

ADLERIAN PLAY THERAPY: EFFECTIVENESS ON DISRUPTIVE BEHAVIORS OF
EARLY ELEMENTARY-AGED CHILDREN

Kristin K. Meany-Walen, M.A.

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APPROVED:

Sue C. Bratton, Major Professor
Dee Ray, Committee Member
Natalya Edwards, Committee Member
Terry Kottman, Committee Member
Janice Holden, Chair, Department of
Counseling and Higher Education
Jerry R. Thomas, Dean of the College of
Education
James D. Meernik, Acting Dean of the Robert
B. Toulouse School of Graduate Studies

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Approximately 20% of children experience serious mental health problems severe enough to meet diagnosis criteria, and less than one third of these children receive the services they need. Identifying effective school-based counseling interventions provides a viable and accessible solution, especially for families with financial barriers. This randomized, controlled outcome study examined the effectiveness of Adlerian play therapy (AdPT) compared to reading mentoring (RM) with 58 kindergarten through third grade students who qualified with clinical levels of disruptive behavior in the classroom. Participants were identified as 48% Latino, 33% European American, and 19% African American. Approximately four-fifths of participants were male. Children were randomly assigned to AdPT (experimental group) or RM (active control group) for 16 sessions of treatment. Children in both groups participated in twice weekly, individual, 30-minute interventions that took place in their schools. Results from a two (group) by two (repeated measures) split plot ANOVA indicated that, compared to the RM group over time, the AdPT group demonstrated statistically significant improvement on (a) disruptive behaviors in the classroom, as directly observed by objective raters and as reported by teachers, and (b) stress in the teacher-child relationship, as reported by teachers. Teachers and observers were blinded to children's treatment group assignment. AdPT demonstrated moderate to large effect sizes on all measures, indicating the practical significance of treatment. Further, 72% of children receiving AdPT improved

from clinical/borderline levels of disruptive behavior problems to more normative functioning post-intervention, demonstrating the clinical significance of results. Whereas further research is warranted, results from this preliminary study are promising and support the use of AdPT in elementary schools to meet the needs of children exhibiting disruptive classroom behavior.

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TABLE OF CONTENTS

| | |
|---|-----|
| ACKNOWLEDGEMENTS | iii |
| LIST OF TABLES | vi |
| Chapter | |
| CHAPTER 1 INTRODUCTION | 1 |
| Statement of the Problem | 5 |
| Purpose of Study | 6 |
| CHAPTER 2 REVIEW OF LITERATURE | 8 |
| History of Play Therapy | 8 |
| Adlerian Theory | 10 |
| Basic Tenets | 10 |
| Counseling Process | 15 |
| The Progression of Adlerian Theory Applications | 16 |
| Home Environment | 17 |
| School Environment | 17 |
| School Guidance and Counseling | 19 |
| Play in the Counseling Process | 20 |
| Adlerian Play Therapy | 21 |
| Building an Egalitarian Relationship | 23 |
| Exploring the Child's Lifestyle | 24 |
| Helping the Child Gain Insight | 27 |
| Reorientation/Reeducation | 28 |
| Adlerian Play Therapy in Schools | 29 |
| Play Therapy in Elementary Schools | 30 |
| Cognitive Functioning | 32 |
| Disruptive Behavior and Child Adjustment | 33 |
| Emotional Regulation | 35 |
| Teachers' Role | 36 |
| School-based Play Therapy | 37 |
| Play Therapy Research in Elementary Schools | 38 |
| Current Status of Play Therapy | 51 |
| Conclusion | 53 |

| | |
|---|-----|
| CHAPTER 3 METHODS AND PROCEEDURES | 55 |
| Definition of Terms | 55 |
| Research Hypotheses | 57 |
| Instrumentation | 58 |
| Participants | 62 |
| Treatment | 66 |
| Experimental Group (AdPT) | 66 |
| Active Control Group (RM) | 71 |
| Data Collection | 73 |
| Data Analysis | 75 |
| CHAPTER 4 RESULTS | 77 |
| Hypothesis 1 | 78 |
| Hypothesis 2 | 79 |
| Hypothesis 3 | 80 |
| Hypothesis 4 | 81 |
| Clinical Significance | 82 |
| Total Behavior Outcomes | 83 |
| On-task Behavior Outcomes | 84 |
| CHAPTER 5 DISCUSSION | 86 |
| Adlerian Play Therapy's Effects on Disruptive Behaviors | 87 |
| Adlerian Play Therapy's Effects on Stress in the Teacher-Relationship Stress | 93 |
| Research Observations | 95 |
| Significant Emotional and Behavioral Needs of Students | 95 |
| The Impact of Banning Teacher Consultations | 98 |
| Teacher Feedback | 100 |
| Summary of Findings | 103 |
| Limitations of the Study | 105 |
| Recommendations for Future Research | 107 |
| Implications and Conclusions | 108 |
| Appendices | |
| A. INFORMED CONSENT: ENGLISH VERSION | 113 |
| B. INFORMED CONSENT: SPANISH VERSION | 118 |
| C ADLERIAN PLAY THERAPY SKILLS CHECKLIST | 123 |
| D. READING MENTORING PROTICOL | 138 |
| REFERENCES | 141 |

LIST OF TABLES

| | |
|--|----|
| Table 1 Demographic Information for Participants in Experimental and Active Control Groups..... | 65 |
| Table 2 Demographic Information for Adlerian Play Therapy Treatment Providers and Reading Mentoring Treatment Providers | 73 |
| Table 3 Mean Scores on the Externalizing Problem Scales on the Caregiver-Teacher Report Form (C-TRF) | 78 |
| Table 4 Mean Scores on the Total Behavior Scale on the Direct Observation Form (DOF)..... | 79 |
| Table 5 Mean Scores on the On-task Scale on the Direct Observation Form (DOF)..... | 81 |
| Table 6 Mean Scores on the Total Stress scale on the Index of Teacher Stress (ITS)..... | 82 |

CHAPTER 1

INTRODUCTION

Children in elementary schools suffer each day due to a lack of resources available to meet their mental health needs. Mental Health America (MHA, 2009) estimated that 20% of children experience serious mental health problems severe enough to meet diagnosis criteria. However, only one third of these children receive the services they need. The surgeon general's report (U.S. Public Health Services, 2000), as well as the President's New Freedom Commission on Mental Health (2003), revealed that this discrepancy is related in part to a shortage in access to appropriate mental health services, a lack of mental health professionals trained to work with children, and the inaccessibility of services to the children in need. The reports also acknowledged a gap in mental health services for children and stressed the need for early intervention.

One way for children to receive services at school is for teachers to refer students to school counselors or school-based counselors. The most common reason for student referral is disruptive classroom behavior (Abidin & Robinson, 2002). Disruptive behaviors include those externalized behaviors in the classroom that interfere with the teacher's ability to teach and children's ability to learn. Disruptive behaviors may include such behaviors as noncompliance, rule breaking, aggression, and destruction of property. These behaviors tend to remain stable without intervention (Barkley, 2007; Brinkmeyer & Eyeberg, 2003; Webster-Stratton & Reid, 2003). It is important to note

that disruptive behaviors are usually a result of more significant underlying emotional problems (Abidin & Robinson, 2002).

The consequences of failure to intervene early to meet the needs of these children are strained relationships, ongoing behavioral problems, difficulty in school, and poor social skills (Myers & Pianta, 2008). The President's New Freedom Commission (2003) recommended that schools improve mental health services available for children. Teachers and school staff commonly use behavior modification strategies in an attempt to reduce children's problematic behaviors. However, these types of teaching strategies do not provide students with the emotional support and counsel they may need.

When children's disruptive behaviors remain unchanged, the critical relationship between teacher and student may be damaged or strained due to the teacher's frustration with a particular student (Abidin & Robinson, 2002; Hamre, Pianta, Downer, & Mashburn, 2007; Myers & Pianta, 2008). Thus, the importance of early interventions that are developmentally appropriate and responsive to early-elementary-aged children's needs is evident. Children spend approximately 7 hours each day at school. Therefore, school becomes an optimal and convenient environment to provide mental health services to children.

Play therapy is a developmentally appropriate intervention for children between the ages of 3 and 10 years because it utilizes the child's natural mode of communication (Bratton, Ray, & Landreth, 2008; Kottman, 2003; Landreth, 2002). Children have a limited ability to verbally express their emotional needs. Therefore, play therapists use toys and play materials to help children communicate their needs in a developmentally

sensitive and concrete manner. Play therapists use play because they respect the child's development, and play therapists join the child in the child's world. Other treatment interventions require the child to meet the therapist in the therapist's adult world.

Meta-analytic results for play therapy outcome research have shown play therapy to be an effective intervention for children with a variety of presenting concerns (LeBlanc & Ritchie, 1999; Bratton, Ray, Rhine, & Jones, 2005). The most thorough and comprehensive meta-analysis known to date, with a total of 93 controlled studies, revealed a large treatment effect (.80) for children who received play therapy compared to children who did not receive play therapy or children who received a comparable treatment. Studies included children who presented with a variety of concerns and in a variety of settings (Bratton et al., 2005). The meta-analysis further revealed that humanistic approaches to play therapy, primarily child-centered play therapy and nondirective play therapy, demonstrated an even larger treatment effect (.92) than directive approaches to play therapy. School-based outcome research has also shown play therapy to be an effective treatment for children with a range of issues (Baggerly & Jenkins, 2009; Blanco, 2009; Bratton, 2010; Fall, Balvanz, Johnson, & Nelson, 1999; Fall, Navelski, & Welch, 2002; Flahive & Ray, 2007; Garza & Bratton, 2005; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Packman & Bratton, 2003; Paone & Douma, 2009; Post, 1999; Raman & Kapur, 1999; Ray, Schottelkorb, & Tsai, 2007; Shashi, Kapur, & Subbakrishna, 1999; Shen, 2002).

Despite these studies, the field of play therapy has failed to be recognized as an evidence-based treatment (EBT). Classifying specific interventions as EBTs has become

the primary objective for many mental health organizations. The current push within the Association for Play Therapy (APT), a professional credentialing organization for play therapists, is to conduct rigorous research which can propel play therapy towards gaining credibility and becoming an EBT for children (APT, 2009; Baggerly & Bratton, 2010; Frick-Helms & Drewes, 2010; Urquiza, 2010).

As with any reputable modality of therapy, therapists identify with and work from numerous theoretical approaches. Play therapy is no different. Regardless of the therapeutic approach used, the common thread among all play therapists is that *play* is the primary method of communication.

The integration of toys and play into mental health interventions began with Sigmund Freud from psychoanalytic theory. Following his reported experiences with Hans and Hans's father, others have appreciated and implemented play into their theoretical work with children (Bratton et al., 2008). Virginia Axline (1974) was the first to document her use of nondirective play therapy, which has been continued and popularized by Garry Landreth. Nondirective play therapy is sometimes referred to as child-centered play therapy (CCPT), based on Rogers's person-centered theory (Landreth, 2002). Since that time, other play therapists developed and adapted theoretical approaches to play therapy. In 1987 Terry Kottman completed her dissertation, which involved training therapists in the concepts and skills of Adlerian play therapy (AdPT). Kottman's development of AdPT was based on Alfred Adler's philosophy of individual psychology (1956/1964) and adapted to meet children's developmental needs. Since that time, AdPT has been used by play therapists in clinic

and school settings (Kottman, 2003). To date, no known research studies have been conducted with AdPT being the identified treatment.

One requirement for research designs to be considered rigorous is the use of a clear treatment protocol (Chambless et al., 1998; Nathan & Gorman, 2002). Adlerian theory is the third most popular theoretical orientation of mental health professionals who use play therapy as therapeutic intervention (Lambert et al., 2007). Based on this knowledge, it seems logical for a treatment protocol to be developed. Terry Kottman, developer of AdPT, designed an Adlerian treatment protocol (Kottman, 2009) that can be used to determine the effectiveness of AdPT.

Statement of Problem

Government reports (President's New Freedom Commission, 2003; U.S. Public Health Service, 2000) have brought national attention to the urgent need to identify effective interventions for children who suffer from emotional and behavioral disorders. Estimates indicate that one out of five children experiences distressing emotional problems, and fewer than one third of these children will receive treatment (MHA, 2009). This is largely due to (a) a shortage of mental health interventions that are responsive to the needs of young children and (b) the inaccessibility of services (President's New Freedom Commission, 2003; U.S. Public Health Service, 2000).

The U.S. Public Health Service (2000) and the President's New Freedom Commission (2003) reports discussed the vital role of schools in the early identification and treatment of childhood disorders in order to prevent more severe and costly problems. Without treatment, disruptive behaviors show a high degree of stability over

time, often leading to the development of a host of serious problems across the child's lifespan, including antisocial behavior, violence, drug abuse, and juvenile delinquency (Barkley, 2007; Brinkmeyer & Eyeberg, 2003; MHA, 2009; Webster-Stratton & Reid, 2003). The importance of early intervention as a means of altering a course of increased and more severe behavioral problems is clear.

Schools have access to children in need and can provide resources for children and mental health professionals. Teachers have prolonged contact with children and are aware of students who demonstrate disruptive or problem behaviors in the classroom (Abidin & Robinson, 2002). These students are frequently referred by teachers for counseling.

A secondary problem is that, although play therapy is a developmentally appropriate intervention for early elementary-age children and has empirical evidence to demonstrate its effectiveness (Baggerly & Bratton, 2010; Bratton, 2010; Bratton et al., 2005), it has yet to be considered an EBT. Research adhering to the accepted criteria for rigorous research must be conducted to lay the foundations of best practices (Nathan & Gorman, 2002).

Purpose of Study

The overarching aim of this study is to establish an effective treatment intervention for elementary-aged children with disruptive behaviors. More specifically, this investigation is designed to determine the effectiveness of Adlerian play therapy in reducing disruptive behavior in children in elementary school who have been identified

as having disruptive behaviors by teachers and reducing teacher stress related to children with disruptive behaviors.

CHAPTER 2

REVIEW OF LITERATURE

History of Play Therapy

Beginning in the early 1900s, mental health and development professionals such as Sigmund Freud, Melanie Klein, Anna Freud, Jean Piaget, and Virginia Axline worked with children and emphasized the need for therapeutic interventions to be appropriate for children's developmental level. These individuals were pioneers in establishing the methods that today's play therapists believe are necessary to best help children who are experiencing emotional difficulties (Landreth, 2002). These professionals experienced and documented significant differences between children and adults. They each acknowledged the intrinsic value of children's free play, highlighted the importance of a safe relationship, and emphasized children's creativity and ability to engage in self-directed meaningful play (Bratton et al., 2008).

Play therapy is a developmentally responsive mental health treatment of choice for children between the ages of 3 and 10, based on the belief that play and activity are a child's natural mode of communication (Axline, 1974; Bratton et al., 2008; Erikson, 1977; Kottman, 2001b, 2003; Landreth, 2002). Typically, young children cannot yet accurately communicate about abstracts concepts verbally; thus, in play therapy they have an opportunity to communicate through their natural mode of expression. Play is

spontaneous and free from external objectives or rewards (Landreth, 2002). Through play, children symbolically express their experiences and interpretations of the world.

Play therapy involves an empathetic, genuine, and unconditional relationship fostered by the therapist and experienced by the child. The child is provided a collection of carefully selected toys in which he or she can express a range of emotions, thoughts, and experiences. Toys are not used as a method of manipulating children to speak; rather, toys are used as the natural form of expression by children (Kottman, 2001a, 2001b; Landreth, 2002).

Over the course of play therapy's history, therapists and researchers have been intrigued with finding the most helpful way to work with children. Some well-accepted theories of play therapy include child-centered (Landreth, 2002; Landreth & Sweeney, 1997); psychoanalytic (Lee, 1997); cognitive-behavioral (Knell, 1997); Jungian (Allan, 1997); developmental (Brody, 1997); Gestalt (Oaklander, 1988); ecosystemic (O'Conner, 1997); prescriptive (Schafer, 2001); and Adlerian (Kottman, 1987, 1997, 2001a, 2001b, 2003). While theorists differ in their conceptualization of how children change through play therapy, play therapists agree that engaging in play, the child's natural medium of communication, is the most appropriate mode of working with children. For the purposes of this study, Adlerian play therapy (AdPT; Kottman, 1987, 2001a, 2001b, 2003, 2009; Kottman, Bryant, Alexander, & Kroger, 2009), based on the work of Alfred Adler, will be explored in more detail and translated into its use with children.

Adlerian Theory

Alfred Adler initially referred to his theory of personality and psychotherapy as individual psychology, based on his belief in the uniqueness and creativity of each person to develop an individual lifestyle, belief about self, and fictional goals (Adler, 1927/1998, 1956/1964). Social interest is a major tenet of individual psychology and refers to how one connects with others. People strive to feel a sense of belonging. Starting in infancy, people subconsciously construct lifestyles that assist in creating a relatively stable path toward their perception of how they belong in the world.

All persons are in constant movement from being in a position in which they perceive themselves inadequate, or inferior, to actively striving for superiority, or a sense of perfection, significance, and mastery (Adler, 1956/1964). Adlerian therapy is a phenomenological approach to therapy, based on a belief in the individual's perception of reality. Adler focused heavily on the influence of early childhood and family-of-origin as paramount in individuals' development of their perception of their significance in relationships. Subsequent Adlerian theorists emphasized the experiences of early childhood and the impact a child's early experiences have on the development of the person (Dinkmeyer, 1965; Dreikurs, 1950; Dreikurs & Soltz, 1964; Muro & Dinkmeyer, 1977). The following section attempts to describe basic beliefs about human nature according to Adlerian theory.

Basic Tenets

Overriding all Adlerian concepts is what Adler termed *Gemeinschaftsgefühl*, which is loosely termed *social interest* in English. Social interest is translated to mean

one's feeling of connection to a community, including family, other people, and the metaphysical world. It refers to one's ability to cope in the social world and one's interrelatedness with all humankind (Adler, 1927/1998, 1956/1964). According to Adler, everyone is born with the potential to develop social interest. This involves meeting one's needs for belonging, as well as contributing to others (Dreikurs, 1950). Adler also emphasized the value of social embeddedness, his belief that all humans are born into a social environment, their original family, and cannot be studied in isolation (Adler, 1927/1998; Dinkmeyer, 1965). People constantly interact with others, as one part of a larger society. The individual's view of society and how he or she contributes to society is an indicator of healthy functioning (Adler, 1956/1964).

