time as a function of normal development, irrespective of any intervention. However, the likelihood that the decreases in aggressive behavior and social problems were solely attributable to maturation effects seems minimal because the evaluation period was relatively brief. Moreover, if maturation explained the trends then the data would have shown greater improvements made by younger children, but no systematic differences in the results were observed across participants of different ages (ranging from nine to eleven years). Similarly, because all students had attention problems and exhibited behaviors that could interfere with their receptivity to the interventions provided, student maturation level could have impacted their internalization of the principles shared during lessons. Nevertheless, the fact that all students shared those conditions mitigates the threat to study internal validity.

Participants knew that they were involved in a research study. Thus some of their decreases in aggression and social problems could possibly be explained by the novelty of the study itself and the accompanying attention that the students received, relative to their peers in the center who were not involved in the study. For instance, if the students came to expect the examiner to be present in their classroom at a certain time, they may have been less likely to exhibit aggression during that time period. However, students' explanations during the individual interviews did not suggest that they had attended to non-therapeutic aspects of the interventions, meaning that their reports focused on the aspects on the intervention that were intended to decrease aggressive behaviors. And students remained uninformed about teacher

ratings or observations of their behaviors. Although students could not help but notice that the experimenter was often in their classroom, the students were never informed about the purpose of the experimenter's presence.

A further plausible limitation to this study could be related to teachers' perceptions of the students' behaviors. Teachers' ratings of overall behavioral problems can become biased by intense behavioral events that may exaggerate ratings on relevant items. However, observations of aggressive acts help to mitigate this potential bias. Thus, the design of this study in which both teacher ratings and direct observations were conducted helps to provide a clearer picture of student behavior.

With respect to construct measurement, the observations conducted focused on verbal and physical acts of aggression, but they did not include relational aggression. For some students, particularly young women, relational aggression may be a more prevalent method of externalizing behaviors of overt acts of kicking, hitting, etc. Thus, the observational measures may have underrepresented aggressive acts of some participants. Nevertheless verbal acts were recorded and most relational acts of aggression occur verbally, so this particular limitation of not recording relational aggression should not be detrimental to the overall findings of the study.

A limitation of the intervention itself was that it occurred without full integration in the ongoing residential treatment program. Thus, the skills presented in bibliotherapy were not practiced or reinforced outside of the experiment. Optimally, a bibliotherapy intervention would be fully integrated into all aspects of a treatment program with staff, teachers, and therapists reinforcing concepts and skills.

Finally, the cooperation of the sample and the integrity of the implementation of the intervention and the completion of the observations and rating scales were of concern. The

intervention was conducted by the experimenter who created lesson plans to follow for each bibliotherapy session and thus sought to achieve the strong integrity of implementation. While the intervention was originally planned to take place over eight consecutive weeks, this did not take place due to student absences, changes in scheduling, and holidays. Events like these occur regularly and unfortunately cannot be controlled. The increased duration of time over which the study was conducted also presented problems in terms of changes to schools schedules, classes, and teachers.

Furthermore, the data on the TRF involved different raters from pre- to post-test in two instances, specifically Adriana and Keisha. In these cases, students were moved to classrooms with a new teacher during the study, such that a teacher who had not completed the pre-test ratings completed the post-test evaluations. To minimize the likelihood of subjective differences in ratings, those teachers did communicate with one another about the students past and current behaviors. Unfortunately it is unknown how the change in rater affected the difference between the pre- and post-ratings. It is possible that the teachers' were unreliable in their evaluations; nevertheless, any possible unreliability on the TRF would be problematic in only those two cases.

Despite the multiple limitations, the internal validity of the study was strengthened due to the controlled environment of the residential treatment center: All participants received essentially the same conditions and were not subjected to the widely varying circumstances that can affect children in the public schools when they leave the school premises. Each student receives the same amount of individual, family, and recreational therapy. Furthermore, living conditions are equalized by amenities available to all participants, and all students have equal

access to all activities offered at the treatment center. Thus, the treatment center itself acted as a control to many potential confounding variables.

The external validity, or the generalizability, of the study is restricted to residential treatment centers. The specific residential treatment center involved in this study is similar to many other residential treatment centers in terms of amenities and services. However, the results cannot be assumed to generalize to public school settings, which differ markedly, even though the center had an integrated school with classes, classrooms, schedules, certified teachers, and other features of public schools. Overall, the results of case study designs, even those involving multiple conditions, cannot be presumed to have external validity without systematic replication. Future research will be needed to confirm or refute the findings of this study.

Implications for Future Research

This study was characterized by multiple limitations that can be corrected and controlled in future research. First, future research could investigate larger samples of aggressive students to more adeptly ascertain whether the effects of bibliotherapy may generalize to the larger population and to specific sub-groups (e.g., across participant gender, race, age).

The treatment itself could be examined more in depth, with future research continuing to study the difference of effectiveness of bibliotherapy as a function of various post-reading activities. In this study success was apparently associated with using role plays as a post-reading activity, but future research could ascertain which particular components of the intervention are most effective.

It would be helpful for future research to investigate possible differences across the type of aggression exhibited. The definition of aggression could be expanded to include relational

aggression, given that that is a particularly common form of aggression. Relational aggression is also more complex and more difficult to observe than direct, physical aggression.

Finally, it will be important to verify that the effects of bibliotherapy endure over time. Future research should involve bibliotherapy interventions of greater length with longer periods of follow-up (Shechtman, 1996; 2000; 2006; 2009).

Zipora Shechtman has also offered several additional directions for future research. Expanding the definition of bibliotherapy to include the use of other literature could be examined, such as short stories, poems, and even clips of films (Shechtman, 1999). Also, further research could explore differences in response to bibliotherapy amongst individuals, specifically investigating the effect upon those who are aggressive and those who are withdrawn (Shechtman, 1996), and the differences amongst boys and girls (Shechtman, 2006). Another aspect to consider and examine is the possible difference in effects of bibliotherapy upon those in individual versus group therapies, as well as individual or small group interventions versus whole class interventions (Shechtman, 2000; 2009). Finally, large differences in demographics, such as geographic location around the world, culture, ethnicity, and socio-economic status could be studied more intently to identify populations where bibliotherapy might be most effective (Shechtman, 2009).

Implications for Practitioners

This study indicates bibliotherapy was somewhat effective in helping decrease verbal and physical acts of aggression elementary aged boys and girls in a residential treatment center. Students in the center are commonly less responsive to interventions than their peers outside of the treatment center, so it stands to reason that if bibliotherapy benefits those students, it may

also assist students who would typically be even more open to interventions. Previous research has supported that claim (Shechtman, 1996; 1999; 2000; 2001; 2006; 2009).

Bibliotherapy principles and techniques create an intentional use of literature as a therapeutic tool. Because bibliotherapy techniques are simple to learn, they can easily be used within the school setting by school psychologists, counselors, or teachers. As the social validity interviews in this study suggested, teachers and students alike can find value and enjoyment in bibliotherapy, as it naturally supports the literacy learning that teachers emphasize in schools. Additionally, the simplicity of the implementation of the intervention lends itself to being used by other mental health professionals who serve youth. While the therapists interviewed did not find it a strong stand-alone treatment, they did support its use as a supplemental or alternative treatment modality.

Interviews about the interventions suggested that role plays were an integral part of the effectiveness of bibliotherapy. Therapists and teachers identified bibliotherapy as providing a model, or internal narrative, for behavior that could then influence the students' own choice of behavior when confronted with similar emotions or situations. Quantitative data from the study also supported role plays as a post-reading activity that was seen as one of the strongest ways to bring about a change in aggressive behavior; the largest and most consistent decrease in aggressive behaviors were observed during the second half of the treatment phase when role plays were the only post-reading activity used. Thus, when using bibliotherapy, role plays seem to be a key piece in helping create a stronger link between the cognitive understanding and actual behavioral outcomes that were observed.

Conclusion

Bibliotherapy has been promoted as a plausible intervention in schools to reduce aggression among elementary-aged children because it naturally combines psychoeducation and psychotherapy through identification, catharsis, and insight (Fincher, 1980; Kramer & Smith, 1998; Lenkowsky, 1987; Morawski, 1997; Pardeck & Pardeck 1984; Riordan & Wilson, 1989; Tews, 1970). And it is easily employed in a variety of settings by a variety of professionals, including teachers (Sullivan & Strang, 2003; Tews, 1970).

Only within the past 20 years has bibliotherapy been considered a treatment for aggression. Zipora Shechtman has led out six research studies to discover the effectiveness of bibliotherapy in helping children with aggression (Shechtman, 1996; 1999; 2000; 2001; 2006; 2009). All six studies took place in public schools outside the United States, and investigated the effect that bibliotherapy had upon decreasing aggressive behaviors in boys and girls. Compared to those in control groups, Shechtman found that aggression, or beliefs and attitudes towards aggression, did decrease amongst those students who participated in bibliotherapy, while aggressive behaviors, beliefs, and attitudes amongst those in the control groups did not.

This study specifically investigated the effect that bibliotherapy had upon six elementary-aged children in a residential treatment center in the United States. Data consisted of observed aggressive acts in the classroom, as well as teacher pre- and post-treatment ratings of aggressive behavior and social problems. Additionally, information about the social validity of bibliotherapy was obtained through interviews of student participants, along with their teachers and therapists.

Findings from this study indicate that four of the six students demonstrated notable decreases in aggressive behaviors as well as decreases in teachers' ratings of aggression and/or

social problems. Additionally, interviews indicated that all students, teachers, and therapists saw bibliotherapy as a viable and enjoyable intervention for aggressive behaviors.

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APPENDIX A: REVIEW OF LITERATURE

Scholars have examined many aspects of bibliotherapy and its effectiveness as an intervention with children and youth. Much of that literature has focused on problematic internalizing behaviors with relatively less literature focused on externalizing behaviors, such as aggression. In this section the research on bibliotherapy and aggression will be reviewed.

Aggression Defined

Any intentional act used to injure another, whether physically or psychologically, is identified as aggressive behavior, thus taking in anything with the range of violent physical acts to verbal insults or name calling (Loeber & Hay, 1997; Moeller, 2001). To further understand the range of behaviors that are included under this broad term, aggression is identified as various forms and types (Shechtman, 2009).

Forms. Aggression is expressed in three different forms: physical, verbal, and relational (Shechtman, 2009). Physical aggression consists of any physical act to direct harm towards another person, animal, or object. Verbal aggression involves the use of words by the aggressor to injure another. Relational aggression takes place when damage to social relationships and accompanying feelings of inclusion, acceptance, and friendship is caused by the behavior of the aggressor.

Types. Types of aggression are defined by the motive for the aggressive act committed, and include proactive and reactive, with the aggressor expressing their aggression through one of the forms listed above (Shechtman, 2009). Proactive aggression is motivated by the aggressor in seeking to accomplish or obtain predetermined goals, perceiving that his or her act aggressive act will lead to the positive outcomes that he or she desires. It is often found as a common way to cope among impoverished and delinquent youth. Bullying is a type of proactive aggression that

is most common in schools. Bullying occurs when an aggressor uses repetitive force on a vulnerable victim to perpetuate an imbalance of power to purposefully reach predetermined goals. In any type of proactive aggression there is a great lack of empathy, moral judgment, or any outside perspective-taking by the aggressor (Shechtman, 2009).

On the other hand, reactive aggression takes place in reaction to a perceived provocation directed towards the aggressor, and is motivated by the feelings of anger or frustration experienced by the aggressor. Youth who demonstrate this type of aggression generally attribute the actions of others to be motivated by hostility. Students who are pervasively aggressive do not display only one type of aggression, but oftentimes display both proactive and reaction aggression (Shechtman, 2009).

Causes of Aggression in Students

The exact causes of aggression are difficult to determine, as there are many risk factors that lead to a student developing aggressive behaviors, and rarely do they act in isolation. These risk factors have a complex interaction during a child's development; thus, it is not always *which* factor a child is experiencing, but *how many* factors he or she is experiencing that will establish the probability of developing aggressive behaviors (Shechtman, 2009).

Genetic, biological, or temperamental factors that appear at birth or within the first few years of life are identified as physical or neurological impairments or anomalies. There is a common consensus that the family plays a major role in the development of any child, as a child that grows up without securely attaching to their parents—whether due to a lack or over-indulgence of parental supervision and monitoring, neglect, or even violence—do not develop adequate emotional regulation. Thus, the child learns that aggressive or violent behavior is an appropriate, or even necessary, way to act to get what is wanted (Shechtman, 2009).

Social influences on both the macro and micro levels also influence the development of aggression in a child when modeling of aggression or messages of aggression as societal norms are presented to the child (Shechtman, 2009). As peer groups, especially in adolescence, begin to have a stronger influence on a student, if aggression is condoned as acceptable among a student's peer group, they will be encouraged to act aggressively themselves. Furthermore, rejection from peers or the mainstream of their social environment, can lead students to turn to alternatives, such as antisocial groups and behavior which often turn to aggression.

Within schools, aggression can be found among students where social and academic influences combine (Shechtman, 2009). When a student experiences peer rejection and academic struggles or failure within an environment where aggression is tolerated, they become prone to act aggressively. Moreover, students who struggle with learning disabilities also have difficulties with information processing, social relations, and self-control, and thus are at risk for acting out aggressively.

Proactive aggressive behavior in schools is reinforced by the direct or indirect support of other children and bystanders who witness the act (Shechtman, 2009). While there may be some social rejection experienced by the aggressor, the aggressor feels that they are supported by the gain of social power or influence that they have over others (Farmer, Farmer, Estell & Hutchins, 2007; Shechtman, 2009).

Characteristics of Aggressive Youth

The factors that play into the probable development of aggression creates an environment where students are either encouraged to act aggressively or choose to act aggressively to control their environment so that they feel they can adequately live within it. As such, there are similar traits that aggressive students share. Four common characteristics of students who display

aggressive behaviors are (a) they have difficulty in verbalizing their own emotions, (b) they lack empathy for others, (c) they display deficits in social informational processing, and (d) they lack self-control (Shechtman, 2009).