Every individual impacts the social world with and/or without conscious recognition. Both consciousness and unconsciousness are parts of a person's experiences (Adler, 1927/1998; Dreikurs, 1950). In Adlerian terms, the unconscious is just out of a person's awareness and can be thought of as an area of one's life that is not understood but which can become understood. Regardless of a person's level of conscious awareness, every action or behavior is purposeful and goal driven and causes a reaction from the social world (Dinkmeyer, 1965; Dreikurs & Soltz, 1964). Thus, people must assume responsibility for their behavior because it inevitably affects all others. People do not need to understand or be aware of their goals of behavior in order to be responsible for their actions (Adler, 1956/1964; Mosak & Maniaci, 2008).

Adlerians believe in the holism of each person; persons cannot be reduced to any one area of being. Individuals are not determined by hereditary nor environment; rather,

they are creative, self-determined, and free to make choices (Adler, 1927/1998). People create lifestyles that remain fairly consistent through the lifespan largely based on their perceptions of their experiences, beginning with their first experience in society, their family (Adler, 1927/1998, 1956/1964; Dinkmeyer, 1965; Dreikurs, 1950; Mosak & Maniacci, 2008). Because children's cognitive functioning, including logic and judgment, are not fully developed, they may draw erroneous conclusions about themselves, others, and the world. Regardless of the accuracy of self-convictions, children interpret these mistaken beliefs and behave in life as if these are true. The amalgamation of one's perceptions of the world becomes one's lifestyle. Lifestyles then become the lens through which people view life.

Starting in childhood, people develop cognitions based on early perceptions of their experiences about themselves, others, and the world which help them to understand, predict, and control life. One's lifestyle is not good or bad, right or wrong. It is simply a way in which one navigates through the world towards one's fictional goal (Adler, 1927/1998, 1956/1964; Dinkmeyer, 1965; Dreikurs, 1950; Mosak & Maniacci, 2008). The primary goal for all people is to feel a sense of belonging with the larger community (Dreikurs & Soltz, 1964).

People create fictional goals which they then strive to meet out of response to their experiences (Adler, 1927/1998, 1956/1964; Dreikurs, 1950; Mosak & Maniacci, 2008). Fictional goals, albeit typically unconscious, provide individuals with security in the world and secure their self-concept. People continuously strive to reach these goals and believe they will overcome all life's challenges when they reach their fictional goals.

People do not arrive in a satisfied state of being; rather, they are in a constant state of becoming.

Life has no intrinsic meaning; people create their own meaning of life. Based on their perceptions of life, their created lifestyle, and fictional goals, individuals will draw their own conclusions about the meaning of life. People then behave as if their perceptions of their world are accurate (Adler, 1927/1998; Dinkmeyer, 1965). Mosak and Maniaci (2008) highlighted this concept with the following examples. In general, persons who are optimistic take chances, do not become discouraged, and respond to the world based on their beliefs that they are capable of overcoming adversity. They can differentiate between failing and being a failure. Pessimists tend not to engage with life. They become discouraged, fear failure, refuse to try, or prove inadequacy. They perceive themselves as failures rather than as people who failed in an isolated situation.

Inevitably individuals develop faulty or inferior thoughts and feelings (Adler, 1927/1998, 1956/1964; Mosak & Maniaci, 2008). Inferiority feelings reflect the discrepancy between how persons view themselves and how they believe they should be. Inferiority feelings are not limited, pre-prescribed, or necessarily logical. When persons shift from inferiority feelings to an inferiority complex, acting as if they are inferior, they become discouraged in life and relationships. Compensation is a defense mechanism labeled by Adlerians. It is used to overcome inferiority feelings (Adler, 1956/1964). Individuals compensate in other areas for areas in which they perceive they are lacking. As with all behavior, compensation can be useful or useless. For example, a child who

feels inferior in his reading ability compared to his peers may compensate by acting out behaviorally to distract the teacher's attention from his lack of reading skills.

Courage is another key component of Adlerian theory (Mosak & Maniacci, 2008). Courage is not synonymous with bravery. Rather, courage refers to the willingness one has to engage in life's challenges when the consequence is unknown or negative. People with courage take chances and actively engage with life, knowing they may not succeed. When people become discouraged, they lack the willingness to engage in life's demands. Discouraged people may choose behaviors that negatively impact society. This is in direct contrast to social interest (Adler, 1927/1998).

Life's challenges are present in five areas known as life tasks. Society/friendship, work, sex/love, spirituality, and self are the five life tasks that challenge humans throughout the life span. Adler (1927/1998) acknowledged the first three life tasks, and over the development of individual psychology, Harold Mosak (Mosak & Maniacci, 1998) included the additional two tasks. The society or friendship life task is the way in which persons cooperate with society. Their contribution to society is the work task. The work task for children is cooperation and success in school (Dinkmeyer, 1965). Adler was a pioneer in feminist-type theory and referred to the sex task as people's challenge in defining how to relate to the other sex, rather than the opposite sex; the love task also involves the close, intimate union between two people. The spiritual realm is each person's journey in defining his or her belief in the nature of the universe. Lastly, the self task is a person's tolerance and acceptance of his or her self (Mosak & Maniacci, 2008).

Counseling Process

Adler firmly believed in the necessity of a collaborative, friendly relationship between client and counselor. This type of relationship must be established in order for the client to trust the therapist, feel safe, be willing to explore his or her lifestyle, accept feedback and education from the therapist, and have the courage to change. Mosak and Maniaci (2008) listed the conditions of faith, hope, and love as necessary but not sufficient for change. Faith is the feeling of security and trust in the relationship as well as the client's and therapist's belief that the therapy can and will be effective. Hope is the client's belief in self and an inner feeling of encouragement that things can be different. The attitude *we are in this together* falls under the condition of hope within the relationship. Love is another necessary condition; the client must feel that the counselor cares about him or her. The counselor's role is to empathize with and support the client, not pity, console, or become a victim of the client.

The process of Adlerian therapy is a collaborative and educational process in which the primary goal is to foster and enhance social interest by helping the client to become enlightened about his or her life patterns. The therapist begins by building the relationship with the client. As the therapist interacts with the client, he or she is collecting information from the client to understand and interpret the client's lifestyle. As the counselor begins to develop a picture of the client's way of navigating through life, the counselor makes soft interpretations and relays that information back to the client so the client can become aware of some of his or her out-of-conscious processes. Counselors educate clients about their personal freedom to make decisions about their

lives, help clients to create alternate goals, and encourage clients to become autonomous (Adler, 1956/1964; Mosak & Maniacci, 2008).

The Progression of Adlerian Theory Applications

Dinkmeyer (1965) emphasized the importance of understanding child development. According to Dinkmeyer, in order to optimize healthy development, children need to perceive that they are unconditionally loved, relatively free from danger and threat, belong and are accepted within a group, are significant and contribute to others, are free to make choices, and are responsible for their choices and actions. Positive physical touch is also vital to healthy development. Starting in infancy, children who perceive their physiological and biological needs as not only being met but being met with nurturance and affection appear to be related to healthy, nurturing, and secure relationships throughout their life (Dinkmeyer, 1965).

Infants are born into a family, their first social group. Starting from this point children develop ways to meet their needs. They cry when they feel hungry, wet, or discomfort to get the attention of adults who can take care of them. How infants interpret their wishes as being met contributes to their view of their place in the world (Dreikurs, 1950). Dreikurs noticed that children adapt their crying and other behavior in accordance to how adults meet their needs. Thus, children begin to co-operate with the social world. Dreikurs concluded that children who experience love and nurturance with boundaries and limits are more likely to become responsible, cooperative, and useful members of society. Based on Dreikurs's observations and conclusions of how children develop

lifestyles, he focused his work on child development and parenting models (Dreikurs, 1950/1964).

Home Environment

Three main factors of the child's environment contribute to the child's development and lifestyle. The influence and combination of family atmosphere, family constellation, and parenting style each play a vital role in the child's perception of how he or she belongs in the family (Dreikurs & Soltz, 1964). Family atmosphere is influenced by social class, religion, ethnicity, social influences, and the relationship between parents. Family constellation is the characteristic relationship between family members; this includes birth order, length of time between siblings, family beliefs about gender, and gender roles. The constellation evolves as more children join the family, sibling illness that may occur, and other events happen that contribute to the ways in which persons find their place in the family. The way in which parents encourage, protect, and discipline their children impact the way children perceive their role in the family. Children develop best when they feel love and acceptance from their parents, are permitted to take chances, are protected from danger, and experience the limits and natural consequences of society (Dinkmeyer, 1965; Dreikurs & Soltz, 1964). Based on the child's view of the combination of these influences, the child uses his or her creative powers to establish how he or she belongs and contributes to the family (Dreikurs & Soltz, 1964).

School Environment

Dinkmeyer (1965) acknowledged the school's role in providing an atmosphere for mental health and social development. Children gradually change their place in the world

from their family relationships to relationships within the school system. The primary purpose of school is to foster an environment where children can learn to take part in a larger community (Dreikurs, 1950).

Positive Discipline in the Classroom ® emerged based on the work of Adler and Dreikurs (Nelsen, Lott, & Glenn, 2000). The authors emphasized the importance of the cooperation among all members of the school environment. Furthermore, like Dinkmeyer (1964), Nelsen et al. (2000) attested that schools have the resources to teach academics as well as provide an atmosphere for nurturance and positive social behavior. Positive Discipline ® is designed to be implemented by teachers in the classroom to foster respect, responsibility, citizenship, and life skills, and to empower children to become cooperative members of society. In this way, teachers become a therapeutic point of contact where children regularly experience an environment of mutual respect and cooperation. This program is based on the belief that character and a felt-sense of social connectedness are essential for healthy development. Positive Discipline ® may not replace the need for additional counseling for all children, but it may address some children's needs without further intervention.

The school's responsibility is to teach academic skills and emotionally mature behavior. School programs should incorporate procedures for early identification of children with emotional and behavioral difficulties (Dinkmeyer, 1965). Furthermore, schools have the resources to encourage children and provide opportunities for accomplishment, as well as establish and model respectful relationships between teacher

and child. The experiences children have in school are incorporated into their child's view of themselves. Dreikurs (1950) summarized the role of parents and teachers:

Good educators will respect the child's personality, love him [*sic*] well enough to understand his [*sic*] mistakes and show kindly firmness in refusing to save him [*sic*] from the unpleasant consequences of his own conduct. They will always find ways of reconciling the child to the social order without arousing his [*sic*] resistance. When the child becomes aware of the existence of the social order, they will help him [*sic*] to fit into it; but they will not make the child feel that they wish to seize the opportunity to assert any claim to personal superiority or power. (p. 81)

School Guidance and Counseling

School guidance and counseling emerged and evolved over the course of the 20th century (Muro & Dinkmeyer, 1977; Muro & Kottman, 1995). As counseling in elementary schools progressed, the direction of the movement shifted based on societal pressures and happenings. In the late 1960s Dinkmeyer noticed that there was relatively no guidance curriculum for elementary-aged children (Muro & Dinkmeyer, 1977). Most elementary schools did not have a guidance counselor. In the elementary schools that did have guidance counselors, the counselors followed the work of nondirective psychotherapists, including play therapists such as Virginia Axline and Clark Moustakas. The other leading counseling materials were heavily problem-focused and required lengthy training. Although the works of these therapists were valued, their noted work was with institutionalized children who had significantly different needs than typical school-aged children. Dinkmeyer also recognized that the training of such professionals was beyond the need for school counselors (Muro & Dinkmeyer, 1977).

Defining counseling for children during this time was also a difficult task (Muro & Dinkmeyer, 1977). Counselors and related professionals recognized that children were

different from adults but were not sure how best to work with children. Furthermore, counselors recognized that the needs of children were different and that the ability to control their environment was substantially different than adults' ability to control their environment. Therefore, Muro and Dinkmeyer (1977) recognized that as many elements as possible in the child's life should be involved in the counseling process. Those elements include counselors, teachers, bus drivers, principals, and parents.

Play in the Counseling Process

Yura and Galassi (1974) and Muro and Dinkmeyer (1977) acknowledged the power of play and its place in child counseling. However, most mental health professionals did not value play in the psychotherapy dynamics, following only talk therapy approaches. Rather than psychotherapy professionals, advocates for play were more often teachers, who witnessed the importance of play in a child's life. Muro and Dinkmeyer, appreciating the work of Virginia Axline (1974), were among the advocates for incorporating play and play materials into the counseling process. During this time, Adlerian theorists acknowledged the value of play and its therapeutic implications and were incorporating play and play activities into their work with children (Muro & Dinkmeyer, 1977; Yura & Galassi, 1974). Muro and Dinkmeyer (1977) emphasized that almost any form of children's play can help therapists understand children's lifestyles.

Adler was concerned with children's cognitive and social development. He acknowledged the differences between adults and children in their respective cognitive ability. Adler was also a proponent of play, not only as developmentally appropriate, but also as necessary for healthy growth and functioning (Adler, 1927/1998). "In observing

children at play we can see their whole attitude towards life; play is of the utmost importance to every child” (Adler, 1927/1998, p. 81).

Adlerian Play Therapy

Terry Kottman, an Adlerian therapist and respected play therapist, created Adlerian play therapy (AdPT) to merge her beliefs about children and people with her therapeutic style of counseling (Watts, 2006). AdPT is suited for children who are referred to counseling for a variety of reasons (Kottman, 2003; Watts, 2006). In the process of AdPT, children are afforded an opportunity to practice socially useful behaviors and experiment with new thoughts and feelings all within the safety of a secure and supportive relationship. The process of play and the therapeutic skill of the Adlerian play therapist allow children to, directly or indirectly, through language and/or metaphor, rehearse their changing perceptions, attitudes, and behaviors (Kottman, 2003; Watts, 2006).

Dreikurs (1950) believed that for therapy to be effective it must instill lasting encouragement and increase the client’s self-confidence. Clients must develop an understanding of their behavior and goals; they must have conscious awareness of their lifestyle and take responsibility for their actions. More specific goals of AdPT include the child’s development of creative thinking; experience of a relationship with unconditional acceptance; improved ability to appropriately connect with others; experience of limits that are permissive enough for a child learn from his or her mistakes yet are grounded in the rules of society; mastery of fears; enhanced or improved imagination and enjoyment of play; and improvement of socially useful behaviors (Watts,

2006). Kottman (2003) reported that AdPT is especially appropriate for children who have an increased need for power and control; have experienced a traumatic event; have a poor self-concept; are discouraged; or have poor cooperation skills and/or weak social skills.

Many aspects of Adlerian therapists' work with children are the same as those of Adlerian therapists who work with adults. They follow the same beliefs about people and how people change. Play therapy as opposed to talk therapy is typically used with children between the ages of 3 and 10 because many children are not yet capable of accurately verbally communicating their thoughts, feelings, perceptions, and experiences (Kottman, 2001a, 2001b, 2003; Muro & Dinkmeyer, 1977; Watts, 2006).

In the collaborative play therapy relationship, Kottman (2001a) described play as a means for

a) establishing rapport with children; b) helping adults understand children and their interactions and relationship; c) helping children reveal feelings, thoughts, reactions, and attitudes that they have not been able to verbalize; d) constructively acting out feelings of anxiety, tension, or hostility; e) teaching children social skills; f) providing a way for children to explore their desires and goals; g) creating a relationship in which children can test limits, explore their perceptions of themselves, others, and the world; and h) providing an atmosphere in which children can gain insight about their own behavior and motivation, explore alternative and learn about consequences. (p. 1)

This section briefly describes how Adlerian theory is used in the context of the therapist-child relationship. Kottman (2009) developed an AdPT treatment protocol, as well as the AdPT skills checklist to assist play therapists in their work with children (Appendix C).

Building an Egalitarian Relationship

Children need to feel that they are loved, secure, belong, and contribute in relationships with others in order to optimally function and develop (Dinkmeyer, 1965). The ideal relationship is one of give and take (Dreikurs, 1950). Therefore, the first task of the Adlerian play therapist is to develop an egalitarian relationship with the child. Adlerian play therapists create a relationship in which the child feels a shared partnership, with collaboration, trust, and respect between child and therapist. The therapist communicates respect and trust in the child and earns the respect and trust from the child by being consistent, dependable, accepting, caring, and respectful (Kottman, 2001a, 2003; Watts, 2006).

The therapist must have an underlying personal philosophy that all people, including children, are valuable, deserve respect, and have a sense of power in their lives (Kottman, 2001a, 2003). The child is honored as a person of worth, choice, creativity, and uniqueness. The child is not coerced or forced to answer questions or participate in activities. He or she is free to choose whether or not to interact or avoid the therapist, and the therapist respects the decision of the child. Rather than simply being told of the shared relationship, the child needs to experience a relationship in which he or she feels a sense of power, respect, collaboration, and responsibility (Kottman, 2003). An egalitarian relationship is necessary before moving on to subsequent phases (Dreikurs, 1950; Kottman, 2001a, 2003). However, the therapist consistently and intentionally works to maintain and strengthen the relationship throughout the counseling process.

The relationship process begins even before the therapist meets the child (Kottman, 2001a, 2001b, 2003). Adlerian therapists work with parents, teachers, and other important adults in the child's life. Because Adlerian therapists believe that all beings are socially embedded, play therapists seek to understand and help children by gathering information from other significant adults in children's lives and try to improve the social atmosphere of their clients. Thus, Adlerian play therapists often communicate with others in the child's world, such as parents and teachers.

Exploring the Child's Lifestyle

The second phase of AdPT involves the therapist gathering information about the child's lifestyle (Kottman, 2001a, 2001b, 2003; Watts, 2006). Children develop lifestyles based on their perceptions of the world around them. They begin to develop their lifestyle at birth, and it becomes more solidified, although never permanent, around age 8 (Kottman, 2001a). Adlerian play therapists are more interested in how the child views and makes sense of the world rather than the objective events of the child's life (Dinkmeyer, 1965; Dreikurs & Soltz, 1964). Just as adults, children are socially embedded, with their primary social group being family, and they respond to the world based on their perceptions of themselves, others, and the world.

Two areas of keen interest to Adlerian play therapists are the goals of misbehavior (Dinkmeyer, 1965; Dreikurs, 1950/1964) and the crucial Cs (Bettner, & Lew, 2005). Both concepts are used as tools to help the counselor conceptualize the client. Goals of misbehavior were developed by Dreikurs (1950) as a way to delineate the goals of children's behavior. All behavior is purposeful, and Adlerian play therapists aim to

understand how children use their behaviors to meet their goals (Dinkmeyer, 1965; Dreikurs, 1950/1964). The immediate goal of all behavior is to belong (Dreikurs & Soltz, 1964). Misbehavior is used in attempt to meet the primary objective of belonging. Dreikurs and Soltz (1964) described four goals of misbehavior, believing that universally children use these behaviors to meet their perceived needs. The four goals of misbehaviors are (a) undue attention, (b) struggle for power, (c) retaliation and revenge, and (d) complete inadequacy. Adlerians typically believe that children are behaving out of their unconsciousness to meet their needs and use goals of misbehavior because they are discouraged and lack socially useful ways of connecting with others (Dreikurs, 1950/1964).

Bettner and Lew (2005) developed the crucial Cs as a way to help parents identify and encourage particular characteristics of their child. The four crucial Cs are (a) count, (b) connect, (c) capable, and (d) courage. Bettner and Lew believed that children need to perceive themselves as having attributes of the crucial Cs in order to be successful in society as they grow and mature. Adlerian play therapists use the crucial Cs to make hypotheses about a child's assets and limitations and the ways in which the child approaches life (Kottman, 2003). In this way, Adlerian play therapists view the crucial Cs on a continuum to examine how the child (a) believes he or she counts in the world and in relationships with others, (b) connects with others, (c) believes he or she is or is not capable of success, and (d) demonstrates the courage to be imperfect and attempt new tasks.

The therapist attempts to understand the child's patterns and perceptions through interviews with family, discussions with teachers or other social relationships, and the therapist's own interactions with the child. Information may also be gathered informally through casual conversation and observation. Topics of formal communication with adults and the child may include the child's assets, family atmosphere, early recollections, and functioning at life tasks, among others (Kottman, 2003, 2009; Watts, 2006). Adlerian play therapists may observe children with their parents in the waiting room or watch children on the playground, in class, or at lunch during school hours to gather valuable information about how children view themselves.

In the playroom, the therapist may be nondirective or directive, at times letting the child lead and at other times requesting that the child participate in a specific activity (Carlson et al., 2006; Kottman, 2003). Activities such as family drawings, school drawings, puppet shows, role plays, and games are often intentionally introduced by the therapist as a means of gathering information about the child's lifestyle. Adlerian play therapists value free, spontaneous, and uninhibited play. The activities, interaction style, and patterns in which children play provide valuable information for the therapist and allow the child to experience power, self-control, responsibility, freedom, and mastery, among other valuable experiences.

The therapist does not expect the child to change at this point in therapy (Kottman, 2001a). The purpose of this phase is for the therapist to develop an understanding of the child's lifestyle which the therapist can then use to guide the child,

family, or teacher to make changes in their perceptions, thoughts, and behaviors in later stages of therapy (Kottman, 2003).

Helping the Child Gain Insight

This phase introduces a significant shift in the therapist's expectations for the child to change (Kottman, 2003). The primary goal of this phase is to bring into the child's awareness his or her lifestyle through strengths; goals of behavior; basic convictions about self, others, and the world; personality priorities; perceptions of how he or she belongs with others; and how he or she navigates through the world. The child is then free to make informed decisions about whether he or she wants to change and how he or she could go about making changes. The therapist also works with the child's social spheres, such as family and school, to help create the most supportive environment for change (Kottman, 2001a, 2003).

Adlerian play therapists help children gain insight by metacommunicating about their lifestyle and making guesses about their perceptions, feelings, and behaviors. Another unique Adlerian technique is *spitting in the soup*, which involves the therapist pointing out to clients the ways in which their own behavior is interfering with them achieving their goals (Kottman, 2001a). A therapist may choose to use confrontation or humor in their interaction with a child depending on the therapist's belief of what the individual child needs in that moment. Adlerian play therapists, at a philosophical level, value play and metaphoric expression as the children's primary means of communication. Therefore, therapists use directed or nondirected metaphors, storytelling, and role plays (among other activities) to help children gain new understandings of themselves, which

can help them take responsibility in the changes they choose to attempt (Kottman, 2003, 2009; Watts, 2006).

Reorientation/Reeducation

The reorientation/reeducation phase emphasizes the need for action. Children begin to (a) generate new ways of thinking about themselves, others, and the world; (b) change the way they feel or behave in various situations; and (c) relate to people differently than they had in the past (Kottman, 2001a, 2003, 2009; Watts, 2006).

Adlerian therapists believe that action is more meaningful than words (Dreikurs & Soltz, 1964). Adlerian play therapists provide opportunities for children to apply these new perceptions, both in the playroom and in other settings and relationships. Parents and teachers are also updated on the child's current functioning and progress and are asked to encourage the child in new ways of thinking, feeling, and behaving. During this phase, families, teachers, or friends may even be asked to join in the therapy process in the playroom.

Adlerian therapists are often more directive during this phase of therapy than in any of the prior three phases. Therapists use encouragement and support during this phase; they act out their philosophical belief in the child's creatively ability to solve problems and make changes. There are endless solutions to problems, and therapists must remain imaginative and open to alternatives (Kottman, 2003). Through toys, art, role play, puppets, games, music and dance, brainstorming, and other teaching tools, children can practice new behaviors, more adaptive patterns of thinking, and socially appropriate expression of feelings. Therapists are most instrumental with children when

they allow themselves the freedom to attempt various interventions with children and families. Children are often wiser than adults believe they are and are more likely to follow through with solutions they have generated for themselves than those solutions offered by adults.

Children may have shown improvement in the playroom, but reports from the child, parents, or teacher may indicate the child's continued struggle in other social interactions. As always, the Adlerian play therapist uses clinical judgment to determine the next possible course of action. Group play therapy is a natural progression for children who need additional encouragement, support, and practice in interacting with others. The therapist may teach the parent and teacher techniques to help the child try new behaviors, thoughts, and feelings outside of the therapy sessions (Kottman, 2003).

Termination is determined based upon evidence in the playroom as well as reports from parents and/or teachers of the child's positive changes in perceptions, attitudes, or behavior (Kottman, 2003). Observing children a child in his or her natural setting, such as observing a child in a classroom, recesses, or waiting room with family members, can provide keen evidence to the therapist about the appropriateness of termination,

Adlerian Play Therapy in Schools

AdPT is reported to work well in school environments (Kottman, 2003; Kottman et al., 2009; Watts, 2006). Children spend numerous hours each week at school with teachers and peers. Therefore, Adlerian play therapists have access to the child's natural environment. They can observe children at different times throughout the school day. Furthermore, therapists have access to adults in the child's life, such as teachers.

Teachers can offer valuable information about the child's functioning, and direct observation by the therapist can provide further detail about the child's lifestyle and functioning.

Play Therapy in the Elementary Schools

Mental Health America (MHA, 2009) reported that 20% of children have mental health problems and that only one third of those children receive the mental health care needed to address their needs. The U.S. Public Health Services (2000) and the President's New Freedom Commission (2003) declared that children are suffering because institutions intended to address such issues are failing to meet their emotional, behavioral, and developmental needs. Schools have access and means to bridge that gap (U.S. Public Health Service, 2000; President's New Freedom Commission, 2003). The reports suggested that school-based prevention and intervention should be implemented to address children's emotional and mental health needs.

Teachers have many hours of access to children. They are aware of how the children in their class function socially, emotionally, behaviorally, and academically. Teachers are aware of students who demonstrate problems in the classroom (Abidin & Robinson, 2002). Abidin and Robinson also revealed the most frequent referral for counseling in the school setting comes from teachers who have concerns about a child's behavior and academic competence.

Teachers can offer a unique source of support in the school atmosphere. Elementary students spend a large portion of their daily lives at school with a single teacher. This opportunity allows teachers to be instrumental in the therapeutic process by

referring children in need to the school counselor for counseling. Counselors (with proper consent from the child's guardian) can interact, inform, and interview the teachers of these children. Counselors can help teachers better understand the referred child, resulting in a strengthened child-teacher relationship. Several authors encouraged counselors to include teachers for more efficient and effective therapy with elementary children (Barkley, 2007; Bratton et al., 2005; Kottman, 2003; Kottman et al., 2009; Landreth, Ray, & Bratton, 2009; Morrison & Bratton, in press; Paone & Douma, 2009; Raman & Kapur, 1999; Ray, 2007; Shaski et al., 1999).

According to the American School Counseling Association (ASCA, 2009), school counselors have the training and expertise to work with children who show emotional, social, and behavioral difficulties. However, due to the extensive demand on school counselors' time, they rarely have the luxury of working intensively with a child or children who need ongoing individual assistance. School counselors are encouraged to be just one part of a larger educational team (ASCA, 2009). Therefore, they are advised to seek system support from others, including school-based counselors, outside agencies, and community experts for cases that have the potential to interfere with the overall implementation of the school counseling program. Responsible school counselors seek help and refer students' families to resources that use developmentally appropriate interventions.

Beyond physical contact and daily interactions with children, school personnel typically understand child development and cognitive processes. In the classrooms, teachers attempt to educate children based on their level of cognitive development.

Counseling with children should be held to the same standards. Based on the developmental levels and cognitive functioning of children, play therapy appears to be the most appropriate intervention for children in elementary school (Bratton, Ray, & Landreth, 2008; Kottman, 2003; Landreth, 2002).

Cognitive Functioning

Children function cognitively differently from adults. Children between the approximate ages of 2 to 7 years are in what Piaget (1962) called the preoperational stage of development, a stage in which children have not yet mastered the skill of verbal language. They operate in rigid ways, believing only in how things appear to them at the time. Play behaviors of these children are largely imaginary, and they immerse themselves in make-believe play. The preoperational stage is a time of learning cognitive concepts. Children learn about the world, objects, others, and relationships through play and the manipulation of objects. While children are internally learning about complex patterns, they are often unable to accurately verbalize their new understanding and knowledge (Erikson, 1977; Piaget, 1962). Therefore, play is the natural means of communication for children in this stage of development.

Between the ages of 8 and 11 years, children shift to the concrete operational stage of development (Piaget, 1962). This stage is characterized by children's growing ability to reason and organize thoughts. However, they continue to be able to think only of physical, concrete objects; abstract reasoning has not yet been developed. Children are now beginning to understand the logical rules of society and shift their black-and-white thinking to more thinking in the gray areas. Children in the concrete operational stage

become better at verbalizing their internal processes and emotions compared to previous stages of development. It is important to note that these children are blending their cognitive functioning, moving from immediate and concrete thinking to more abstract reasoning. Play can provide the link for this age group. Children often use play to connect their already mastered way of understanding the world to their new higher ordered functioning way of understanding the world.

Regardless of the specific phase the child is in, therapists may not be absolutely sure of a child's development without allowing the child to show the therapist how he or she cognitively operates in the world. Play therapy allows the play therapist to enter into the child's world. The child experiences his or her world through concrete manipulation and as the child cognitively matures, the child interprets and communicates his or her understanding of the world to the play therapist in a way that is meaningful and useful for the child and therapist (Bratton et al., 2008). Ray (2007) described how play therapy is a developmentally appropriate intervention for children in the preoperational and concrete operations stage of development:

Children more comfortably, safely, and meaningfully express their inner world through concrete, symbolic representation in play. Through toys or role-playing, children have the opportunity to develop a sense of control over their world as they reenact their experiences in the safety of the playroom. (p. 429)

Disruptive Behavior and Child Adjustment

Disruptive behaviors are behaviors with outward momentum, sometimes referred to as externalized behavior. More specifically, disruptive behavior may include irritability, negative mood, intense negative reactions, anger, aggression, rule breaking, distractibility, and an inability to adapt (Achenbach & Rescorla, 2001; Sanson, Hemphill,

& Smart, 2004). Externalizing behaviors are usually disruptive to others, such as peers, teachers, and parents. Children's disruptive behaviors in school, social, or family settings are among the most challenging aspects of children's behavior for adults (Abidin & Robinson, 2002; Hamre et al., 2007; Myers & Pianta, 2008; Ray, 2007). Children who have poor social adjustment, including excessive disruptive behavior, have difficulties in school with teachers and peers. Moreover, without intervention, these behaviors appear to be relatively stable over time (Barkley, 2007; Brinkmeyer & Eyeberg, 2003; Webster-Stratton & Reid, 2003).

Several authors have described the correlation between disruptive behavior in childhood and ongoing difficulties in personal and social development (Baggerly & Jenkins, 2009; Hamre et al., 2007; Myers & Pianta, 2008; Persson, 2005; Ramos, Wright Guerin, Gottfried, Bathurst, & Oliver, 2005; Ray et al., 2007; Sanson et al., 2004; Teisl & Cicchetti, 2008; Webster-Stratton & Reid, 2003; Wood, Repetti, & Roesch, 2004). Children need peer and adult relationships for healthy functioning and adjustment (Hartup, 1989; Myers & Pianta, 2008). However, children who are aggressive, unpredictable, irritable, hyperactive, and/or demonstrate many disruptive behaviors experience difficulty in creating and maintaining positive relationships with others. Therefore, these children become isolated, which increases their maladjustment by giving them fewer opportunities to learn social skills such as cooperation and intimacy.

Some authors suggest that disruptive behaviors are associated with a child's perception of the social environment (Hartup, 1989; Teisl & Cicchetti, 2008; Wood et al., 2004). Children who believe that the world is dangerous, that people are mean, or that

they are not liked by others, or children who perceive experiences as threatening to their emotional or physical well-being have a higher tendency to react to their environment with aggressive and negative behaviors. Thus, the disruptive behaviors are in response to the child's perception of a threat in the environment. In Adlerian terms, the child is compensating for his or her feelings of vulnerability by acting aggressive, impulsive, or disruptive.

The feelings and responses described above are exacerbated in the lives of these children, because children who exhibit externalizing behaviors such as aggression, conduct problems, or hyperactivity are less likely to have positive relationships and social interactions with others (Myers & Pianta, 2008). Negative experiences confirm their already-held belief that they are bad and are not liked by others; this stimulates a reciprocal cycle between the child and adult, reinforcing negative behavior. Furthermore, even at young ages, children develop reputations among peers based on others' perceptions of their behaviors. Students also develop reputations among teachers based on their conduct at school. Reputations follow children throughout the school system, and soon many teachers within the school have a preconceived perception of certain children. Without intervention, the children who have reputations of being mean, aggressive, or impulsive have a high probability of maintaining these patterns as they age and progress through their academic years (Persson, 2005).

Emotional Regulation

Emotional regulation is broadly defined as a person's ability to control his or her emotions (Myers & Pianta, 2008; Sanson et al., 2004). People who demonstrate

emotional regulation have increased positive social experiences and relationships with others, which results in social competence (Ramos et al., 2005; Sanson et al., 2004; Teisl & Cicchetti, 2008; Wood et al., 2004). Thus, children who are able to regulate their emotions have increased opportunity for positive social interaction, adjustment, and relationships. Just as children with disruptive behaviors maintain their negative reputation, children with high degrees of emotional regulation maintain their positive reputation of being predictable, friendly, and safe as they mature.

Children learn emotional regulation through safe, consistent, trusting relationships with others (Hartup, 1989; Myers & Pianta, 2008; Teisl & Cicchetti, 2008). As children experience a range of emotions, they learn appropriate ways of expressing heightened emotional states. Typically, children learn to regulate their response to emotions through their own experience, encouragement and education from caregivers, and their caregivers' ability to appropriately model emotional regulation (Teisl & Cicchetti, 2008). Unfortunately, not all children are afforded these opportunities. Play therapy can be a developmentally suitable response in early intervention for these children.

Teachers' Role

A teacher's primary responsibility is to teach children, yet disruptive behaviors make it difficult for children who act out, as well as for the other children in the class, to learn. Thus, children who are disruptive to others in the classroom become a concern for teachers (Abidin & Robinson, 2002). The tension created as a result of the incongruence between children's behavior and teachers' expectations of children lends itself to negative teacher-child relationships (Hamre et al., 2007; Myers & Pianta, 2008).

Hamre and Pianta (2007) reported that the relationship between teacher and child is instrumental in predicting student success. Children who experience chronic levels of stress with teachers have an increased risk of developing any of a number of social and academic challenges. These children are usually then referred to the school counselor or school-based mental health professional because of the teacher's exhaustion, frustration, time constraints, and lack of sympathy in helping these children. On the other hand, children with less disruptive behaviors have less negative impact on teacher stress. By reducing children's disruptive behaviors, teachers experience less stress and are more able to meet the social and academic needs of all children. Those children are then able to experience and benefit from a more positive relationship with their teachers.

School-based Play Therapy

School-based play therapists can provide opportunities for children to experience and express a wide range of emotions in the safety of the playroom in schools. The school environment offers opportunities for school-based play therapists to work once or twice a week for 30 to 45 minutes with a child. This format has been shown to be appropriate for play therapists working with children (Bratton & Ray, 2000; Bratton et al., 2005; Kottman, 2003; Landreth et al., 2009; Ray et al., 2005).

It is also important to involve significant adults from the child's life in the therapeutic intervention. Teachers have the capacity to provide a stable and consistent model of emotional regulation for children in their classroom (Myers & Pianta, 2008). Ray (2007) found teacher consultations to positively affect the teacher-child relationship between the classroom teacher and the child referred to play therapy.