Having difficulty verbally expressing their own emotions, aggressive students generally act out for two reasons. First, they may have a lower verbal IQ, which means that since they have greater difficulty in expressing themselves verbally, they choose to express themselves physically. Second, it is a way for these students to suppress the fear, guilt, shame, or anger that they feel because of the disabilities they have, or the familial or social environment that treat them in such a way to feel these emotions. They try to dissociate or ignore these feelings, but instead they build up and are released through aggressive acts towards others (Shechtman, 2009).

Another common characteristic is the lack of understanding emotions, or low emotional intelligence. Emotional intelligence has been defined as an ability to recognize, understand, and regulate emotions (Goleman, 1995; Salovey & Sluyter, 1997). It is difficult for aggressive students to feel or express any empathy towards others. They generally have difficulty in understanding their own emotions, and if they cannot understand their own emotions, it is even more difficult to understand others' feelings. Cognitively, they have difficulty in taking on the viewpoint or perspective of another. Taken together, this is seen as a lack of perspective and a lack of feeling, or low emotional intelligence. This translates to a lack of empathy in these students' words and actions, which results in aggressive behaviors. At the same time, there may be some aggressive students who are cognitively able to understand another's perspective, but choose to act non-empathically because they believe that any display of emotion could lead to a loss of their power (Shechtman, 2009). Others often alienate or reject students who show low

emotional intelligence, which further hinders their development of emotional and social skills (Sullivan & Strang, 2003).

Besides lacking in emotional understanding, a student may also have deficits in cognitively processing information from situations. Combined with learning from experience and observing others, these deficits will lead a student to act aggressively (Crick & Dodge, 1994; Nigoff, 2008). The behaviors that students exhibit are directly related to the way they've processed information from a situation, termed social informational processing (SIP) or social cognitive informational processing (SCIP) (Crick & Dodge, 1994; Nigoff, 2008; Shechtman, 2009). Thus, the more competently a student processes social situations, the more adaptive his or her social behavior is. SIP, or SCIP, includes six stages: (a) encoding, (b) interpretation, (c) goal selection, (d) response selection, (e) evaluation, and (f) behavior enactment. If there is problem with any one of the six stages within the process, this leads to detrimental outcomes from processing a situation in a way that does not align with reality (Crick & Dodge, 1994; Nigoff, 2008; Shechtman, 2009).

If social situations are misinterpreted to be negative or threatening in any way, anger can be triggered. Anger is the emotion most frequently aligned with aggressive behavior, and is the most difficult emotion to control. As anger grows, it further physically arouses the student while simultaneously impairing his or her cognitive processing, which leads to increased impulsivity and decreased problem-solving actions, ultimately equating to aggressive outbursts of behavior (Shechtman, 2009).

Problems Related to Aggression

While the victims of aggressive acts do suffer short- and long-term consequences, the aggressors themselves experience many negative consequences (Shechtman, 2009). Research

has brought to light the clear link of aggressive behavior and many at-risk factors that aggressive students experience at school and throughout their lives (Kazdin & Johnson, 1994; Larson, 1998; Shechtman, 2000, 2001, 2009). Aggressive behaviors have multiple consequences, including academic and social, and quality of life.

Academic and social. Anger and aggression have been linked to many problems in school, such as poor or inappropriate behavior, rejection from peers, poor academic performance, and psychosomatic complaints (Kochenderfer & Ladd, 1996; Olweus, 1978; Shechtman, 2009; Smith & Furlong, 1998). In the short-term, aggressive students usually experience some degree of social rejection and punishment, which in turn leads to more angry and aggressive behaviors, creating a cycle of aggression and social rejection, also directly affecting academic performance (Shechtman, 2009).

Quality of life. In the long-term, aggression that begins in childhood and adolescence has a susceptibility to continue throughout the aggressor's life, and is related to poor outcomes throughout the life span in major domains, such as general success in life, criminal behavior, psychosocial functioning (Huesmann, Dubow, & Boxer, 2009), and physical health (Gibbs, 1995). Other research has also found that aggressive behavior tends to be moderately stable throughout life, progressing from mild acts in childhood, to serious acts in adolescents, and then very serious acts as older adolescents and adults (Broidy et al., 2003; Loeber et al., 1993; Moffitt, Caspi, Dickson, Silva, & Stanton, 1996). Furthermore, aggression is associated with poor outcomes over time across a variety of life domains, including: educational or vocational difficulties, alcohol or drug abuse, mental-health disorders, violent crimes, along with familial issues of assault, abuse, or divorce (Shechtman, 2009).

Treatments for Aggression

A common response to aggression is to adopt a zero-tolerance policy, with school officials thinking that the threat of punishment, or punishment itself, is powerful enough to address the problem (Shechtman, 2006). However, empirical evidence supports the use of proactive approaches to work at the center of the issue.

To address the problem of aggression, schools have begun to proactively focus on prevention program and intervention programs. Programs have included large-group, classroom, or systemic interventions that focus on problem-solving and conflict resolution skills, or even changing attitudes and classroom environments (Shechtman, 2006). Other programs have recognized the effectiveness of small-group counseling of aggressive students when large-scale interventions aren't able to reach students with social issues (Shechtman, 2006, 2009). Large- or small-scale group approaches may be educational, may involve counseling students, or may be psychotherapeutic as cognitive-behavioral theoretical approaches are often used in schools (Shechtman, 2006, 2009; Horne et al., 2007).

In working to define best practices in aggression prevention and intervention programming in schools, Leff, Power, Manz, Costigan, and Nabors (2001) reviewed five model programs, which helped them to determine which issues might be most important to consider when implementing a treatment for aggression. First, interventions should be aimed at treating a broad definition of aggression so as to treat all forms and types of aggression, thus not limiting who the intervention may help. Second, the largest opportunity for change is when aggression is targeted both by prevention efforts throughout the whole school as well as by direct intervention efforts for those students who struggle with aggressive behaviors. Third, as research has defined the clear link between mild aggression early in life with much more serious acts of aggression

and other serious implications across life domains (Loeber et al., 1993; Moffitt et al., 1996), it is important for focus treatment and prevention efforts on preschool and elementary children and thereby ultimately reduce aggressive behaviors and outcomes among older children and adults. Fourth, treatments should be provided in the most natural settings, encouraging generalization of skills across environments (e.g., classroom, lunchroom, playground, home) in order to truly reduce aggressive behaviors. Fifth, treatments should be empirically based and supported by research, having a way to collect data to determine treatment effectiveness. Finally, prevention and intervention programs in the schools should also be linking schools, families, and community health centers, thus capitalizing on the various available resources to help children with their aggressive behaviors (Leff et al., 2001).

Despite the best intentions of preventative programs, there will still be children who display aggressive behaviors, and interventions are often exclusively educational or psychotherapeutic. Thus, an approach that can work with aggressive students by combining both educational and therapeutic approaches is needed.

Bibliotherapy Defined

Biblioeducation, bibliocounseling, bibliopsychology, bookmatching, biblioprophylaxis, library therapeutics, literatherapy, guided reading, and biblioguidance are all names that have been used to mean the same thing: bibliotherapy (Pehrsson & McMillen, 2005; Rubin, 1978). Bibliotherapy comes from the Greek *biblio*, meaning book, and *therapy*, meaning help—thus, the most simple definition being to use books to help, or treat, those with problems (Pardeck, 1995; Pardeck & Pardeck, 1984; Shechtman, 2009). However, a more clear definition needs to be identified to understand the diversity and range of literature that is used in treatment, along with

understanding the difference between using literature for leisure, expressive, or educational purposes versus using literature with a psychotherapeutic intent (Favazza, 1966; Fincher, 1980).

In a very broad sense bibliotherapy is the use of books to help people with personal problems, whether they be emotional, physical, or developmental (Abdullah, 2002; Fincher, 1980). However, Franklin Berry's (1978) definition clarifies the roles of those who participate in the process of bibliotherapy, along with the literature used, stating:

Bibliotherapy is a family of techniques for structuring an interaction between a facilitator and a participant, an interaction which is in some way based on their mutual sharing of literature in the broadest sense possible (p. 25).

As such, bibliotherapy is not limited to superior authority figures, such as psychiatrists or psychologists, but to a variety of trained professionals within the realm of education, psychotherapy, or other helping professions (Pardeck & Pardeck, 1984). Furthermore, patients in treatment or hospitals are not the only recipients of bibliotherapy, as practically anyone can take part as a participant. Interaction between the facilitator and the participant may take place within a group or one-on-one setting, but bibliotherapy sources can be experienced either inside or outside the direct relational setting. Bibliotherapy is provided using the medium of literature, of which a variety of written or spoken vehicles, self-created or otherwise, are used, such as: music, cinema, theater, poems, short stories, or novels (Fincher, 1980).

To be clear, however, bibliotherapy lies in two different categories, with therapists practicing clinical bibliotherapy to help those with more significant behavioral, emotional, and psychological problems. Lay helpers and professionals, such as teachers, implement developmental bibliotherapy by using literature to facilitate normal development and self-

actualization with a more or less healthy population (Afolayan, 1992; Catalano, 2008; Kramer & Smith, 1998; Pehrsson & McMillen, 2005).

History of bibliotherapy. The idea of bibliotherapy has existed for many centuries, with the specific term being put into use only within the last one hundred years (Fincher, 1980; Shechtman, 2009). The Greeks' library at Thebes displayed the message, "The Healing Place of the Soul," and Aristotle believed that literature led to the arousal of healing feelings and emotions within people (Fincher, 1980; Tews, 1970; Zaccaria & Moses, 1968). Additionally, a medieval library in Switzerland bears the words, "The Medicine Chest of the Soul" (Fincher, 1980).

Afolayan (1992) cites 1840 as the first documented use of bibliotherapy as an intervention, and was first recognized and accepted as part of librarianship in 1904 (Tews, 1970). Beginning in the late 1800s and early 1900s, librarians would assist doctors to "prescribe" books to patients in hospitals to familiarize them with the symptoms of their medical conditions (Catalano, 2008; Pehrsson & McMillen, 2005). Crothers (1916) coined the phrase "bibliotherapy" in a published article, using it to describe the process of introducing literature to help medical patients understand their conditions and problems. In the 1930s, librarians worked with counselors to assist in compiling lists of written material to help people modify their own thoughts and feelings (Pardeck, 1994).

In the first half of the 20th century the focus was on using literature to help adults with medical or emotional problems, but beginning in the latter half of the century, the practical applications of bibliotherapy began to expand to schools, correctional facilities, and everyday life situations (Tews, 1970). In the 1950s and 1960s, counselors and therapists began using literature psychodynamically to prevent and solve personal problems or improve self-concept

(Lenkowsky, 1987). Through this expansion books could be used as a strategy to help children handle their own developmental needs and problems (Sullivan & Strang, 2003).

Goals of bibliotherapy. Those who have researched and used bibliotherapy list the following as possible goals that might be achieved through the bibliotherapy process: (a) to provide awareness that others have dealt with a similar problem and that they are not the first or only one to have dealt with such a problem, (b) to provide information about problems, (c) to provide new insight into a specific situation or problem, (d) to help an individual more freely discuss a problem, and thus be led to understanding and insight of the problem, (e) to help communicate new values and attitudes toward a specific problem, (f) to help an individual understand that there is more than one solution to a problem, (g) to give insight into new or alternative solutions to a problem, (h) to help an individual plan a practical and positive course of action to solve his or her problem, (i) to help relieve mental and emotional pressure, (j) to nurture an individual's honest self-appraisal, (k) to increase an individual's understanding of human behaviors and motivations, and (l) to provide a way for a person to find interests outside of him- or herself (Aix, 1993; Cook et al., 2006; Pardeck, 1995).

Implementation of bibliotherapy. A book cannot be expected to stand alone, but is to be accompanied by forethought, research, planning, anticipation of questions, and should be read ahead of time (Catalano, 2008). Stephens (1981) provides five steps for the implementation of bibliotherapy.

First, students should be identified by observing classroom behaviors, along with interviewing teachers and parents (Sullivan & Strang, 2003). Once specific students have been identified who would benefit from a bibliotherapeutic intervention, the logistics of how the intervention will be conducted should be determined—whether it be strictly with individuals,

small groups, or the whole classroom (Sullivan & Strang, 2003). Aiea (1993) explains that some individuals feel freer to express themselves when working one-on-one with a facilitator, but the group experience can provide an opportunity for students to feel a sense of belonging and security as members share common experiences that then lessen the anxieties increase insight and perspective about problems.

Next, it is very important to select books or literature that directly address the problems that the students are facing. These books must also deal with the problem in a realistic way, have characters that allow the students to identify with, and take into account the participant's age, reading level, emotional development, gender, backgrounds, interests and cultural perspectives (Pardeck, 1995; Sullivan & Strang, 2003).

The person facilitating the intervention must decide how the literature will be read (e.g., out loud, with partners). It is important for an open, active dialogue to take place while reading, as discussion about themes and ideas will help the leader to assess how the participant's level of understanding of the story, as well as identification taking place with the character(s) (Eppler, Sullivan, & Strang, 2003).

Other activities, such as drawing, role-playing, and writing, allow each student to express and share his or her feelings, demonstrating their experience of identification, catharsis, and insight (Sullivan & Strang, 2003). To help students apply what they are reading and understanding into their own lives, it is important to implement follow-up activities, such as drawing, creative writing, puppetry, and role-plays, letting children further reveal their understanding of the themes and how they might generalize them to everyday situations (Sullivan & Strang, 2003).

Pehrsson & McMillen (2005) recommend that those who implement bibliotherapy understand the history, potential benefits and limitations, as well as application and techniques for specific populations so that it can be ethically used in the most beneficial way. More recently Prater, Johnston, Dyches, and Johnston (2006) provided ten steps of how to implement bibliotherapy in a school setting.

The first five steps take place before beginning bibliotherapy. First, the teacher who will use bibliotherapy with a student must be sure that they have undertaken the effort and time to get to know and understand the student. Then, the facilitator should work to identify if there are others at the school who are able to help them work with the student. Next, the parents should be informed about and solicited for information that can provide help and support in understanding the problem as well as provide specific support to the student in working with their problem. The last step before implementing bibliotherapy is to create a plan of action by defining the specific problem and goals for the student, along with planning the activities that can help them (Prater et al., 2006).