Adlerian play therapists believe the child is a socially embedded being and can be understood only from a social context (Kottman, 2003). A therapist who operates from an Adlerian perspective values and makes use of the teacher's ability to build relationships with children, identify the goals of a child's behaviors, and educate children about prosocial behaviors in the immediate social arena. Therefore, Adlerian play therapy seems to be an effective method of intervention for elementary school children who demonstrate disruptive behaviors.

Play Therapy Research in Elementary Schools

Children's behavior interests many researchers. Recent research has attempted to demonstrate the effectiveness of school-based play therapy for children referred by teachers or parents because of problematic behaviors (Bratton, 2010; Ray et al., 2007). Child-centered play therapy (CCPT) and nondirective play therapy have shown to be effective methods of working with children who present with a variety of problems in multiple settings, including schools (Bratton, 2010; Bratton et al., 2005). Several researchers have found school-based CCPT and nondirective interventions to be successful in a variety of presenting concerns, including emotional and behavioral problems (Fall, Balvanz, Johnson, & Nelson, 1999; Fall, Navelski, & Welch, 2002; Garza & Bratton, 2005; Muro, Ray, Schottelkorb, Raman & Kapur, 1999; Smith, & Blanco, 2006; Packman & Bratton, 2003; Shashi, Kapur, & Subbakrishna, 1999), as well as more specific areas of concern such as Attention Deficit Hyperactivity Disorders (ADHD) (Ray et al., 2007); anxiety (Shen, 2002); external locus of control (Post, 1999); development (Baggerly & Jenkins, 2009); and academic achievement (Blanco, 2009).

Fall et al. (1999) conducted a randomized control group design with 62 children between the ages of 6 and 9. Researchers were interested in exploring the efficacy of brief nondirective play therapy in improving the behavior and beliefs about the self-efficacy of elementary-aged children. Children in the experimental group received six, 30-minute nondirective play therapy sessions by elementary school counselors trained in nondirective play therapy. All participants were measured on three scales before and after the intervention. Researchers used the Self-Efficacy Scale for Children (S-ES), the Conners Teacher Rating Scale (CTRS), and direct observation to measure change over time.

Results of this study indicated a statistically significant improvement in self-efficacy over time for children who received brief nondirective play therapy as reported on the S-ES. Children in the control group worsened slightly. There was not a statistically significant difference between groups in any of the three assessments. Children in both groups showed an improvement in classroom behaviors as reported by teachers on the CTRS. No difference of off-task behaviors was found from pretest to posttest or between groups through direct observation. Researchers concluded that six, 30-minute nondirective play therapy sessions can positively impact a child's perception of his or her self-efficacy and thereby potentially increase the child's awareness of his or her ability to make positive choices in school (Fall et al., 1999).

Fall et al. (2002) conducted a randomized no-treatment control group design to investigate the effect of brief CCPT on the self-efficacy, classroom behavior, social problems, and anxiety of children who qualified for special education. All children who

qualified for special education services in their school district were eligible for participation. The sample was made up of 66 participants who ranged in age from 6 to 10. Participants were randomly assigned to the brief CCPT group ($n = 43$) or the no-treatment control group ($n = 23$). Children in the experimental group received 30 minutes of CCPT once a week for 6 weeks.

Classroom teachers and the children's educational case managers completed the assessment instruments prior to and following the intervention for children in both groups. The S-ES was used to estimate teachers' and case managers' perceptions of the children's belief about their ability to meet their own needs. In both groups the children demonstrated an improvement in self-efficacy. Although there was not a statistically significant difference between groups, the experimental group indicated more improvement in self-efficacy than the no-treatment control group. The CTRS was used to assess children's behavior in the classroom. No statistically significant difference was found on this assessment, and improvements varied between teachers' and case managers' reports. Teachers' ratings indicated a decrease in problem behaviors and anxiety for children in the CCPT group and an increase in both areas for children who did not receive treatment. Case managers' ratings of children in the CCPT group demonstrated no change in classroom behavior and an increase in anxiety. Case managers also reported an improvement in behavior and decrease in anxiety for children in the no-treatment control group. Both raters indicated an increase in social problems for children in either group (Fall et al., 2002).

Fall et al. (2002) hypothesized that the results could be due to the learning environment for children identified as needing special education services. All participants received special education services throughout the duration of the study. The special education teaching methods used behavioral modification techniques such as reinforcement to teach students to manage their behavior and depend on adults for direction. The researchers suggested that the juxtaposition between behavior modification and a client-led intervention may deter the potential benefits of CCPT. They further postulated that a play intervention more directive in nature such as Adlerian, cognitive-behavioral, or systemic may be better suited for this population (Fall et al., 2002).

Garza and Bratton (2005) conducted a comparison group design. The researchers compared CCPT with a nationally recognized, curriculum-based small-group counseling intervention with 30 elementary Hispanic children referred to counseling for problem behaviors in the classroom. The experimental and the comparison control group each had 15 randomly assigned students in their respective groups. The children in the experimental group received weekly 30-minute CCPT sessions for 15 weeks with therapists who were fluent in both English and Spanish. Parents and teachers completed the Behavior Assessment System for Children-Parent Rating Form (BASC) prior to and after children received the services.

Results indicated statistical significance and large treatment effect (.76) for externalized behaviors with children who participated in the CCPT intervention compared to children in the comparative treatment as reported by parents on the assigned

assessment instruments (Garza & Bratton, 2005). Results showed no statistically significant difference per teachers' rating form. Researchers believed this may be due to teachers' stress during data collection, because they were asked to complete the forms during a busy part of the academic year. Anecdotal evidence provided researchers with parents' and school personnel's perceptions of changes in student behavior. Parents and school personnel alike reported improvements in problem behaviors and a noticeable reduction in office referrals for those students who participated in school-based CCPT. Thus, as children reduced their externalized behaviors and improved their social skills, they were able to behave more appropriately in class and increase their likelihood of learning in the classroom. According to parent reports, children showed a statistically significant decrease in externalizing behaviors, with a large treatment effect size of .76.

Using repeated measures, one group design, Muro et al. (2006) examined the effects of CCPT with 23 elementary-aged children. Teachers referred students for behavioral and emotional difficulties. Teachers completed the Teacher Report Form (TRF) and Index of Teaching Stress (ITS) 1 week prior to the children receiving treatment (CCPT), after 16 sessions, and again following 32 sessions. The results of the study demonstrated statistically significant improvement on the Total Problem scale of the TRF, Total Stress of the ITS, ADHD Domain of the ITS, and Student Characteristics of the ITS after 32 sessions of CCPT, with large effect sizes. While conclusions were limited by lack of a control group, researchers reported a steady decline in problem behaviors and emotional difficulties between pretest and mid-measurement and again from mid-measurement to posttest.

Shashi et al. (1999) screened 800 children between the ages of 5 and 10 for behavior problems on the Children's Behavior Questionnaire completed by teachers and the revised Child Behavior Checklist (CBCL), completed by parents. Ten students were ultimately selected and randomly assigned to no-treatment control and experimental groups. The experimental group children ($n = 5$) received nondirective play therapy for 10 one-hour sessions. Therapists also consulted with the children's parents to offer support, feedback, and identification of the child's behavioral changes. Although the generalizability of results is limited due to the small sample size, researchers found statistically significant reduction of problems in the experimental group. Parents also reported improvement in their child's functioning. Improvements included reduction in anxiety, increased parent-child interaction, improvement in academics, and improvement in home behavior, including assuming responsibility for chores.

Packman and Bratton (2003) investigated the effectiveness of humanistic nondirective group play therapy/activity therapy with 30 fourth and fifth grade students who had learning disabilities and exhibited behavior problems. Participants were referred for services by teachers or parents based on their perceptions that their student or child exhibited behavioral difficulties. Students were randomly assigned to participate in 12, one-hour weekly sessions of the experimental condition or to the no-treatment control group. Participants were assigned to small groups of 2 or 3 students for the intervention. Parents and teachers of the 30 participants completed the BASC and the CBCL prior to services and following the conclusion of services for their child. Results indicated a large treatment effect size for internalizing behaviors on the BASC (1.03) and the CBCL (.90)

over time. Results for externalizing behavior indicated a medium effect size on the BASC (.53) and a large treatment effect size on the CBCL (.78) from pretest to posttest. Packman and Bratton concluded that humanistic, developmentally appropriate nondirective play therapy/activity therapy meets the needs of children in this age range and has a beneficial effect on children's behavior, coping, and social skills.

Raman and Kapur (1999) studied effects of nondirective play therapy with 10 kindergarten-aged children who had been diagnosed with emotional disorders and referred to the study by teachers. Students were randomly assigned to the no-treatment control ($n = 5$) or experimental groups ($n = 5$). The experimental group received 15 sessions of nondirective play therapy, twice weekly for 45 minutes. Teachers completed the Rutter's Child Behavior Questionnaire (A and B scales), and the Raven's Controlled Projection Test prior to the child beginning the intervention to determine a baseline and completed both tests following the intervention. Findings revealed a statistically significant reduction in problem behaviors on both assessments in the experimental group compared to the no-treatment control group. While limited by a small sample size, results indicate that nondirective play therapy is an effective intervention for children with problem behaviors.

Ray et al. (2007) conducted a randomly assigned two-group design with 60 elementary-aged children who exhibited ADHD symptoms. Teachers completed the Conners Teacher Rating Scale – Revised: Short Form which identifies ADHD-type problematic behavior of children. Teachers also completed the ITS, which measures the teacher's stress related to a particular student. The participants were randomly assigned

to one of two treatment groups (CCPT or mentoring). Children in the CCPT treatment group showed a statistically significant reduction of ADHD symptoms from pre- to posttest and a large effect size, with partial eta squared equaling .18. Results further indicated a statistically significant within-group reduction in teacher's stress on subscales of Student Characteristics for participants in the CCPT group with a moderate effect size for time (.10) and moderate effect size for interaction effect (.08); Emotional Lability/Low Adaptability subscale had an interaction effect with a moderate effect size (.10); and Anxiety-Withdrawn subscale resulted in a statistical significance for time with a moderate effect size (.12) and statistical significance for interaction effect with a moderate effect size (.09). Results indicate that CCPT is effective in reducing children's ADHD symptoms as well as teachers' stress related to children's ADHD behaviors, anxiety, and ability to adapt.

Shen (2002) investigated the effectiveness of short-term CCPT with child victims of 1999 Chinese earthquakes. Shen used a pretest-posttest control group design with 30 elementary-aged students. Results indicated that CCPT was statistically significant in reducing anxiety levels of children as compared to the no-treatment control group between groups over time.

Post (1999) performed a pretest-posttest design with 168 elementary-aged children who were referred for play therapy by teachers or parents. Referrals were based on the adult's report of the child's problems such as poor self-esteem, depression, anxiety, abuse, poor social skills, low school achievement, or behavior problems. The experimental group ($n = 77$) participated in CCPT, while the control group ($n = 91$)

received no intervention. Participants received one play therapy session per week; children received various numbers of sessions, with a mean of four sessions. Using the Coopersmith Self-Esteem Inventory, completed by the child, Post found that participation in CCPT appeared neither to help nor hinder children's self-esteem and locus of control. However, children who did not receive treatment showed a statistically significant decrease in locus of control and self-esteem. Results indicated a statistically significant difference between groups. Post concluded that play therapy may help prevent children identified with low-self esteem and anxiety from worsening over time compared with children who do not receive CCPT.

Baggerly and Jenkins (2009) were interested in the impact of CCPT on developmental factors related to the classroom learning process of homeless children referred for social, emotional, or behavioral difficulties. Thirty-six teacher-referred students between the ages of 5 and 12 years qualified for the study and were able to complete the single group intervention. Children received weekly 45-minute play sessions; the average number of CCPT sessions received was 14. Teachers completed the Boxall Profile which assesses developmental and diagnostic aspects of children with emotional, behavioral, and social difficulties. This instrument is specifically used to measure the effectiveness of interventions in a school setting. Results indicated a statistically significant improvement of internalization of controls and a statistically significant reduction of self-limiting features for children in the CCPT group. Thus, after receiving CCPT, children had an increased ability to respond constructively to others,

accept constraints, accommodate others, become more emotionally secure, and engage with others. The children also demonstrated an increase in self-esteem.

Blanco (2009) investigated the effectiveness of CCPT on the academic achievement, self-concept, and teacher-child relationship stress of first grade students. Forty-one students between the ages of 6 and 7 were eligible to participate in the study based on their academic at-risk status as assigned by the school district and completed the intervention. Students were assigned to the CCPT group ($n = 21$) or the no-treatment control group ($n = 22$). Students in the CCPT assignment received twice weekly 30-minute play sessions for a total of 16 sessions. Assessment instruments were completed on all study participants prior to and following the intervention.

Following receipt of consent from the participants' parents, children and teachers were administered the assessment instruments. The Young Children's Achievement Test (YCAT) and the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter) were administered to each participant and the Student-Teacher Relationship Scale (STRS) was administered to each student's teacher at pre- and posttest. Results indicated a statistically significant improvement for children in the CCPT group over time compared to children who did not receive treatment on the YCAT, with a large effect size (.44). A statistically significant difference was not found for either the children's self-concept as reported on the Harter or the student-teacher relationship as reported on the STRS. Blanco (2009) concluded that CCPT is an effective school-based intervention to assist children in their academic achievement.

In a comprehensive review of play therapy research synthesizing play therapy research studies from 1942 to 2000, Bratton and Ray (2000) found play therapy to be effective in a variety of presenting issues such as social maladjustment, emotional maladjustment, withdrawn behavior, anxiety and fear, conduct disorder, ADHD, maladaptive school behavior, depression, post-traumatic stress disorder, self-concept, and sexual abuse. It was also found to be effective for children from families of divorce, domestic violence, and substance abuse. Bratton and Ray also determined that play therapy is a viable intervention for a range of populations, including Puerto Rican children; African American children; Japanese boys; children with learning difficulties, physical or learning disabilities; children identified as mentally challenged; and children with speech or language problems.

The previous studies all used CCPT or nondirective play therapy as the intervention for the experimental group. CCPT and nondirective play therapy interventions demonstrate a history of successful treatment results with children of varying ages and presenting problems. Although the skills and attitudes of the therapists appeared to be similar among all studies, the duration and length of treatment sessions ranged from 6 to 25 play sessions and 30- to 50-minute play sessions. This indicates that CCPT and nondirective play therapy can successfully be adapted to meet population, setting, or circumstantial variables. Furthermore, CCPT and nondirective play therapy have been shown to be effective in schools as well as clinic-based trials.

To date, one play therapy study which included an Adlerian theory component has been identified. Amplo (1980) conducted his study on the effectiveness of group

play therapy compared to the teacher's implementation of an Adlerian-based teacher study group on children's social maturity and school adjustment. Thirty-three participants between the ages of 5 and 9 were assigned to either the group play therapy ($n = 16$) or the teacher study group ($n = 17$) intervention. Participants attended 8 weeks of their assigned group (group play therapy or Adlerian teacher study group).

The assessment scales used to determine the results of the study included the Vineland Social Maturity Scale (VSMS) and the Child Behavior Rating Scale (CBRS). Results demonstrated no statistically significant difference between groups for children's improved social maturity or school adjustment. However, results did demonstrate an increase on the Willingness to Try New Tasks subscale of the CBRS for children in the group play therapy assignment. Amplo (1980) inferred from the results that neither group play therapy nor the Adlerian teacher study group model are effective in improving children's social maturity or school adjustment. Amplo recommended that future studies investigate longer term group play therapy interventions and other interventions based on Adlerian principals.

In the most recent meta-analysis of play therapy, Bratton et al. (2005) conducted a review of all available play therapy research to that date. To avoid publication biases, their study included published and unpublished research in attempts to create the most accurate and thorough picture of play therapy effectiveness. Ninety-three studies involving a total of 3,248 children were ultimately included in the meta-analysis. Requirements for inclusion included use of controlled research design, sufficient data for computing effect size, play therapy as the intervention, and age of participant.

Bratton et al. (2005) found a large treatment effect (.80) for play therapy interventions across the 93 studies, regardless of approach. However, nondirective approaches showed a larger treatment effect (.92) than directive approaches (.71). Overall, play therapy was shown to be beneficial in a range of presenting issues, including internalizing, externalizing, and total behavior problems, as well as social adjustment, personality, family functioning, and adaptive measures. They also found that studies including teacher and parent involvement showed a stronger treatment effect than interventions without parent or teacher involvement.

In a post hoc analysis, Bratton et al. (2005) separated school-based play therapy research from the total play therapy research. In this analysis, 36 of the 93 play therapy studies were conducted in school settings. Treatment results demonstrated a moderate treatment effect size of .69. While this is smaller than the treatment effect of clinic settings (.81), it is important to note that the average number of sessions in school-based research was 8.4 compared to clinic-based research, with 22.4 sessions. Bratton et al. suggested that the difference in treatment effect might be related to the number of sessions the children received. The findings from this meta-analysis supported play therapy as an effective treatment intervention for children with a variety of presenting issues in a variety of settings, including schools.

More recent studies have attempted to demonstrate the effectiveness of particular theoretical approaches to play therapy. Child-centered play therapists have conducted several research studies which suggest that CCPT is an effective and developmentally appropriate intervention for children. Researchers show CCPT as a viable approach for

children with a variety of presenting issues, including anxiety (Baggerly, 2004; Fall et al., 1999; Fall et al., 2002; Shen, 2002); external locus of control (Post, 1999); intermittent explosive disorder (Paone & Douma, 2009); autism (Josefi & Ryan, 2004); homeless children (Baggerly, 2004; Baggerly & Jenkins, 2009); ADHD (Ray et al., 2007), behavior and emotional difficulties (Fall et al., 1999; Fall et al., 2002; Muro et al., 2006); self-concept (Baggerly, 2004; Fall et al., 1999; Fall et al., 2002) and academic difficulties (Blanco, 2009). Baggerly (2004) suggested that future research explore the effectiveness of various theoretical approaches to play therapy.