The last five steps take place during as the facilitator and student are engaged in bibliotherapy. To begin bibliotherapy, appropriate literature should be selected for use, being aware of the suitability of a book according to the developmental age and reading ability of the student, the portrayal of the topic, the realism and honesty of the characters that can provide realistic expectations, and the literary quality (Aix, 1993; Cook et al., 2006; Pehrsson & McMillen, 2005; Prater et. al, 2006). Next, the literature is introduced to the student in an interesting way to incite interest, and is presented with plenty of time for discussion and other activities to help students explore and express their feelings about the story as they are able to identify the parallels between their own lives and the characters' (Catalano, 2008; Cook et al.,

2006; Prater et al., 2006). Post-reading activities are important to help students advance in the stages of bibliotherapy by allowing further expression of their own feelings and experiences, while also identifying what they have learned in terms of solutions to their issue or other real life applications to their problem (Cook et al., 2006; Prater et al., 2006). Finally, the bibliotherapy experience should be evaluated and improved as the facilitator identifies those things that went well and other things that did not seem to work as well and could be improved (Prater et al., 2006). When these steps are followed, it reiterates that the facilitator, and not the book itself, is the “therapist,” and thus separates bibliotherapy from other reading experiences (Catalano, 2008).

Stages of bibliotherapy. The goals of bibliotherapy are met as a participant is led through the stages, or process, of bibliotherapy as it carefully implemented as an intervention. Literature that approaches and portrays the inner feelings, hopes, and dreams of a reader creates a world that differs by only a small degree to the psychological reality of the reader (Tews, 1970). Bibliotherapy creates an emotional response that brings about change through a process of phases that parallels those in psychoanalysis: identification, catharsis, and insight (Fincher, 1980; Kramer & Smith, 1998; Lenkowsky, 1987; Morawski, 1997; Pardeck & Pardeck, 1984; Riordan & Wilson, 1989; Tews, 1970). By identifying and connecting with the characters in the story, a participant empathizes with the characters as they see that others with similar needs, problems, situations, and feelings as their own; this then helps the participant to understand that they are not alone, validating his or her own thoughts and emotions (Cook et al., 2006; Herbert & Furner, 1997; Morawski, 1997; Pardeck, 1995). This lessens the fright, isolation, and anxiety that a participant feels about his or her own problems and associated feelings, which allows for a

verbal or nonverbal release of emotions to take place as the participant is able to watch the character successfully resolve a particular dilemma (Herbert & Furner, 1997; Morawski, 1997).

After releasing emotional tension, a participant is then better able to apply what they learn to their own situations (Kramer & Smith, 1998; Morawski, 1997; Pardeck, 1995; Sullivan & Strang, 2003). Through the basic plot, storyline, or development of a character, the participant gains insight about his or her own self and others, developing greater insight into their own emotions and empathy for others, thus recognizing ideas and alternatives into how a problem can be realistically dealt with and solved (Fincher, 1980; Pardeck, 1995; Pardeck & Pardeck, 1984).

Each stage in the process leads to the next, and ultimately leads to positive changes in attitudes and behaviors in the participant (Lenkowsky, 1987). To be certain that identification, catharsis, and insight take place, care must be taken to plan and follow a basic course for implementing bibliotherapy (Catalano, 2008; Cook et al., 2006).

Strengths of bibliotherapy. Resistance to identifying or working on problems is a major issue in any form of therapy, and bibliotherapy seeks to break down the participant's resistance by focusing the attention outside of him or her, thus creating a safe space within a story situation similar to real life where the problem can be objectively discussed (Pardeck & Pardeck, 1984; Prater et al., 2006). By helping the participant to feel safe, bibliotherapy also encourages the development of rapport between the facilitator and student participant (Eppler, Olsen & Hidano, 2009).

Benefits from bibliotherapy for the participant have been reported to involve self-awareness; clarification of emerging values and the development of one's own ethnic or cultural identity; greater empathic understanding of others; increased appreciation of others from different cultures, viewpoints, and experiences; improvement of coping skills; exploration of

alternative solutions; reduced negative emotions such as stress, anxiety, or loneliness; and increased self-esteem, interpersonal skills and emotional maturity (Pehrsson & McMillen, 2005). If nothing else, stories can serve as a stimulus or vehicle for expression of emotions and the telling of one's own story (Eppler et al., 2009; Pehrsson & McMillen, 2005).

At times a student may not be resistant to talking about their thoughts and feelings, but they may have a difficulty in verbalizing or processing their own thoughts and feelings (Cook et al., 2006). By allowing the students to read literature or create their own stories, bibliotherapy provides a foundational space where thoughts, feelings, behaviors, and actions of characters can be identified and analyzed in relation to the students themselves (Cook et al., 2006; Eppler et al., 2009; Prater et al., 2006). Manifold (2007) and Pardeck (1995) both have acknowledged and described the influence of the images and words as an art that ignites the imaginative thinking of a child that guides them as they create a psychologically safe space to explore their memories, the meaning of the words, and the thoughts and feelings of the character. McArdle and Byrt (2001) affirm that bibliotherapy enables participants to take on a vicarious role to identify and give voice to feelings and emotions, along with exploring problems and possible solutions.

Not only does bibliotherapy facilitate discussion of the problem as a context for change, but facilitates change to take place as the participant obtains greater insight and problem solving skills, learning by imitation of positive models who demonstrate problem solving and adaptive behavior for similar problems (Pardeck & Pardeck, 1984; Prater et al., 2006). Moreover, bibliotherapy may prevent more serious emotional or psychological distress through emotional relief that takes place as the participant understands that their own issues are "normal," being validated by the similar story and characters within the literature (Pardeck & Pardeck, 1984; Prater et al., 2006).

For children and adolescents, bibliotherapy is very helpful in guiding students along in their development, apprising them of the normal stages of development, issues they'll face, and solutions other children or teenagers have used to address those issues (Abdullah, 2002).

Additionally, books and stories are a simple and fun way to teach social skills and solutions to social situations by allowing students to learn to try new solutions to their problems (Orton, 1997; Prater et al., 2006).

Finally, books are an inexpensive and easily obtainable resource, making bibliotherapy a cost-effective treatment, especially where resources are limited (Favazza, 1966; Pehrsson & McMillen, 2005; Sullivan & Strang, 2003). Bibliotherapy can be implemented as an intervention with little training as long as advanced planning and preparation have taken place, making it very cost efficient to implement in a variety of settings with a variety of groups or individuals (Cook et al., 2006; Pehrsson & McMillen, 2005). Moreover, bibliotherapy is a non-invasive, safe method of intervention that is familiar and friendly to children and students (Sullivan & Strang, 2003).

Limitations of bibliotherapy. Despite the many benefits that bibliotherapy offers, researchers do acknowledge that it is not a panacea on its own, and for best results should be used in conjunction with help from professionals who can provide additional therapeutic treatments (Pardeck, 1995; Pardeck & Pardeck, 1984; Riordan & Wilson, 1989; Shechtman, 2009; Tews, 1970; Zaccaria & Moses, 1968). Furthermore, bibliotherapy has not been shown to be effective for all problems (Pardeck & Pardeck, 1984). This may be due to the fact that books are not available for specific topics, that students are not ready or willing to confront their personal problems, or that they unwilling or have a difficulty reading (Abdullah, 2002; Pardeck, 1995; Prater, et al., 2006;).

Pardeck and Pardeck (1984), as well as Kramer and Smith (1998) caution bibliotherapy providers about the shortfalls that may happen during the bibliotherapy process, such as: (a) participants failing to identify themselves with the character in the story, and instead thinking about the presented problem as something separate from themselves; (b) frustration felt by the participant, resulting from materials not being matched to his or her reading level; (c) the participant having fears or anxieties aggravated by reading about their own problems; or (d) the helper not being aware that the relationship between the participant and helping person may actually contribute in larger part to the resolution of the problem than the bibliotherapy process. Furthermore, the effectiveness of bibliotherapy may be negated by the facilitator if they themselves do not have a good understanding of children, of the subject matter, of literature, or are ineffective at interacting with children through discussion and follow-up activities that are key in solidifying identification, catharsis, and insight for the child (Catalano, 2008).

Another frustration in the implementation of bibliotherapy is the lack of clarity from empirical research about the effectiveness of bibliotherapy for specific problems (Marrs, 1995; Riordan & Wilson, 1989), especially when using literature with children, as empirical research still mostly focuses on the use of self-help literature for adults (Prater et al., 2006; Riordan & Wilson, 1989). In the case of imaginative literature, anecdotal and case studies are abundant but empirical studies are very few, while the empirical studies that have been completed generally have insufficient details for replication (Pehrsson & McMillen, 2005). However, most studies and meta-analyses do conclude that bibliotherapy is effective one way or another, and to some degree or another (Marrs, 1995; Pehrsson & McMillen, 2005).

Bibliotherapy as Treatment

Bibliotherapy is used across almost every helping profession by a variety of professionals to help treat diverse illnesses and issues people face, among various age groups and populations (Shechtman, 2009). In early part of the 20th century, bibliotherapy was usually used for clinical problems of physical and emotional health among adults, but more currently has been provided as a therapy in helping children with a range of emotional and developmental difficulty, such as academic achievement, adoption and foster care, lack of assertiveness, anxiety, chemical dependency, child abuse and neglect, conflict resolution, dealing with death, depression, diversity awareness, divorce, family violence, giftedness, homelessness, increased self concept, stress, unhealthy attitudes, inappropriate behaviors, problem solving, self-destructive behavior, separation and loss, coping with teasing or bullying, and maintaining social relationships (Catalano, 2008; Cook et al., 2006; Pehrsson & McMillen, 2005; Prater et al., 2006; Sullivan & Strang, 2003). Pardeck and Pardeck (1984) indicate the use of bibliotherapy to specifically address issues of children, such as: alcohol and drug addiction, divorce and separation of parents, emotional and behavioral problems, moving to a new home, physical disabilities, pregnancy and abortion, serious illness and death, sexual awareness, sibling relationships, and stepparents.

Bibliotherapy is currently used by a variety of professionals in a variety of settings (Sullivan & Strang, 2003; Tews, 1970). Clinical psychologists and counselors, with the help of librarians, find and choose specific books to help individuals with psychological needs. Health professionals, such as doctors and nurses, provide pamphlets, brochures, and other information to educate and help their patients cope with the emotional stress of illness and medical procedures. Communities rely upon religious teachers and advisers to guide them in their spiritual and emotional progress by imparting sacred and religious texts. Teachers and librarians provide

books to people of all age and stage to help them with basic life problems (Catalano, 2008).

Those who use bibliotherapy follow the theory that reading will influence thinking, which will then influence behavior, especially when focused on specific needs (Lenkowsky, 1987; Tews, 1970).

Bibliotherapy as Treatment for Aggression

As mentioned previously, most prevention or intervention efforts focus solely on either educating students about their aggression and helping them develop appropriate social skills, or on the psychotherapeutic benefit from counseling or cognitive behavioral therapy. Educating students can easily be implemented in any size of group, but therapeutic benefits can usually only be offered to small group sizes and are time and resource intensive. Bibliotherapy is an indirect prevention or intervention technique that can be implemented in large or small groups. When implemented carefully and intentionally, bibliotherapy helps guide students through a psychotherapeutic process (i.e., identification, catharsis, insight) that naturally leads to student learning of new skills or insights (Shechtman, 2009).

Using bibliotherapy to specifically treat aggression in youth has only been researched within the last twenty years, with six studies led out by Zipora Shechtman. All studies used checklists or report forms to measure aggression and associated domains, and any study with a large number of participants divided the treatment students into manageable group sizes. The first study (Shechtman & Nachshol, 1996) used bibliotherapy as an intervention for a large group (N=117) of aggressive male students in special education junior high schools in Israel, and found that aggressive acting-out and beliefs that endorse aggression did not increase as they did in the control group. Next, a smaller scale, single-subject design study in Israel compared five eight-year-old boys who participated in bibliotherapy to five eight-year-old boys in a control group;

there were some aggressive and non-aggressive boys in each group (Shechtman, 1999). Overall, aggression decreased in the boys who participated in bibliotherapy, while aggression stayed the same in the boys in the control group.

One year later, a large scale study that included male and female students in special education classrooms from grades five to nine in Israel (N=70) comparing their pre- and post-measurements of aggression after participating in bibliotherapy (Shechtman, 2000). The study identified a decrease in aggressive behavior. The next year, a single-case design study in Israel found that aggression decreased in all four fourth-grade students, two boys who were identified as aggressive and two girls who were not identified as aggressive, who participated in bibliotherapy, while aggression remained the same in a aggressive boy who did not participate (Shechtman, 2001).

More recently, a Shechtman (2006) conducted a study of 61 aggressive boys in various schools from northern Israel, ages eight to 16, randomly assigning them to one of three groups: no treatment, counseling, or counseling and bibliotherapy. Aggression decreased in the boys receiving some type of treatment compared to those receiving none, but those who received counseling and bibliotherapy also experienced increased empathy, insight, and therapeutic change compared to those who received counseling alone.

Finally, in 2009 (Shechtman & Ifargan) conducted a study to compare the treatment of effectiveness of small group counseling using counseling and bibliotherapy, versus large group class interventions using a psychoeducation approach with a small amount of bibliotherapy. Participants included 904 students from fifth to eighth grade classrooms in 39 schools in Israel, with 166 students being identified as aggressive before the treatment. All students divided into three groups: psychoeducational, counseling, or control. Again, children receiving some form of

intervention for their aggression showed a decrease in their aggression when compared with the control group.

All six studies show promising results of a decrease in aggression when using bibliotherapy in the treatment of aggressive students. However, all studies took place outside of the United States. Furthermore, the studies used global scales of measuring behavior, which do not directly measure aggressive behaviors. Finally, these studies only examined the effects of bibliotherapy on aggressive students within public schools and special education classrooms, but did not exclusively study the effects of bibliotherapy on highly aggressive children in residential treatment centers. Thus, research studying the impact of bibliotherapy on highly aggressive students in a residential treatment center in the United States, using direct observation and measurement of aggressive behaviors would be beneficial in further exploring the effectiveness of bibliotherapy as an intervention.