Current Status of Play Therapy

A recent push for evidence-based treatment (EBT) currently guides the mental health field. EBTs refer to interventions based on theories that have demonstrated evidence of effectiveness. According to a program of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA, 2009), for a treatment modality to be considered evidence-based, it must be based on scientific evaluation through rigorous research, rather than relying on anecdotal evidence, belief in a program, or tradition. The Task Force on Promotion and Dissemination of Psychological Procedures (American Psychological Association, APA, 1995) published criteria for establishing the efficacy of mental health interventions. Since this publication, the Society of Clinical and Child and Adolescent Psychology and Network on Mental Health (n.d.) has placed greater emphasis on finding EBTs for children. The Association for Play Therapy (APT, 2009) described their active agenda as one of producing rigorous research, as outlined by Nathan and Gorman (2002), designed

to provide support for play therapy as an effective treatment modality for children.

Currently, a treatment modality in the mental health field is considered viable only after the proven effectiveness of the treatment (Ray, Bratton, Rhine, & Jones, 2001).

Play therapy is a well-researched, empirically supported method of working with children within diverse populations, settings, and presenting issues (Bratton & Ray, 2000; Bratton et al., 2005; LeBlanc & Ritchie, 1999). As previous editor of the *International Journal of Play Therapy*, Ray (2004) brought attention to the need for rigorous, empirical research. In order for play therapy to continue to be respected as a viable and effective treatment, play therapists must conduct and publish such research (Baggerly & Bratton, 2010; Frick-Helms & Drewes, 2010; Urquiza, 2010). Manualization is a common practice in therapies which have been considered an EBT. Play therapy treatments often do not have treatment manuals or protocols (Bratton et al., 2005; Ray, 2006). A helpful step in proving the efficacy of play therapy would be to develop treatment protocols and to use those protocols in research. Protocols must then be followed in the treatment design, with adequate measures to assure that the intervention follows the treatment protocol. Protocols provide a means for researchers and practitioners to replicate the treatment method (Baggerly & Bratton, 2010; Chambless et al., 1998; Ray, 2006).

Several suggestions have been offered for future research. Many researchers and practicing professionals in the last decade have suggested that future play therapy research projects (a) be experimental in design with randomized control and experimental groups, (b) use larger sample sizes to increase the ability to generalize findings, and (c) investigate the most efficient and effective ways of delivering the intervention (Baggerly,

2004; Baggerly & Bratton, 2010; Bratton & Ray, 2000; Bratton et al., 2005; Ray, Armstrong, Warren, & Balkin, 2005; U.S. Public Health Service, 2000). Bratton et al. (2005) found, after analyzing 93 play therapy studies, that treatment protocols are rarely used and suggested that future research investigate different theoretical approaches and describe the training and protocols for the intervention being measured. Current literature also suggests that more research should attempt to determine the effectiveness of play therapy in schools (Bratton, 2010; Bratton & Ray, 2000; Ray et al., 2005; Ray et al., 2001).

Conclusion

Many more children are in need of mental health services than are receiving therapeutic interventions. Schools have the means and access to bridge this gap. Teachers have regular contact with children and are often the first to recognize emotional and behavioral impairments of their students. Teachers can refer such children to the school counselors or school-based play therapists who can, in turn, provide the appropriate services. As research has demonstrated, CCPT is an effective intervention for children's emotional and behavioral difficulties. However, no known research has been conducted to investigate the efficacy of Adlerian play therapy.

Adlerian theory is one of the most commonly used theoretical perspectives with which counselors align. Therefore, research is necessary in order to educate these therapists about the effectiveness of Adlerian play therapy with children who have disruptive behaviors in the classroom. Even though counselors and play therapists have the resources to work with children referred to counseling, no known research confirms

or refutes the efficacy of Adlerian play therapy with elementary-aged children with disruptive behaviors.

Moreover, although empirical evidence has demonstrated the effectiveness of CCPT with elementary-aged children, play therapy is still not recognized as an EBT. Therefore, rigorous research that includes a treatment protocol, large sample size, randomized assignment, and a control group needs to be conducted. This type of research will add to the body of literature for identifying EBTs for targeting children who exhibit disruptive behaviors. Furthermore, an AdPT study would create a foundation for demonstrating the effectiveness of AdPT.

CHAPTER 3

METHODS AND PROCEDURES

Using a randomized control group design with 2 treatment conditions (experimental/active control) and 2 points of measurement (pretest/posttest), this study examined the effectiveness of Adlerian play therapy (AdPT) compared with an active control treatment, reading mentoring (RM). Participants were kindergarten through third grade children between the ages of 5 and 9 years, identified by teachers as exhibiting disruptive behaviors in the classroom. AdPT is based on the principles of Adlerian theory which is grounded in the principles of individual psychology (Adler, 1956/1964) and has been adapted to meet the developmental needs of children by Kottman (1987, 2003, 2009). Definition of terms, hypotheses, instrumentation, participant selection, details of treatment, data collection, analysis of data, and suspected limitations to the study are discussed in this chapter.

Definition of Terms

For the purpose of this study the following terms have been operationally defined as indicated below.

- Adlerian play therapy (AdPT)

Defined by Kottman (2003) as:

a process in which the counselor (a) builds an egalitarian relationship with the child; (b) explores the child's life style...; (c) helps the child gain insight and make new decisions about self, the world, and others; (d) teaches the child new

skills for relating to others; (e) helps the child practice new skills for interacting with others; and (f) consults with parents and teachers. (p. xi)

- Disruptive behavior problems

Disruptive behaviors are outward manifestations of an inner conflict, including rule breaking behaviors, aggressive behaviors, conduct problems, oppositional behaviors, inattention, hyperactivity, immaturity, and attention seeking (Achenbach & Rescorla, 2001; McConaughy & Achenbach, 2009). For the purposes of this study, disruptive behavior in the classroom was of specific interest and was operationally defined by (a) the Externalizing Problems scale score of the Caregiver-Teacher Report Form (CTRF) as reported by teachers (Achenbach & Rescorla, 2001), and (b) the Total problems and On-task/Off-task scale scores on the Direct Observation Form (DOF) as rated by independent observers (McConaughy & Achenbach, 2009).

- Reading mentoring (RM)

For the purpose of this study, reading mentoring is defined as a relationship between an adult trained in reading mentoring and a child assigned to the reading mentoring control group. Mentors were college students who had interest in working with children. The primary task within this relationship is to spend time together and read children's books. Books ranged in topics and were not specifically selected for particular children or problems.

- Teacher-child relationship stress

Teacher-child relationship stress is the stress a teacher experiences in his or her relationship with a particular student. Relationship stress components include the teacher's perception of (a) the impact of a student's behavior on the teacher's self

perception; (b) the teacher's teaching ability; and (c) the quality of support from other adults in the particular child's life (Abidin, Greene, & Konold, 2004). For the purposes of this study, teacher-child relationship stress was operationally defined by the Total Stress score on the Index of Teaching Stress (ITS) (Abidin, Green, & Konold, 2004).

Research Hypotheses

For the purpose of this study, the following research hypotheses were formulated to investigate the effects of the experimental treatment, (AdPT) on kindergarten-third graders identified with disruptive behaviors in the classroom, when compared to the active control treatment (RM).

1. Children in the experimental treatment group will demonstrate a statistically significant decrease in pre- to post-test mean scores on the CTRF Externalizing Problems scale compared to students in the active control group, as reported by teachers.
2. Children in the experimental group will demonstrate a statistically significant decrease in pre- to post-test mean scores on the DOF Total Behaviors scale compared to students in the active control group, as reported by independent raters blinded to the study.
3. Children in the experimental group will demonstrate a statistically significant increase in pre- to post-test mean scores on the DOF On-task scale compared to students in the reading mentoring active control group, as reported by independent raters blinded to the study.
4. Experimental group teachers will report a statistically significant decrease in teacher-child relationship stress as measured by pre- to post-test mean scores on the ITS Total Stress scale, when compared to the active control group teachers' scores.

Instrumentation

- Teacher Report Form

The Caregiver-Teacher Report Form (C-TRF; Achenbach & Rescorla, 2001) is a teacher report instrument used to assess children's academic performance, adaptive functioning and behavioral/emotional functioning. The C-TRF has two forms: one for children between the ages of 1.5 and 5 and another form for youth between the ages of 6 and 18 years. The self-administered checklist takes approximately 20 minutes to complete. It was designed to record, in a standardized format, behavioral symptoms of children that parents perceive as competencies or limitations. The instrument requires teachers to rate a student's academic performance and behavior compared to classmates on a 118 problem item form. The student's behavior is rated on a three-point scale of 0-2 indicating: "not true (0)," "sometimes true (1)," or "very true (2)."

The C-TRF provides adaptive scores, problems scores, and *DSM*-oriented scores. The C-TRF syndrome profiles are computed and based upon teacher reports of nonreferred samples. The normed sample of C-TRF was based on teachers' reports of 976 nonreferred children aged 6 to 18. The C-TRF provides two broad scores: internalizing behavior and externalizing behavior. The specific scores that fall within the Internalizing domain are: Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints. Conversely, the externalizing syndrome score "represents conflicts with other people and with their expectations for children's behavior" (Achenbach & Rescorla, 2001, p. 93). The specific subscales that fall within the Externalizing domain are: Rule Breaking Behavior and Aggressive Behavior. Achenbach and Rescorla (2001) found that

three remaining syndrome scores have loadings on both internalizing and externalizing domains: Social Problems, Thought Problems, and Attention Problems, which includes Inattention and Hyperactivity/Impulsivity.

Achenbach and Rescorla (2001) reported adequate internal consistency for the C-TRF: an alpha of .90 for the Total Adaptive scale; for the problem scales, alphas of .72 to .95; and for the DSM-oriented scales, alphas ranging from .73 to .94. The test-retest reliability for the C-TRF was high, and scaled scores were stable. The content, criterion-related, and construct validity of the C-TRF is strongly supported.

- Direct Observation Form

The Direct Observation Form (DOF) is an instrument used to assess student's behavior during a 10-minute segment of time using standardized observations (McConaughy & Achenbach, 2009). A trained examiner observes an identified child within a natural setting such as classroom, group, lunch, or recess. In one minute intervals, the observer tracks on-task and off-task behavior and writes a description of the child's behavior. Immediately following the observation, the observer completes an 89 item problem checklist, ranking the witnessed behavior on a scale of 0 (behavior not observed) to 3 (definite occurrence with severe intensity or occurrence lasting more than 3 minutes in duration). DOF procedures require a minimum of 2 observations and a maximum of 6 observations within an observation set to obtain a single score on an individual child. The DOF scoring software allows for computation of a child's average scores.

The DOF provides scores in Total Problems scale, On-task scale, and six syndrome subscales: withdrawn/inattentive, nervous/obsessive, depressed, hyperactive, attention/demanding, and aggressive. The 2009 version of the DOF was developed using a sample of 649 children between the ages of 6 – 11 years who were clinically referred for evaluations based on their emotional, behavioral, or learning difficulties (McConaughy & Achenbach, 2009). The DOF was normed from a sample of 661 children from 4 different states (Arizona, New York, Pennsylvania, and Vermont) to represent a broad range of United States' geography.

The mean inter-rater reliability for classroom observations was calculated .88 for the Total Problems score and .97 for On-task/Off-task score. McConaughy and Achenbach (2009) also reported that validity of the DOF was evaluated and established. Furthermore, the DOF was designed to be used separately or in combination with the Child Behavior Checklist (CBCL) and/or C-TRF (Achenbach & Rescorla, 2001; McConaughy & Achenbach, 2009).

- Index of Teacher Stress

The Index of Teaching Stress (ITS; Abidin, Greene, & Konold, 2004) is a 90-item teacher-report assessment designed to measure a teacher's level of stress in response to a specific student. The ITS was developed for use with teachers of students in grades preschool through 12th grade. Teachers rate specific behaviors of an individual student on the 90-item assessment form on a scale of 1 (*never stressful or frustrating*) to 5 (*very often stressful or frustrating*). These items translate to scores on three global scales: Attention-Deficit/Hyperactivity Disorder, Student Characteristics, and Teacher

Characteristics. The Attention-Deficit/Hyperactivity Disorder scale measures the amount of stress the teacher perceives to be related to the specific student's inattentive and hyperactive behavior. The Student Characteristics domain measures the overall degree of stress the teacher experiences as a result of the identified student's behaviors and temperament. The Teacher Characteristics domain measures the amount of self-perceived distress and expectations the teacher has in relation to the student. These three global scale scores generate a Total Stress score.

The ITS was normed with 814 teachers who were randomly assigned to a student who scored in the clinical range for Aggressive Behavior and Rule-Breaking Behavior subscales within the Externalizing domain on the CBCL. The students that were a part of this normative sample ranged in age from 5 to 18 years and resided in one of six states primarily in the northeast and southern United States. Validity for the ITS was established through several methods. Abidin, Greene, and Konold (2004) found that the ITS had a moderate amount of correlation with the C-TRF (between .73 and .83). The reliability of the ITS was established through test-retest and internal consistency measures. Abidin, Greene, and Konold (2004) reported the ITS demonstrates a high degree of internal consistency due to the alpha coefficients for the domain scores and the total stress score meeting or exceeding .90. Test-retest reliability was determined through the examination of the results of the ITS on two occasions one month apart. The results suggested that the coefficients are relatively stable, with coefficients ranging from .57 to .70.

Participants

Human subjects approval was obtained from the University of North Texas Internal Review Board (IRB) prior to participant recruitment. Confidentiality of data was maintained by the researcher by coding all instruments, notes, and recordings in order to protect subjects' identity and privacy. Ethical research responsibilities included in the American Counseling Association Code of Ethics (2005), Section G, were followed including informed consent, confidentiality, and reporting results. No participant was excluded from the study based on race, ethnicity, gender, religious beliefs, or social class.

I gained approval from the administration of 5 Title 1 elementary schools from a school district located in the southwest region of the United States. Title 1 schools are identified by the state for school-wide assistance due to a high percentage of their population labeled as economically disadvantaged; 40% of the student body must qualify for free or reduced lunch in order to meet the Title 1 designation. School 1 listed 80% of its populations as economically disadvantaged; School 2 listed 65.9% as economically disadvantaged; School 3 listed 76.4% as economically disadvantaged; School 4 listed 64.6% as economically disadvantaged; and School 5 listed 81.5% of their student population as being economically disadvantaged. The ethnicity breakdown for each of the five schools is as follows: School 1 – African American (11.8%), Hispanic (61.25%), Asian/Pacific (2.45%), American Indian (1.11%), White (23.39%); School 2 – African American (5.6%), Hispanic (49.6%), Asian/Pacific (1.2%), American Indian (0.3%), White (43.3%); School 3 – African American (13.9%), Hispanic (60.8%), Asian/Pacific (0.5%), American Indian (0.3%), White (24.5%); School 4 – African American (7.1%),

Hispanic (49.2%), Asian/Pacific (1.8%), American Indian (0.4%), White (41.5%); School 5 – African American (16.8%), Hispanic (62.2%), Asian/Pacific (0.9%), American Indian (0.3%), White (19.9%).

Prior to the start of the school year, meetings were held with school staff to explain the purpose of the study, along with procedures for participant recruitment and data collection. Upon receiving IRB approval and permission from the school district, kindergarten, first, second, and third grade teachers were asked to identify children who exhibited disruptive behaviors such as rule breaking, conduct problems, oppositional behaviors, yelling, attention seeking, immaturity, hyperactive behavior, swearing, aggression, fighting, or crying. After participants were referred for the study, consent forms were sent home with identified students. School counselors identified students' families who would need an English version (Appendix A) or a Spanish version of the consent form (Appendix B). Following the researcher's receipt of participant consent, pretest data was collected. In order to qualify children to the study, teachers were administered the C-TRF and participants were observed by trained observers according to the DOF manual. Children who met the following criteria qualified for the study.

1. Child was enrolled in kindergarten, first, second or third grade at participating elementary schools.
2. Child was not labeled with significant cognitive delay as determined by special classroom placement.
3. Child was referred for disruptive behavior by classroom teacher.

4. Teacher agreed to participate in the study by completing the C-TRF and the ITS.
5. Parent consented for child to participate in study.
6. Child assented to participate in study.
7. Child scored in the borderline or clinical range on at least one of the following as an indicator of target behavior (disruptive behaviors in the classroom): the DOF Total Behaviors scale, the C-TRF Externalizing Problems scale, or on one of the following C-TRF subscales: Attention Problems, Rule Breaking, Aggressive Behavior, ADHD, Oppositional Defiant Problems, or Conduct Problems.

Sixty-seven students qualified for the study and were randomly assigned to the experimental (AdPT) and active control (RM) conditions. Initially, 32 were assigned to Adlerian play therapy (AdPT) and 35 were assigned to reading mentoring (RM). Due to attrition, 58 students completed the study, 27 in AdPT and 31 in RM. Over the course of the study, 9 students were removed: 5 children moved schools, AdPT, $n = 3$, RM, $n = 2$; 2 children were excluded due to excessive absenteeism resulting in less than 4 play therapy or reading mentoring sessions, AdPT, $n = 1$, RM, $n = 1$; and 2 children were removed from the study due to being placed in an alternative behavioral school AdPT, $n = 1$, RM, $n = 1$.

Ethnicity among the participants was represented as 48% Hispanic, 19% African American, and 33% White/Caucasian. Participants were 33% kindergarten, 31% first, 21% second, and 15% third grade students. Male students represented 79% of the

participants, and female students represented 21% of the participants who completed the study. Age distribution among participants at the beginning of the study was as follows: 24% 5-year-olds; 31% 6-year-olds; 29% 7-year-olds; 12% 8-year-olds; and 3% 9-year-olds.

Table 1 summarizes demographic information of participants.