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APPENDIX B: EXAMPLE OBSERVATION FORM

| Observation Form of Aggressive Behaviors | | Participant 1 | Participant 2 | Participant 3 |
|---|---------------------------------|---|----------------------|----------------------|
| | | Instructions: Place a tally mark for each instance the aggressive behavior is observed during the observation period. | | |
| Date Day 1, Week 1 | Hitting | | | |
| | Kicking | | | |
| | Pushing | | | |
| | Screaming | | | |
| | Throwing an Object | | | |
| | Slamming an Object | | | |
| | Spitting | | | |
| | Biting | | | |
| | Pulling Hair | | | |
| | Swearing (directed at a person) | | | |
| | Put Downs | | | |
| Date Day 2, Week 1 | Hitting | | | |
| | Kicking | | | |
| | Pushing | | | |
| | Screaming | | | |
| | Throwing an Object | | | |
| | Slamming an Object | | | |
| | Spitting | | | |
| | Biting | | | |
| | Pulling Hair | | | |
| | Swearing (directed at a person) | | | |
| | Put Downs | | | |

APPENDIX C: EXAMPLE TEACHER REPORT FORM (TRF) QUESTIONS

Please print. Be sure to answer all items.

Below is a list of items that describe pupils. For each item that describes the pupil *now or within the past 2 months*, please circle the **2** if the item is *very true or often true* of the pupil. Circle the **1** if the item is *somewhat or sometimes true* of the pupil. If the item is *not true* of the pupil, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to this pupil.

| 0 = Not True (as far as you know) | 1 = Somewhat or Sometimes True | 2 = Very True or Often True | |
|-----------------------------------|---|-----------------------------|---|
| 0 1 2 | 1. Acts too young for his/her age | 0 1 2 | 34. Feels others are out to get him/her |
| 0 1 2 | 2. Hums or makes other odd noises in class | 0 1 2 | 35. Feels worthless or inferior |
| 0 1 2 | 3. Argues a lot | 0 1 2 | 36. Gets hurt a lot, accident-prone |
| 0 1 2 | 4. Fails to finish things he/she starts | 0 1 2 | 37. Gets in many fights |
| 0 1 2 | 5. There is very little he/she enjoys | 0 1 2 | 38. Gets teased a lot |
| 0 1 2 | 6. Defiant, talks back to staff | 0 1 2 | 39. Hangs around with others who get in trouble |
| 0 1 2 | 7. Bragging, boasting | 0 1 2 | 40. Hears sound or voices that aren't there (describe): _____ |
| 0 1 2 | 8. Can't concentrate, can't pay attention for long | 0 1 2 | 41. Impulsive or acts without thinking |
| 0 1 2 | 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____ | 0 1 2 | 42. Would rather be alone than with others |
| 0 1 2 | 10. Can't sit still, restless, or hyperactive | 0 1 2 | 43. Lying or cheating |
| 0 1 2 | 11. Clings to adults or too dependent | 0 1 2 | 44. Bites fingernails |
| 0 1 2 | 12. Complains of loneliness | 0 1 2 | 45. Nervous, highstrung, or tense |
| 0 1 2 | 13. Confused or seems to be in a fog | 0 1 2 | 46. Nervous movements or twitching (describe): _____ |
| 0 1 2 | 14. Cries a lot | 0 1 2 | 47. Overconforms to rules |
| 0 1 2 | 15. Fidgets | 0 1 2 | 48. Not liked by other pupils |
| 0 1 2 | 16. Cruelty, bullying, or meanness to others | 0 1 2 | 49. Has difficulty learning |
| 0 1 2 | 17. Daydreams or gets lost in his/her thoughts | 0 1 2 | 50. Too fearful or anxious |
| 0 1 2 | 18. Deliberately harms self or attempts suicide | 0 1 2 | 51. Feels dizzy or lightheaded |
| 0 1 2 | 19. Demands a lot of attention | 0 1 2 | 52. Feels too guilty |
| 0 1 2 | 20. Destroys his/her own things | 0 1 2 | 53. Talks out of turn |
| 0 1 2 | 21. Destroys property belonging to others | 0 1 2 | 54. Overtired without good reason |
| 0 1 2 | 22. Difficulty following directions | 0 1 2 | 55. Overweight |
| 0 1 2 | 23. Disobedient at school | | 56. Physical problems <i>without known medical cause</i> : |
| 0 1 2 | 24. Disturbs other pupils | 0 1 2 | a. Aches or pains (<i>not</i> stomach or headaches) |
| 0 1 2 | 25. Doesn't get along with other pupils | 0 1 2 | b. Headaches |
| 0 1 2 | 26. Doesn't seem to feel guilty after misbehaving | 0 1 2 | c. Nausea, feels sick |
| 0 1 2 | 27. Easily jealous | 0 1 2 | d. Eye problems (<i>not</i> if corrected by glasses) (describe): _____ |
| 0 1 2 | 28. Breaks school rules | 0 1 2 | e. Rashes or other skin problems |
| 0 1 2 | 29. Fears certain animals, situations, or places, other than school (describe): _____ | 0 1 2 | f. Stomachaches |
| 0 1 2 | 30. Fears going to school | 0 1 2 | g. Vomiting, throwing up |
| 0 1 2 | 31. Fears he/she might think or do something bad | 0 1 2 | h. Other (describe): _____ |
| 0 1 2 | 32. Feels he/she has to be perfect | | _____ |
| 0 1 2 | 33. Feels or complains that no one loves him/her | | _____ |

APPENDIX D: EXAMPLE INTERVIEW QUESTIONS

Student Participant's Interview Questions

1. What did you enjoy/like most about our group? Why?
2. What did you dislike about our group? Why?
3. What have you learned to do better from our group?
4. What are new things that you learned from our group?
5. What is something you think you are better at now from participating in our group?
6. What were some of your favorite books? Why?
7. What were some of your favorite activities? Why?
8. Would you want to take part in another group like this one? Why?

Teacher/Therapist Interview Questions

1. What impact on the aggressive behaviors of student participants would you attribute to their participation in the bibliotherapy group?
2. What do you see as the strengths of bibliotherapy? Weaknesses?
3. Do you think that bibliotherapy makes enough of an impact to justify the time that students are taken away from classroom learning activities to participate in the group?
Why or why not?
4. Do you feel that there are other more effective interventions for aggressive children?
Why or why not?

APPENDIX E: PARENTAL PERMISSION FOR A MINOR TO PARTICIPATE IN
RESEARCH FORM

Bibliotherapy as an Intervention for Aggressive Elementary Children

Introduction

My name is Kari Newman. I am a graduate student at Brigham Young University and am conducting a research study to explore the impact that picture books (bibliotherapy) have upon aggressive behavior. I am inviting your child to take part in the research because he/she is in the elementary class at Provo Canyon School that I am studying.

PROCEDURES

If you agree to let your child participate in this research study, the following will occur:

- Your child will participate in a bibliotherapy group during the school day, two times a week for eight weeks. These groups will primarily include picture books and other small activities to aid in discussion of the story, characters in the story, possible solutions that characters in the story used or could use instead of aggression, your child's thoughts about his/her own aggression and associated emotions, and possible solutions that your child could use instead of aggression.
- Your child will be observed for one hour each school day for at least one week before they participate in the group, and all eight weeks they participate in the group. Observations will only record aggressive behaviors that your child displays.
- Your child will participate in a final interview to find out what they liked or disliked about the group, what they felt they learned from the group, and what they felt they improved upon because they participated in the group.