Table 1

Demographic Information for Participants in Experimental (n = 27) and Active Control (n = 31) Groups

| | | Experimental Group | Control Group |
|-----------|------------------|--------------------|---------------|
| Gender | Male | 22 | 24 |
| | Female | 5 | 7 |
| Grade | K | 8 | 11 |
| | 1 | 10 | 8 |
| | 2 | 5 | 7 |
| | 3 | 4 | 5 |
| Age | 5 | 7 | 7 |
| | 6 | 10 | 8 |
| | 7 | 6 | 11 |
| | 8 | 3 | 4 |
| | 9 | 1 | 1 |
| Ethnicity | Hispanic | 13 | 15 |
| | African American | 4 | 7 |
| | White/Caucasian | 10 | 9 |

Participants were randomly assigned by school site to AdPT or RM through the use of a randomization table. Stratified random assignment was used to control for site-specific variables. Due to differences between schools, such as discipline management

practices, school climate, frequency of guidance lessons, etc., stratified randomization was used to maintain equality amongst each group.

Treatment

Experimental Group (AdPT)

Students in the experimental group ($n = 27$) received AdPT for 30 minute sessions, twice a week for 14 to 17 sessions over an average of 14 weeks. Due to holiday breaks, teacher in-service training days, and cancelled school days because of weather, 3.5 weeks of the school schedule were unavailable for play sessions throughout the intervention period. The mean number of play sessions was 15.6; the mode number of play sessions was 16. The number of sessions varied based on student absences due to illness, field trips, school dismissals, or academic testing. Bratton, Ray, Rhine, and Jones (2005) found through a meta-analysis of play therapy research that play therapy revealed medium to large treatment effects with as few as 14 sessions. Furthermore, to accommodate the academic schedule it was determined that intensive sessions, twice each week for 30 minute sessions, seemed appropriate for school-based play therapy compared to the typical weekly sessions for 50 minute periods of time (Landreth, Ray, & Bratton, 2009).

Counselors in the AdPT treatment group were master's level counselors with additional doctoral level training in play therapy. Counselors had successfully completed a master's degree in counseling, a minimum of 2 graduate level courses in play therapy, as well as had prior training, experience and supervision in the use of Adlerian theory in counseling and in the AdPT intervention. Additionally, all AdPT treatment providers

participated in a twenty-four hour training of the AdPT protocol by developer, Dr. Terry Kottman, prior to the working with participants of this study. All AdPT treatment providers were female. Of the 8 treatment providers, 5 identified as White/Caucasian; 2 identified as multiracial; and 1 identified as Latina/Hispanic. The age distribution of AdPT counselors was as follows: 24-26 year-olds, $n = 2$; 27-29 year-olds, $n = 3$; 30-32 year-olds, $n = 3$. Table 2 summarizes demographic information of AdPT treatment providers.

AdPT protocol. For the purposes of this study, AdPT principles and procedures were followed as outlined by Kottman (2009), the developer of the AdPT protocol. ADPT treatment providers participated in protocol training with Dr. Kottman over three consecutive eight hour days in which lecture, discussion, experiential activities, video demonstration, and micro-practicum experiences with supervision were used to ensure that counselors were able to demonstrate AdPT skills prior to beginning treatment.

AdPT trainees practiced AdPT skills in a video recorded and supervised session with a child from a campus-clinic child care facility; all child participants had informed consent and permission from a parent or guardian as well as permission from the childcare staff. Trainees participated in group supervision, facilitated by Dr. Kottman, for a minimum of 8, 30-minute supervision sessions, which were scheduled into the three day training. Dr. Kottman taught the principles of AdPT as well as techniques and skills used in AdPT. The principles of AdPT describe persons as: (a) socially embedded, (b) goal directed, (c) subjective, and (d) creative. They must be understood from a holistic point of view. Adlerian play therapists use these principles to conceptualize their clients.

The visual attitude of Adlerian play therapists include: (a) actively involved, (b) interested, (c) relaxed and comfortable. The tone and affect of the therapist must match the child's affect, and the therapists' responses must be congruent with therapists' tone and affect.

In the AdPT treatment manual, Kottman (2009) reported that within each phase of AdPT, play therapists use some techniques with every child and other techniques with selective children depending on the unique needs of the children. Consistent throughout all phases of therapy are the following skills: (a) tracking behavior, (b) restating content, (c) reflecting feelings, (d) encouraging, (e) asking questions, (f) metacommunicating, and (g) giving explanations and answering questions. With selected children in the playroom, Adlerian play therapists may (a) return responsibility to the child, (b) use the child's metaphor, (c) interact actively with the child, (d) clean the playroom with the child, and (e) set limits with the child.

During the first phase of AdPT, building an egalitarian relationship, the therapist meets the child and asks the child what he or she has been told about coming to play therapy. The Adlerian play therapist may also demystify the play therapy process for the child by explaining to the child what he or she can expect in play therapy. In the second phase of AdPT, exploring the child's lifestyle, the therapist uses free play, questioning strategies, art techniques, metaphoric and storytelling techniques, or sand tray play therapy techniques to (a) explore the child's functioning at life tasks, (b) explore the family atmosphere, (c) explore family constellation, (d) examine goals of misbehavior or purposes of behavior, (e) explore Crucial Cs, (f) explore personality priorities, and (g)

explore lifestyle convictions, mistaken beliefs, and private logic. With selected children, an Adlerian play therapist may solicit the child's early recollections. During the third phase of AdPT, helping the child gain insight, an Adlerian play therapist metacommunicates about (a) a single event, behavior, or interaction, (b) the meaning of a specific event, behavior, or interaction, (c) a pattern within a session, (d) a pattern across sessions, (e) a pattern in the playroom that extends to other situations or relationships outside the playroom, and (f) a lifestyle theme or conviction, mistaken beliefs, or private logic. Adlerian play therapists will also "spit in the client's soup," pointing out to the child the ways in which his or her behavior interferes with his or her goals, about mistaken beliefs, private logic, or self-defeating behaviors; they may also use a metaphor or art technique to help a child gain insight. In addition to the consistent skills and techniques used in each of the previous stages, within the fourth phase of AdPT, the therapist may also "spit in the child's soup" or use a metaphoric technique to help the child move toward more constructive patterns of thinking, feeling, and behaving. Adlerian play therapists in Phase 4 will use brainstorming, discussion, storytelling, metaphoric and art techniques, puppet play, didactic teaching, modeling, and/or role play with the child as well as provide homework assignments for the child to help generate ideas for: (a) capitalizing on his or her assets, (b) improving functioning in one of the life tasks, (c) improving on the Crucial Cs, (d) moving toward healthier functioning in personality priorities, (e) shifting to more positive goals of behavior, (f) shifting from mistaken beliefs to common sense perceptions of him or herself, others and the world, (g) reducing self-defeating behaviors, and (h) increasing social skills such as assertiveness,

communication skills, negotiating skills, and assuming appropriate responsibility for behaviors (Kottman, 2009).

Treatment fidelity. Several procedures were employed to ensure treatment fidelity. First, as described above, counselors participated in intensive training in the use of the AdPT protocol from the developer of the AdPT treatment manual. Dr. Kottman provided an additional two hour in-person group training/supervision session the week prior to the start of the intervention due to the two month period of time from AdPT training until the start of the intervention. Additional procedures designed to enhance adherence to the protocol included video recording all intervention sessions and on-going weekly supervision. Counselors submitted session videos weekly to the principal investigator. Upon receipt of the videos, each recording was de-identified and coded to ensure participant confidentiality. Using randomization procedures, random video observation was completed by Dr. Kottman. Kottman viewed 10% of all sessions over the course of the intervention and used the AdPT Skills Checklist (Kottman, 2009) to ensure therapist adherence to the treatment protocol. Counselors in the AdPT treatment group also participated in either weekly 1 hour triadic or peer supervision to ensure quality of care for children. Weekly supervision was facilitated by a doctoral level counselor familiar with Adlerian theory and play therapy with a ratio of 1 supervisor to 1 or 2 counselors. Peer supervision was conducted amongst advanced doctoral level counselors familiar with Adlerian theory and play therapy. Throughout the course of the intervention, 10, one-hour phone supervision sessions via conference call led by Dr. Kottman were available for AdPTs to participate. All counselors participated in a

minimum of three supervision sessions. In addition to weekly supervision sessions, over the course of the study, AdPT counselors were required to review at least one of their recorded weekly sessions and compare their in-session responses to the AdPT Skills Checklist (Appendix C).

Active Control Group (RM)

Students randomly assigned to reading mentoring, the active control group ($n = 31$), participated in RM for the same amount of time as students in the experimental group; children received 14 to 17, 30-minute sessions, twice each week, over the course of 14 weeks. Due to holiday breaks, teacher in-service training days, and cancelled school days because of weather, 3.5 weeks of the school schedule were unavailable for reading mentoring sessions throughout the intervention period. The mean number of reading mentoring sessions was 15.3; the mode number of reading mentoring sessions was 16. Mentors were undergraduate college students trained according to the reading mentoring protocol (Appendix D). Despite research evidence that suggests that mentoring can have a beneficial effect on children's aggressive behavior (Cavell, Elledge, Malcolm, Faith, & Hughes, 2009), the reading mentoring intervention was designed as an active control condition to control for time and attention received by students, rather than a comparison treatment. All RM treatment providers were female. Of the 10 treatment providers 1 identified as Hispanic/Latina; 6 identified as White/Caucasian; 2 identified as African American; and 1 identified as multiracial. The age distribution of RMs was as follows: 18-20 year-olds, $n = 3$; 21-23 year-olds, $n = 6$;

24-26 year-olds, $n = 1$. Table 2 summarizes demographic data for AdPT and RM treatment providers.

Reading mentoring protocol. Reading mentors were trained by an advanced doctoral research assistant who had completed five doctoral level courses in research. Furthermore, the research assistant had prior experience with reading mentoring programs in the school setting. Mentors were trained in the logistics of working with children in elementary schools, how to get the child from and return the child to his or her classroom, and what skills to use during the reading mentoring sessions (Appendix D).

Treatment fidelity. Reading mentoring sessions were audio recorded. The recordings were submitted to the principal investigator who then de-identified the tapes. Ten percent of all audio recordings were reviewed by the research assistant who was responsible for training the reading mentors. The audio recordings were reviewed to ensure reading mentors were following the reading mentoring protocol.

Table 2

Demographic Information for Adlerian Play Therapist Treatment Providers (n = 8) and Reading Mentoring (n = 10) Treatment Providers

| | | Experimental Group | Control Group |
|-----------|-------------------|--------------------|---------------|
| Gender | Male | 0 | 0 |
| | Female | 8 | 10 |
| Age | 18-20 | 0 | 3 |
| | 21-23 | 0 | 6 |
| | 24-26 | 2 | 1 |
| | 27-29 | 3 | 0 |
| | 30-32 | 3 | 0 |
| Ethnicity | Latina/Hispanic | 1 | 1 |
| | African American | 0 | 2 |
| | Multiracial | 2 | 1 |
| | European American | 5 | 6 |

Data Collection

The C-TRF, DOF, and ITS were administered immediately preceding and following the treatment period. Participants' data were coded in order to maintain confidentiality and decrease the likelihood of researcher bias. The integrity of data collection was ensured by monitoring the collection of data. All data was collected at the school sites by research assistants (who were blinded to the study). Teachers were offered assistance in the classroom in order to provide them with an environment free from distraction while they completed the C-TRF and the ITS.

The DOF, a direct observation measure of children's behavior, was conducted to obtain the least-biased, objective observable data. To obtain DOF data, 3 independent

raters who were graduate-level counseling students experienced with children, received training and practice in the use of the DOF until they reached an acceptable level of inter-rater reliability (82% agreement). Raters completed 5 practice cases of randomly selected students in a participating elementary school. The inter-rater reliability following the first round of observations fell short of the 80% benchmark, thus raters met to discuss their discrepancies in order to develop a higher level of consistency in their ratings. An additional 5 practice cases were completed. The inter-rater reliability of the second round of observations was calculated with the Spearman-Brown correction at 82%.

DOF raters were assigned study participants to observe for 10 minute intervals for three observational periods at different times of the day and week to obtain a single score. The goal of observing the child in a variety of school environments is to gather the most accurate account of student behavior. Consistent with the DOF manual (McConaughy & Achenbach, 2009), observations were completed over 2 days within a 4 day time period, with at least 1 observation done in the morning and 1 in the afternoon. The blinded raters observed each participant 3 times at pretest, and 3 times, again, at posttest. The computerized scoring requires a minimum of 2 observations and a maximum of 6 observations to create a single score. Therefore, each participant received a single pre-test assessment and a single post-test assessment. Because the purpose of this study was to examine treatment effects on children's classroom behavior, all observations were completed during academic situations in the class room. Pre-test observations were completed within 2 weeks of beginning the treatment and post-test observations were

completed within 1 week of completion of the treatment. Four children moved prior to completing all post-test observations, hence DOF data was available for 54 of the 58 participants. Teachers, of the children who moved, completed the C-TRF and ITS within one week of the child ending his or her last session. Neither DOF raters nor teachers who completed the C-TRF and ITS were aware of children's treatment group assignment.

Data Analysis

Results obtained from pretest and posttest data were analyzed in order to examine the effects of the AdPT intervention on children's disruptive behavior in the classroom compared to the active control condition, RM. To ensure accuracy the C-TRF and DOF assessments were scored using the assessment scoring computer software which required all data to be entered twice. The ITS was hand scored and double checked to ensure accuracy. Furthermore, data scoring and computing was administered by a research assistant other than the principal investigator to improve treatment fidelity.

For each dependent variable (C-TRF Externalizing Problems, DOF Total Behaviors, DOF On-task, and ITS Total Score), a 2 (group) by 2 (repeated measures) split plot ANOVA was performed in SPSS to analyze group differences, changes across times, and the possible interaction effect of group membership with change across time, which was of particular interest in this study. Prior to conducting analysis, dependent variables were inspected to screen data for normality and homogeneity of variance/covariance matrices. Assumptions for performing repeated measures ANOVA were met. According to Brown, Costigan, and Kendziora (2008), a repeated measures ANOVA model is one of the most effective frameworks to evaluate intervention impact,

allowing for the inclusion of random effects that can account for variation of results attributable to group assignment. Initial power analysis revealed that approximately sixty participants (30 per cell) yielded appropriate power for analysis. Fifty-eight participants completed the study, approximating the target sample of 60 children.

Statistical significance of findings were interpreted at an alpha level of .05 (Thompson, 2002). Partial eta squared effect sizes (η_p^2) were calculated to assess the magnitude of difference between the two groups over time due to treatment and to better understand the practical significance of the study (Kazdin, 1999). In the absence of existing research on the specific intervention studied, and consistent with the body of current play therapy research, Cohen's (1988) guidelines were used to interpret η_p^2 effect size: .01= small, .06= medium, and .14 = large. The number and percentage of participants who moved from clinical or borderline levels of disruptive behaviors to normal functioning are reported as an indicator of the clinical significance of this intervention on the lives of participants (Kazdin, 2003).

CHAPTER 4

RESULTS

This chapter includes the results of this study. Results of data analysis are presented in the order in which the hypotheses were tested.

For each dependent variable (Caregiver-Teacher Report Form (C-TRF) Externalizing Problems, Direct Observation Form (DOF) Total Score, DOF On-task, and Index of Teacher Stress (ITS) Total Score), a 2 (group) by 2 (repeated measures) split plot ANOVA was performed in SPSS to analyze group differences, changes across times, and the possible interaction effect of group membership with change across time, which was of particular interest in this study. Prior to conducting the analysis, dependent variables were inspected to screen data for normality and homogeneity of variance/covariance matrices. Assumptions for performing repeated measures ANOVA were met.

The C-TRF, ITS and DOF were administered prior to treatment and at the end of treatment. A reduction in scores on the C-TRF and ITS scales indicated improvement in the targeted behavior. A reduction in scores on Total Behavior scale on the DOF indicated an improvement in the targeted behavior, and an increase in scores on the On-task scale on the DOF indicated an improvement in the targeted behavior. Pallai's Trace was utilized to interpret results. Partial eta squared effect sizes (η_p^2) were calculated to assess the magnitude of difference between the two groups over time due to treatment

and to better understand the practical significance of the study (Kazdin, 1999). In the absence of existing research on the specific intervention studied, and consistent with the body of current play therapy research, Cohen's (1988) guidelines were used to interpret η_p^2 effect size: .01 = small, .06 = medium, and .14 = large.

Hypothesis 1

Students in the experimental treatment group will demonstrate a statistically significant decrease in scores on the Externalizing Problems subscale as compared to students in the active control group over time, as reported by teachers on the C-TRF. Table 3 presents the pre-test and post-test means and standard deviations for the experimental ($n = 27$) and control group ($n = 31$) on the Externalizing Problems scale of the C-TRF.

Table 3

Mean Scores on the Externalizing Problems Scales on the Caregiver-Teacher Report Form (C-TRF)

| | <i>Experimental Group n = 27</i> | | <i>Control Group n = 31</i> | |
|------------------------|----------------------------------|----------|-----------------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Externalizing Problems | | | | |
| Mean | 65.67 | 64.22 | 66.00 | 67.55 |
| SD | 5.421 | 5.833 | 7.394 | 8.656 |

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis indicated that the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pre-test, post-test) x group membership (experimental, active control); Pillai's Trace = .081, $F(1, 56) = 4.923$, $p <$

.031, $\eta_p^2 = .081$. These results indicate that according to teacher report, students who participated in the experimental group (AdPT) showed a statistically significant decrease in participants' externalizing problems from pre-test to post-test, when compared to students who were in the active control group (RM). On the basis of these results, Hypothesis 1 is retained. Results further indicate that the effects of Adlerian play therapy compared to RM was moderate ($\eta_p^2 = .081$).

Hypothesis 2

Students in the experimental group will demonstrate a statistically significant decrease in scores on Total Behaviors when compared to students in the reading mentoring active control group on the DOF as reported by independent raters blinded to the study. Table 4 presents the pre-test and post-test means and standard deviations for the experimental ($n = 26$) and control group ($n = 28$) on the Total Behavior scale of the DOF.

Table 4

Mean Scores on the Total Behavior Scale on the Direct Observation Form (DOF)

| | <i>Experimental Group n = 26</i> | | <i>Control Group n = 28</i> | |
|-----------------------|----------------------------------|----------|-----------------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Externalized Behavior | | | | |
| Mean | 74 | 58.04 | 71.96 | 67.25 |
| SD | 11.658 | 7.507 | 11.714 | 10.585 |

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis of the dependent variable, Total Behaviors scale, revealed a statistically significant interaction effect of time (pre-test, post-test) x group membership

(experimental, active control); Pillai's Trace = .236, $F(1, 52) = 16.087$; $p < .001$, $\eta_p^2 = .236$. These results indicate that students who participated in the experimental group reported a statistically significant decrease in observable externalizing behavior from pre-test to post-test, when compared to students who were in the active control group. On the basis of these results, Hypothesis 2 is retained. Results further indicate that the AdPT demonstrated a large treatment effect ($\eta_p^2 = .236$) on students' total behaviors when compared to the RM group.

Hypothesis 3

Students in the experimental group will demonstrate a statistically significant increase in scores in On-task behaviors when compared to students in the reading mentoring active control group on the DOF as reported by independent observers blinded to the study. Table 5 presents the pretest and posttest means and standard deviations for the experimental ($n = 26$) and control group ($n = 28$) on the On-task scale of the DOF.

Table 5

Mean Scores on the On-task Behavior Scale on the Direct Observation Form (DOF)

| | <i>Experimental Group n = 26</i> | | <i>Control Group n = 28</i> | |
|---------|----------------------------------|----------|-----------------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| On-Task | | | | |
| Mean | 33.08 | 40.15 | 33.79 | 33.21 |
| SD | 5.706 | 6.272 | 7.161 | 7.445 |

Note: An increase in mean scores indicates an improvement in behavior

Results of analysis of the dependent variable, On-task Behaviors, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental, active control); Pillai's Trace = .188, $F(1, 52) = 12.059$, $p < .001$, $\eta_p^2 = .188$. These results indicate that students who participated in the experimental group reported a statistically significant increase in on-task behavior from pre-test to post-test, when compared to students who were in the active control group. On the basis of these results, Hypothesis 3 is retained. Results further indicate that the AdPT demonstrated a large treatment effect ($\eta_p^2 = .188$) on the On-task scale when compared to the RM group.

Hypothesis 4

Experimental group teachers will report a statistically significant decrease in teacher-child relationship stress as measured by ITS Total Stress, when compared to active control group teachers' scores. Table 6 presents the pre-test and post-test means and standard deviations for the experimental ($n = 27$) and control group ($n = 31$) on the Total Stress scale of the ITS.

Table 6

Mean Scores on the Total Stress Scale on the Index of Teacher Stress (ITS)

| | <i>Experimental Group n = 27</i> | | <i>Control Group n = 31</i> | |
|--------------|----------------------------------|----------|-----------------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Total Stress | | | | |
| Mean | 207.30 | 188.26 | 199.68 | 208.13 |
| SD | 53.075 | 53.511 | 58.199 | 70.037 |

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis indicated that the dependent variable, Total Stress, revealed a statistically significant interaction effect of time (pre-test, post-test) x group membership (experimental, active control); Pillai's Trace = .076, $F(1, 56) = 4.606$, $p < .036$, $\eta_p^2 = .076$. These results indicate that teachers of referred students who received AdPT reported a statistically significant decrease in stress in the teacher-child relationship from pre-test to post-test, when compared to the RM group. On the basis of these results, Hypothesis 4 is retained. Results further indicate that the AdPT demonstrated a moderate treatment effect ($\eta_p^2 = .076$) on teacher-child relationship stress when compared to the RM group.

Clinical Significance

According to Kazdin (2003), clinical significance refers to the benefit the treatment offers to the client in real life. To better understand if the AdPT intervention positively impacted children's disruptive behavior in the classroom, individual children's pre- and post-test scores on the Total Problems and On-task scales of the DOF were examined. Experts in clinical assessment have discussed the advantages of measurements that use direct observations conducted by independent assessors

(McConaughy & Achenbach, 2009; Sattler & Hoge, 2006; Shapiro & Heick, 2004; Volpe, DiPerna, Hintze, & Shapiro, 2005). Volpe et al. proposed that systematic direct observations such as the DOF provide an unbiased measure of participant characteristics due to their objectivity and face validity. Specifically, clinical significance was assessed by determining the number of experimental children who moved from clinical/borderline levels of concern at pre-test into a more normative range of functioning following treatment.

Total Behavior Outcomes

Children's *t*-scores on the Total Behaviors scale of the DOF were analyzed to determine the clinical significance of AdPT on students' behavior. Total Behaviors *t*-scores above 64 are considered in the clinical range, *t*-scores between 60 and 63 are considered in the borderline range, and *t*-scores below 60 are considered in the normal range.

An examination of data revealed that a total of 22 of the 26 treatment group children demonstrated clinical or borderline levels of concern for behavior problems at pre-test. The total sample size of this study was 27; one student moved prior the completion of the total observations required to complete an observation set. Therefore, the DOF sample size consists of 26 children. Of the 21 children who presented in the clinical range, 11 improved to normal levels after treatment, 4 moved to borderline levels, and 6 children stayed in the clinical range, but showed an average of an 8.8 point decrease. The one child who scored in the borderline range prior to the intervention was functioning in the normal range by the end of treatment. Thus, of the 22 children

demonstrating clinical or borderline levels of externalizing problems prior to treatment, 16 (72.7%) moved into a more normative range of functioning after their participation in AdPT. The findings on this assessment demonstrate the clinical significance of the AdPT intervention on observed problem behaviors of children identified by teachers as displaying disruptive behaviors in the classroom, as rated by independent evaluators, blinded to the study.

On-task Behavior Outcomes

To determine clinical significance, children's *t*-scores on the On-task scale of the DOF were analyzed to assess if functioning was improved from pre-test to post-test. An increase in scores indicates an improvement in targeted behaviors. *t*-scores below or equal to 31 are considered in the clinical range, *t*-scores between 35 and 32 are considered in the borderline range, and *t*-scores 36 or above are considered in the normal range.

A total of 18 of the 26 treatment group children demonstrated clinical or borderline levels of concern for on-task behaviors at pre-test. Of the 10 who presented in the clinical range, 5 improved to normal levels after treatment, 1 moved to the borderline range, and 4 remained in the clinical range, but showed an overall 4 point improvement in on-task behaviors. Of the additional 8 children who scored in the borderline range prior to the intervention, 7 were functioning in the normal range at the end of treatment, and 1 remained in the borderline range with no change in score. Overall, 12 of the 18 children (66.7%) demonstrating clinical or borderline levels of on-task behaviors prior to treatment moved into the normal range of functioning after their participation in AdPT.

These findings demonstrate the clinical significance of the Adlerian play therapy intervention on on-task behaviors of children who have been identified by teachers as having disruptive behavior in the classroom.

CHAPTER 5

DISCUSSION

In this randomized controlled study, the effect of Adlerian play therapy (AdPT) on disruptive classroom behavior was examined. Specifically, this school-based study investigated the outcome of the AdPT intervention on children's disruptive behaviors in the classroom and on stress in the teacher-child relationship, when compared to the active control treatment, reading mentoring (RM), over time. Treatment effects on disruptive behaviors were measured by (a) pre- to post-test scores on the Externalizing Problems scale of the Caregiver-Teacher Report Form (C-TRF), as reported by teachers blinded to children's group assignment and (b) pre- to post-test scores on the Total Problems and On-task scales on the Direct Observation Form (DOF), as rated by independent evaluators who were blinded to the study. Three observations were conducted to create a single DOF score at both pre- and post-test. Treatment effect on teacher-child relationship stress was measured by pre- to post-test scores on the Index of Teacher Stress (ITS) Total Stress score, as reported by classroom teachers in relation to their students referred to the study due to disruptive behavior.

All four hypotheses were retained at the .05 alpha level of significance, indicating that the improvement in children receiving AdPT when compared to the RM group was not likely due to chance. Practical significance of findings was assessed through partial

eta squared (η_p^2) effect size calculations to determine the magnitude of the between-group treatment effect over time (Cohen, 1988). AdPT demonstrated a moderate to large effect across all dependent variables, when compared to RM. These findings are slightly better than the overall treatment effect for play therapy with no caregiver involvement ($ES = .72$) reported in Bratton et al.'s (2005) meta-analysis of 93 play therapy outcome studies.

Adlerian Play Therapy's Effects on Disruptive Behaviors

The Externalizing Problem scale on the C-TRF was used in this study as a means of measuring children's disruptive behavior in the classroom as reported by their teachers. Achenbach and Rescorla (2001) defined the Externalizing Problem scale as consisting of behaviors that affect children's relationships with others; they may include attention problems, irritability, negative mood, intense negative reactions, anger, aggression, rule breaking, distractibility, and an inability to adapt to situations. These behaviors also have an effect on others' expectations of children's behaviors (Hamre & Pianta, 2007; Persson, 2005).

Results of Hypothesis 1 indicated that from pre-test to post-test, teachers acknowledged a statistically significant ($p < .031$) difference on the Externalizing Problem scale on the C-TRF between students who received the AdPT intervention and those who received the active control condition, RM. A visual inspection of group means in Table 3 shows that, while the experimental group demonstrated a 1.5 decrease in t -scores on externalizing problems, children in the active control group demonstrated a 1.5 increase in t -scores on externalizing problems. Furthermore, findings revealed that AdPT

demonstrated a moderate treatment effect ($\eta_p^2 = .081$) on disruptive behaviors when compared to the control group, indicating the practical significance or therapeutic value of the AdPT intervention. It is important to note that research procedures were structured to reduce or eliminate the likelihood for teachers to be aware of children's treatment group assignments. Children in both treatment groups were removed from the classroom for the same number and length of treatment sessions, and neither counselors nor mentors were allowed to discuss participants with teachers during the course of the study. The results of this study are consistent with other outcome studies which showed that child-centered play therapy (CCPT) and nondirective play therapy are effective interventions on children with disruptive or externalized behaviors in the classroom (Fall et al., 1999; Fall et al., 2002; Garza & Bratton, 2005; Muro et al., 2006; Packman & Bratton, 2003; Raman & Kapur, 1999; Ray et al., 2007; Ray, Henson, Schottelkorb, Garofano Brown, & Muro, 2008; Post, 1999).

The Total Problems scale on the DOF was used in this study as a means of measuring children's disruptive behavior in the classroom as reported by independent assessors' direct observation. McConaughy and Achenbach (2009) defined the Total Problems scale on the DOF as consisting of a measure of type and intensity of behavioral problems that occur in the classroom. The Total Problem scale on the DOF consists of observable behaviors that may affect children's relationships with others. Attention problems, hyperactivity, inability to concentrate, oppositional, intrusive, immature, dependent, and aggression are some behaviors that account for the total score on the DOF.

The DOF is designed to be an objective assessment of children's behaviors (McConaughy & Achenbach, 2009). In the present study, the raters were unaware of the children's assigned treatment group and had no relationship with the children they observed. Because the purpose of this study was to examine treatment effects on children's classroom behavior, all observations were completed during academic situations in the classroom.

Results of Hypothesis 2 indicated that from pre-test to post-test, results showed a statistically significant ($p < .001$) difference on the Total Problems scale on the DOF between students who participated in the AdPT treatment group and those who were assigned to the RM group. A visual inspection of group means in Table 4 shows that, while both groups demonstrated a decrease in total problems, participants in the AdPT group showed a greater decrease in scores. The AdPT treatment group demonstrated a 16 point decrease on t -scores and the RM control group demonstrated a 4 point decrease on t -scores on the DOF Total Behavior scale. The finding demonstrates a large treatment effect ($\eta_p^2 = .236$) from pre-test to post-test for the experimental group when compared to the active control group, indicating AdPT's practical significance or its therapeutic value as an intervention. Furthermore, the finding that 72% of the children ($n = 16$) moved from the clinical or borderline levels of concern to a less problematic level of behavior following treatment shows support for the clinical significance of the AdPT's intervention on children's day-to-day functioning.

Disruptive behaviors were also measured on the On-task scale on the DOF. The On-task scale is a measure of the identified child's ability to remain on-task by doing

what is expected of him or her (McConaughy & Achenbach, 2009). An increase in scores indicates an improvement in behavior. Treatment effects for this measure showed a statistically significant increase in scores of the On-task scale for students who participated in the AdPT group.

Results of Hypothesis 3 indicated that from pre-test to post-test, students in the AdPT treatment group showed a statistically significant ($p < .001$) improvement on the On-task score on the DOF when compared to the students who participated in the RM group. A visual inspection of group means in Table 5 shows that the experimental group demonstrated a 7 point increase on t -scores while the active control group showed no change on the On-task scale on t -scores of the DOF. These findings support the use of AdPT for helping children increase the time they spend on-task in the classroom. The finding regarding AdPT's large treatment effect ($\eta_p^2 = .188$) on the experimental group when compared to the control group, over time, demonstrates its practical significance or magnitude of change based on this intervention. Furthermore, the finding that 66% of children who scored in the clinical or borderline levels of concern at pretest ($n = 18$) moved to normal levels of functioning following treatment ($n = 12$) shows strong support for the clinical significance of the AdPT intervention on increasing children's on-task behavior. Schottelkorb and Ray (2009) conducted a well-designed single case design study which demonstrated similar results for On-task behavior outcomes. Three of the 5 participants (60%) in Schottelkorb and Ray's study demonstrated an increase in on-task behaviors following play therapy or play therapy and teacher consultation intervention. No other play therapy research was found that used the DOF On-task scale to compare

the results of this study. However, based on research that used teacher reports to measure students' classroom behavior, the results of this study are consistent with other findings (Baggerly & Jenkins, 2009; Fall et al., 1999; Fall et al., 2002; Muro et al., 2006; Sashi et al., 1999; Packman & Bratton, 2003; Ramen & Kapur, 1999; Ray et al., 2007). Previous findings report that play therapy is effective in reducing children's disruptive behavior, would suggest an increase in on-task behaviors.

Experts suggest that, without intervention, disruptive behaviors such as aggression, noncompliance and rule breaking tend to be stable or worsen over time (Barklay, 2007; Brinkmeyer & Eyeberg, 2003; Janosz, LeBlanc, Boulerice, & Tremblay, 2000; Webster-Stratton & Reid, 2003). In addition, Webster-Stratton and Reid (2003) suggested a link between externalized behaviors in young students and long-term effects such as violence, drug abuse, juvenile delinquency and anti-social personality disorders. Janosz et al. (2000) also found that early problem behaviors were a predictor of future school dropouts. Abidin and Robinson (2002) stated that children who demonstrate disruptive classroom behavior become a concern for teachers and this type of behavior is the most common reason for school-counselor referral. When teachers can early-identify and seek treatment for children with disruptive behaviors, school-based counselors can intervene and potentially prevent continued and increased problems that may result from the delay or absence of treatment.

Children with disruptive behaviors also tend to have difficulty in creating and maintaining positive relationships with others (Abidin & Robinson, 2002; Hamre et al., 2007; Myers & Pianta, 2009; Ray, 2007). Children develop healthy functioning and

adjustment through adult and peer relationships (Hartup, 1989; Myers & Pianta, 2008). Children with more acceptable classroom behavior often have stronger teacher-child relationships, which aids in children's social and academic success (Hamre & Pianta, 2007). Moreover, children's reputations follow them through school years and can impact future teachers' perceptions of them (Persson, 2005). Based on the results of AdPT, it is evident that this intervention has the potential to decrease problem behavior and increase on-task classroom behaviors, which may then positively impact students' development as students continue to progress through school. The need to reduce socially unacceptable behavior is evident. Based on the findings of this research, AdPT can reduce children's problem behaviors, which in turn increases the likelihood for children to establish positive relationships with adults and peers.

Aside from the play therapy single case research study conducted by Schottelkorb and Ray (2009), no other controlled play therapy research studies were found that used the DOF as a measurement. However, based on the similarity between the C-TRF, CBCL (Achenbach & Rescorla, 2001) and the DOF (McConaughy & Achenbach, 2009), results on the DOF from this study are comparable with studies that found similar reports from parent or teacher reported measures of disruptive behavior. Results from this study are consistent with school-based studies which reported statistical analyses for Externalizing Behavior scale on C-TRF or the CBCL (Muro et al., 2006; Packman & Bratton, 2003; Shashi et al., 1999). The statistical, practical, and clinical significance of the present study's findings support AdPT as an effective treatment for children with disruptive behaviors. This finding is of considerable importance given that children with

disruptive behavior who do not receive treatment continue to have problems throughout their school years (Abidin & Robinson, 2002; Hamre et al., 2007; Myers & Pianta, 2008).

Adlerian Play Therapy's Effects on Stress in Teacher-Child Relationship Stress

The Total Stress Domain on the ITS is designed to measure a teacher's level of stress in relation to a particular student that has the potential for dysfunctional interactions and problematic outcomes (Abidin, Greene, & Konold, 2004). The Total Stress Domain reflects the combination of the Student Characteristics Domain and Teacher Characteristics Domain. The Student Characteristics Domain is characterized by stressful or frustrating behaviors of a particular student that interferes with the teacher's ability to teach, and the Teacher Characteristics Domain reflects the teacher's perception of feeling ineffective and hopeless in his or her role as a teacher. Treatment effects for this study showed a statistically significant decrease in the teachers' scores of the Total Stress Domain in relationship to their referred students who participated in the AdPT group.

Results of Hypothesis 4 indicated that from pre-test to post-test, teachers with students in the AdPT treatment group reported a statistically significant ($p < .036$) improvement on the Total Stress Domain of the ITS when compared to the teacher-student relationship for students who participated in the RM treatment. A visual inspection of group means in Table 6 shows that, while the AdPT treatment group participants demonstrated a 19 point decrease in raw scores on the Total Stress Domain, participants in the RM group demonstrated an 8 point increase in raw scores. These findings suggest that without intervention, teachers' total stress is resistant to reduction

and may increase over time. The finding regarding AdPT's moderate treatment effect ($\eta_p^2 = .076$) on the experimental group when compared to the control group, over time, demonstrates its practical significance or its therapeutic value as an intervention. These results are consistent with other play therapy controlled studies that showed a statistically significant reduction on scores for the Total Stress Domain of the ITS (Muro et al., 2006; Ray, 2007; Ray et al., 2007; Ray et al., 2008).