RISKS

There is a risk of loss of privacy, which the researcher will reduce by not using any real names or other identifiers in the written report. The researcher will also keep all data in a locked file cabinet in a secure location provided at Brigham Young University. Only the researcher will have access to the data. At the end of the study, data will be destroyed and discarded.

There may be some discomfort when discussing aggression and associated emotions.

Discussions may become very sensitive and may cause anxiety or other negative emotions, which the researcher will immediately report to your child's primary therapist. Your child may answer only those questions that your child wants to, or your child may stop the entire process at any time without affecting his/her standing in school, grades in class, or advancement in the therapeutic program at Provo Canyon School.

CONFIDENTIALITY

The research data will be kept in a secure location provided at Brigham Young University, and only the researcher will have access to the data. During the study, all names and any identifying information will be removed when the data is included in written reports. At the conclusion of the study, all data will be destroyed and discarded.

BENEFITS

There are no direct benefits for your child's participation in this project, except the possibility of an increased ability to understand and manage his/her own aggressive behaviors.

COMPENSATION

There will be no compensation for participation in this project.

QUESTIONS ABOUT THE RESEARCH

If you have any further questions about the study, you may contact the researcher, Kari Newman, at 801-372-5854 or kiwi.kari@gmail.com, or you may contact Professor Mary Anne Prater by calling 801-422- or prater@byu.edu.

Questions about your child's rights as a study participant, or comments or complaints about the study also may be addressed to the IRB Administrator, Brigham Young University, A-285 ASB, Provo, UT 84602; 801-422-1461 or irb@byu.edu

You have been given a copy of this consent form to keep.

PARTICIPATION

PARTICIPATION IN THIS RESEARCH STUDY IS VOLUNTARY. You are free to decline to have your child participate in this research study. You may withdraw your child's participation at any point without penalty. Your decision whether or not to participate in this research study will have no influence on you or your child's present or future status at Provo Canyon School, or Brigham Young University.

Child's Name _____

Signature _____ Date _____

Parent

Signature _____ Date _____

Researcher

APPENDIX F: EXAMPLE LESSON PLANS DEVELOPED BY THE AUTHOR

Treatment Phase 1 – Lesson Plan without Role Plays

| | |
|--|--|
| Book(s): <i>Glad Monster, Sad Monster AND The Way I Feel</i> | |
| Global Purpose: To recognize and identify all the different feelings, and what they look like when we, or others, are feeling them or expressing them. | |
| Objective: While reading the book, students will look at pictures of various facial expressions and be able to: 1) identify the feeling, and 2) identify at least one reason why the character is feeling the way they are. | |
| Materials: Dry erase boards and markers | |
| Pre-Reading Activities | <ul style="list-style-type: none"> • Review the rules and point system for the group reward • Review what the group discussed the past week • “Where do feelings come from?” • “What makes us feel the way we feel?” • Discuss that feelings are felt inside of us and we feel certain ways because of things/events that happen • Show the cover of <i>Glad Monster, Sad Monster</i> and explain to the group that they will have a chance to wear a monster mask and act out the feelings/emotions described in the book |
| During Reading Activities | <ul style="list-style-type: none"> • Read <i>Glad Monster, Sad Monster</i> • Have each child take turns at different masks act out the emotion and explain what makes them feel the way they do • Open up to each group member why they would feel a certain emotion • Read <i>The Way I Feel</i> • Cover up the text that describes the picture drawn of the emotion that the character is feeling, and have the group guess what emotion they are feeling |
| Post-Reading Activities | <ul style="list-style-type: none"> • Have each student draw a scene that shows why they would feel a certain emotion • Share what they drew with the group |
| Closure | <ul style="list-style-type: none"> • Closing remarks about where feelings come from, and why we feel the way we feel. • Review the rules and reward the students according to how they followed the rules of the group as they participated |

Treatment Phase 2 – Lesson Play with Role Plays

| | |
|---|---|
| Book(s): <i>I Am I</i> | |
| Global Purpose: To identify how words make ourselves and others feel; to identify that words are positive and negative and the differences in how they make us feel. | |
| Objective: While reading the book, students will look at pictures of various positive and negative interactions between two boys to: 1) identify the words as positive or negative, and 2) identify how the words impacted each other. | |
| Materials: Dry erase boards and markers | |
| Pre-Reading Activities | <ul style="list-style-type: none"> • Review the rules and point system for the group reward • Review what the group discussed the past week • “Sticks and stones may break my bones, but words will never hurt me.” • Can words hurt? Why or why not? • What are some hurtful words? (Name calling, teasing, excluding, lying, yelling, swearing, gossiping, criticizing, etc.) • How does it feel to have others say these things to you? (Upset, angry, embarrassed, uncomfortable) • How does it feel when you say these things others? Positive feelings? Why or why not? • Talk about how hurtful words are often associated to how we feel about a situation, such as: someone takes your pencil or seat; some cuts in line; someone calls you a name; someone blames you for something that you didn’t do; someone takes the last treat/item before you; someone doesn’t share with you their game |
| During Reading Activities | <ul style="list-style-type: none"> • Read <i>I Am I</i> • Talk about the hurtful words in the book and what each character is feeling |
| Post-Reading Activities | <ul style="list-style-type: none"> • Talk about the nice words used • Apologizing or saying “I’m sorry,” “I didn’t mean to,” “Can you please forgive me?” • Talk about how these words: help us to feel better, helps the other person feel better, stops any argument, stops things from getting worse and can help begin making things better • Talk about how these words are usually accompanied by an action, like shaking hands or giving a hug • Role play using the nice words in the same situations/incidences were discussed at the beginning of the session |
| Closure | <ul style="list-style-type: none"> • Talk about how words can be negative or positive; review about what words help us to feel good and are positive • Review the rules and reward the students according to how they followed the rules of the group as they participated |

APPENDIX G: BOOK LIST

1. *I Feel: A Picture Book of Emotions* (by George Ancona) or *How Are You Peeling?: Foods with Moods* (by Saxton Freymann)
2. *Glad Monster, Sad Monster* (by Ed Emberley and Anne Miranda) and *The Way I Feel*
3. *My Many Colored Days* (by Dr. Seuss, illustrated by Steve Johnson and Lou Fancher)
4. *Sometimes I'm Bombaloo* (by Rachel Vail)
5. *When Sophie Gets Angry—Really, Really Angry* (by Molly Bang)
6. *Mouse Was Mad* (by Linda Urban)
7. *The Rain Came Down* (by David Shannon) and *Alexander's Horrible, No Good, Very Bad Day* (by Judith Viorst)
8. *Mr. Wigglebottoms Learns It's Okay to Back Away* (by Howard Binkow)
9. *I Am I* (by Marie-Louise Fitzpatrick)
10. *Howard B. Wigglebottoms Learns to Listen* (by Howard Binkow)
11. *Words Are Not For Hurting* (by Elizabeth Verdick)
12. *Bootsie Barker Bites* (by Barbara Bottner)
13. *Thorndike and Nelson: A Monster Story* (by Jean Jackson)
14. *My Mouth is a Volcano* (by Julia Cook)
15. *How to Lose All Your Friends* (by Nancy Carlson)
16. *The Juice Box Bully* (by Bob Sornson and Maria Dismundy)