Hamre and Pianta (2007) reported that the relationship between child and teacher is critical to children's academic and social success. When incongruence exists between the teacher's expectations and the child's behavior, the teacher-child relationship becomes strained (Hamre et al., 2007; Myers & Pianta, 2008). Teachers who are under considerable stress due to their perception of particular children are less able to attend to the needs of these children, which then increases the risk of children developing increased academic and social problems (Hamre & Pianta, 2007). Collectively, children of this study scored high on the C-TRF Externalizing Behavior problems, DOF Total Problems scale, and ITS Total Stress which supports the notion that teachers' stress is associated with students' disruptive behavior. Additionally, children need consistent and supportive relationships with adults for healthy functioning and adjustment (Hartup, 1989; Myers & Pianta, 2008). Therefore, the need for successful teacher-child relationships is critical to children's social and academic success.

Based on the findings of this research, AdPT reduces teachers' total stress, which in turn has the potential for a strengthened teacher-student relationships that may positively impacting children's development. Moreover, it seems reasonable to believe

that when teachers experience less stress it may potentially benefit all the students in the classroom. The statistical and practical significance of this finding indicates that AdPT is a promising treatment modality that can positively impact teacher-student relationship stress between teachers and students with disruptive behaviors.

On the 2 teacher-reported variables, Externalizing Problems on the C-TRF and Total Teacher stress on the ITS, results demonstrated an improvement for AdPT participants and showed a decrease in desirable outcomes for children in the active control group. Contrarily, results from direct observers who were blinded to the study showed an increase for both groups, with greater improvement for children in the AdPT group. The discrepancy between direct observers' reports and teachers' reports may indicate that teacher stress affects teachers' perception.

Research Observations

Throughout the course of this study, I observed what seemed to be important learnings regarding: (a) the significant emotional and behavioral needs of students, and (b) the impact of banning teacher consultations. My observations seem to be consistent with literature describing the need for children's services (MHA, 2009; President's New Freedom Commission, 2003; U.S. Public Health Services, 2000), and literature that describes unique elementary school-based services considerations (Bratton, 2010; Landreth et al., 2009; Ray, 2007; Ray et al, 2005).

Significant Emotional and Behavioral Needs of Students

This research project was initiated during the end of the previous school year in preparation for this study. Administrators, school counselors, and teachers from each of

the five schools that were approached appeared interested in the proposed research project and expressed the need for this type of study within their school. Consistent with the literature, school staff described children with disruptive behavior as being a high concern for teachers (Abidin & Robertson, 2002; Hamre et al., 2007; Myers & Pianta, 2008). Pre-test results for the C-TRF indicated a mean *t*-score of 66 across all participants on externalizing subscales. Scores equal to or greater than 64 indicate clinical levels of concern, which exemplifies the fact that the children of this study were of high concern for teachers.

While discussing the project with school counselors, they expressed their gratitude for this project. They reported being too busy with other school counseling responsibilities to adequately and consistently meet the needs of individual children with disruptive behaviors. School counselors shared that unless the student demonstrated behavior that warranted extreme concern for the identified student, teacher, or peers, they were most often not able to meet that student's emotional needs. Some school counselors attempted to meet the needs of children with disruptive behavior through social skills groups or other psycho-educational groups and guidance lessons. However, they acknowledged the need for individual counseling services to best meet the needs of many of these students. Thus, school-based counselors are needed in order to meet the needs of students with emotional and behavioral concerns. As acknowledged in the literature, children's services are needed in accessible locations such as school settings (MHA, 2009; President's New Freedom Commission, 2000; U.S. Public Health Services, 2000).

Researchers met with teachers to explain the study procedures. During these meetings, teachers demonstrated their interest in the research investigation as evidenced by asking questions about when they could start referring kids and how kids qualified for the study. They wanted to know the maximum number of children they could refer. When asked if they had children in mind that they would want to refer, several teachers raised their hands, and a collective sigh of acknowledgement passed among the teachers. Upon leaving the meetings, teachers were anxious to get started and looked forward to us beginning the study. Teachers' active engagement in the meeting and interest in the research details demonstrated their awareness of the need of this intervention.

Teacher referrals and data collection began during the 4th week of school. According to school counselors, many teachers had contacted them to attain informed consent forms prior to the beginning of the referral process. Teachers and/or school counselors gladly talked with some parents of children they believed were a particular concern. Teachers' willingness to approach parents to ask for consent for their child to participate in the study demonstrates the teachers' motivation to help their students. One teacher reported that because of the child's evident need for counseling services, she scheduled a meeting at the child's guardian's convenience to discuss the play therapy study. Ultimately, the teacher went to the child's home to visit with the guardian and discussed the play therapy research project.

Other evidence that illustrated the need for services in the schools was the overwhelming number of referrals. Following the referral process, which included receiving completed informed consents and teacher assessments, the total number of

referred participants was 117. Three treatment groups were ultimately used as part of a larger study comparing Child-Centered Play Therapy (CCPT), AdPT, and RM; only two groups were analyzed in the present study (AdPT and RM). The expressed gratitude for this project from school administration and teachers demonstrated the need for interventions for children with disruptive behaviors. As noted in the literature, often children do not receive the services they need due to lack of available resources (Bratton, 2010; MHA, 2009; President's New Freedom Commission, 2000; U.S. Public Health Services, 2000).

The Impact of Banning Teacher Consultations

Perhaps the most challenging aspect of this study was the imposed lack of contact between teachers and counselors. Counselors and teachers alike commented on the lack of support they felt due to not being allowed to discuss student or client concerns with one another. A key principle of Adlerian theory and AdPT is collaboration with other important people in clients' lives (Adler, 1927/1998; Dreikurs, 1950; Kottman, 2003, 2009). However, in attempt to isolate the independent variables (AdPT and RM), teacher-counselor consultations were not permitted. The research procedures were intentionally designed to keep teachers uninformed of the children's assigned treatment groups. Additionally, consultations were not permitted due to the difference in education and understanding of child development between mentor and counselor. It seemed likely that teachers would be able to recognize the difference between mentors and counselors if provided opportunities to discuss mentoring or counseling progress or behavioral concerns with the students' assigned intervention providers.

Despite the fact that prior to the study all teachers were made aware of the study procedures, including that they would not receive consultation from treatment providers until after the post-test data collection period, many teachers approached therapists for suggestions, feedback, or asked for help with regards to a specific child or issue throughout the intervention. Counselors were instructed to be empathic about teachers' desires for consultations and to remind teachers that they would be happy to discuss these types of things following data collection. Teachers complied with the rules, but it was evident to the counselors that teachers really wanted and needed help.

Counselors also expressed frustration about the lack of communication with teachers. Consistent with the philosophy AdPT, the counselors in this study value consultations with systemic networks in their clients' lives (Kottman, 2003, 2009). Therefore, the play therapists felt disconnected from an important part of their clients' lives and isolated in the therapeutic process. Several times throughout the intervention period, the AdPT treatment providers gathered together for supervision and discussed that they felt limited and less helpful than they would have had they been allowed to talk with their clients' teachers.

According to the AdPT treatment manual (Kottman, 2009), Adlerian play therapists who work in schools consult with teachers to help gather information about their client's lifestyle. The gathered information helps Adlerian therapists to better understand their client so they can more accurately metacommunicate about important Adlerian principles such as the client's lifestyle, goals of misbehaviors, Crucial Cs, life tasks, etc. (Adler, 1956/1964; Kottman, 2003, 2009; Mosak & Maniacci, 2008).

Therapists also consult with teachers to provide support, feedback, or education to teachers about their students and suggest possible strategies for the teacher to employ in the classroom to help create a more supportive atmosphere for their students. Based on the belief that all people are a part of a larger community, AdPT is a collaborative effort involving the client and other important people in the client's life (Kottman, 2003, 2009).

Landreth (2002) and Axline (1974) suggest that the involvement of important adults in children's lives can be instrumental in the outcome of play therapy. They also make that claim that children do make positive changes due to their experience in play therapy even without the involvement of adults such as teachers or parents. Despite the lack of teacher consultations in this study, children's disruptive behavior and teacher stress showed a significant decrease compared to children who did not receive play therapy. These results are consistent with child-centered play therapy research results which suggest improvement in children's behavior without teacher and/or parent involvement (Baggerly, 2004; Baggerly & Jenkins, 2009; Blanco, 2009; Bratton et al., 2005; Fall et al., 1999; Fall et al., 2002; Garza & Bratton, 2005; Muro et al., 2006; Packman & Bratton, 2003; Post, 1999; Ray et al., 2008; Ray et al., 2007; Shen, 2002).

Teacher Feedback

Following post-test data collection, the ban on counselor-teacher contact was lifted. Teachers in the experimental group were offered the opportunity to meet with the counselors who provided AdPT to discuss problems, concerns, and progress of study participants. Although teachers were not required to meet with counselors, all teachers requested a meeting immediately upon notification. Consultations were scheduled at the

teachers' convenience, primarily during their planning periods. Teachers' seemingly enthusiastic response to post-study consultation supports researcher observations regarding teachers' frustration about their inability to consult with counselors during the study and provides anecdotal evidence supporting the need for teacher consultations as a component of school-based counseling interventions. Teacher reports of students' progress during follow up consultations was overwhelmingly positive and corroborates study findings. A few examples are included below. It is important to note that teachers were not informed of their students' treatment group assignment until the consultation meetings.

One teacher described a study participant as "the miracle child," noting "remarkable" improvements in the student's classroom behavior and social skills. Another teacher described notable improvement in a child with significant disruptive behavior problems who, at the beginning of the study, had been given "one more chance" before he would be transferred to the local alternative school for kids with severe behavior problems. She shared that he was now one of her most well behaved children. The teacher further stated that his progress was even more impressive given that his behavior problems were of substantial concern during the previous school year and had continued to escalate at the beginning of the current school year. Her report is consistent with current literature which suggests disruptive behaviors remain stable or worsen without intervention (Barkley, 2007; Brinkmeyer & Eyeberg, 2003; Webster-Stratton & Reid, 2003).

Additional teacher comments substantiated theoretical tenets of AdPT, which emphasizes a goal of helping children develop more socially useful behavior (Kottman 2003, 2009). For example, one teacher portrayed a participant as aggressive and unsocial at the beginning of the school year and described him after the study as “considerably less aggressive and more willing to build relationships with me and his peers” following the study. Another teacher of a third grader shared that prior to the intervention the student was failing academically and was now in the top percentage of her class. Although academic achievement was not measured in the present study, the student’s improvement is consistent with recent findings by Blanco (2009) that students receiving play therapy made statistically significant gains on a measure of academic achievement.

While the vast majority of teacher feedback was positive, teachers were encouraged to express lingering concerns about students. In response, counselors provided suggestions and information designed to help teachers respond to children’s disruptive behavior in the classroom. Following Adlerian principles, counselors were able to explain the concepts of goals of misbehavior (Dreikurs & Soltz, 1964), crucial Cs (Bettner & Lew, 2005) and the impact of one’s social environment on the child (Kottman, 2003, 2009). Over the course of the consultation, teachers seemed to gain insight into how the child may perceive his or her role in life and how the child’s perception can impact his or her behavior. Of the teachers who initially appeared defensive and frustrated, many became more thoughtful and empathic. Additionally, most teachers expressed gratitude for the feedback and asked for additional suggestions to use with all children in the classroom. One teacher was so encouraged by the information that she

asked for additional references on the use of Adlerian concepts and strategies in the classroom. Teacher response to information provided during consultation suggests that school counselors should consider a teacher consultation model that includes Adlerian principles (Nelsen et al., 2000). The considerable gains expressed by teachers during the relatively brief, one-time post intervention consultation used in this study supports the AdPT protocol's emphasis on the importance of including teacher consultations throughout the duration of the AdPT intervention (Kottman, 2009). This anecdotal observation is confirmed by literature that emphasizes the importance and effectiveness of teacher consultations (Barkley, 2007; Bratton et al., 2005; Landreth et al., 2009; Morrison & Bratton, 2010; Paone & Douma, 2009; Raman & Kapur, 1999; Ray, 2007; Shaski et al., 1999).

Also important to note, teachers' eagerness for teacher-counselor consultation may be related, in part, to the lack of consultations throughout the intervention period. According to Ray (2007), teachers who received 8, weekly, 10-minute teacher-counselor consultations reported an overall positive reaction to teacher consultations. However, the teachers also reported negative comments related to the amount of time the consultations took from their already busy schedules. Therefore, based on the experiences from this study, it is impossible to determine the number and frequency of teacher consultations that teachers would deem helpful.

Summary of Findings

AdPT uses the cooperative relationship between therapist and child to create a therapeutic atmosphere in which the child is an active partner in therapy (Kottman, 2003,

2009). The AdPT therapist applies principles that align with humanistic philosophy, which have shown to have a positive impact on children's internalizing, externalizing, and total problems (Baggerly & Jenkins, 2009; Fall et al., 1999; Fall et al., 2002; Garza & Bratton, 2005; Muro et al., 2006; Packman & Bratton, 2003; Post, 1999; Raman & Kapur, 1999; Shashi et al., 1999; Ray, 2007; Ray et al., 2007; Shen 2002). Such similarities include a belief in the therapeutic qualities in a therapist-client relationship: reflecting children's feelings, giving choices, encouraging, building children's self-esteem, returning responsibility based on an underlying personal belief in the creative nature of children. According to the AdPT treatment protocol, experimental treatment providers attempt to create an atmosphere in which children experience a relationship composed of respect, unconditional acceptance, safety, security and consistency, encouragement, and a sense of belonging. Moreover, the AdPT relationship is one of shared partnership, collaboration, respect, and trust between child and therapist (Kottman, 2009). According to Bratton et al. (2005), results from the most recent meta-analysis of play therapy demonstrated that humanistic approaches showed a moderate treatment effect (.73). Based on the fact that AdPT and other humanistic theories share similar philosophies, it is logical to believe that AdPT is as effective treatment for children as other humanistic approaches to play therapy, such as CCPT.

Furthermore, several authors attest to the appropriateness for school-based play therapy to work with children twice a week for 30-minutes (Bratton et al., 2005; Kottman, 2003; Landreth et al., 2009; Ray, 2010; Ray et al., 2007; Ray et al., 2008). The authors of these research studies, position articles based on experience, and books

suggested that therapists' use of humanistic skills twice weekly for 30-minute play sessions offers a possible explanation for the experimental group children's significant reduction of scores on disruptive behaviors as reported by both teachers and independent observers blinded to the study, as well as a reduction in teacher-child stress.

Limitations of the Study

Although this study was designed according to Nathan and Gorman's (2002) criteria for rigorous research, including adequate sample size, non-wait-list control group, random assignment, manualized treatment protocol, clearly defined target population/issue, clearly defined inclusion criteria, multiple sources of measurement on target dependent variables, and blinded assessors, limitations exist that should be considered when interpreting results. Recommendations for addressing study limitations appear in the following section.

The adequate yet still small sample size was obtained from one school district, thus results cannot be generalized beyond the participating school district's population of students exhibiting disruptive behaviors in the classroom. While the real world setting of this intervention supports AdPT's applicability in school settings, the setting also contributed to limitations. Treatment providers had no parent contact, thus had no information regarding extended student absences and, in some cases, parents' decisions to remove them from school. A setting that required parent contact might have reduced participant dropout and facilitated more consistency in treatment. While it was impossible to responsibly control for extraneous variables such as students receiving additional in-school services such as gifted and talented classes, speech therapy, math

tutoring, etc., conducting the study in the real world setting of the schools allowed the researcher to ensure that study participants did not receive additional mental health or behavioral interventions. Further, the use of stratified random assignment by school site allowed greater control over confounding variables unique to individual school environments (e.g., discipline procedures) than would be possible had the study been conducted in a clinical setting. In spite of attempts to control for extraneous variables, the limitation exists that factors other than intervention effect could have contributed to the results of this study.

This study compared AdPT to a reading mentoring intervention, which was designed as an active control group. Despite research evidence that exists which demonstrated that mentoring can have a beneficial effect on children's aggressive behavior (Cavell, Elledge, Malcolm, Faith, & Hughes, 2009), this study would have been strengthened by using a true comparison treatment group. Using a proven child therapy comparison treatment group would increase confidence that the finding differences were due to AdPT treatment procedures, rather than attention.

Perhaps the greatest study limitation was the inability to strictly adhere to the AdPT protocol due to omission of teacher consultations. In consultation with my faculty advisor and an expert in research design, I decided that controlling for teacher bias by blinding teachers to participants' group assignment was important to ensuring study rigor. The inclusion of the teacher consultation component of the AdPT protocol would have made teachers knowledgeable of the treatment students were receiving. Theoretically, AdPT would include important adults in children's lives based on the Adlerian principle

that all people are socially imbedded and impacted by their society (Adler, 1927/1998, 1956/1965; Kottman, 2003, 2009). Perhaps due to the lack of collaboration with teachers, the counselors doing the play therapy sessions had no knowledge of how students were performing in the classroom and teachers were prevented from receiving support and education in how to respond to targeted children in their classroom. Findings may have yielded different results if counselors had been able to fully comply with the AdPT protocol and provide teacher consults.

Recommendations for Future Research

Based on the findings and limitations of this study, several recommendations for future research can be made:

1. Through the omission of teacher consultation, the present study did not strictly adhere to the AdPT protocol as developed by Kottman (2009). A future study comparing AdPT with teacher consultations compared to AdPT without teacher consultations is warranted to examine the importance of teacher consultations in AdPT.
2. This study represented an initial investigation of the effectiveness of AdPT on children's disruptive behavior in the classroom. Replicating this study with a larger sample size in multi-site settings, in varying geographic regions, and by an independent researcher is needed to expand the evidence for this intervention and move AdPT towards being recognized as an evidence-based treatment for young children's disruptive behavior problems.

3. The present study is confined to reporting the immediate effects of AdPT on children's disruptive behaviors and teacher-child relationship stress. A follow-up study to investigate the long-term effects of treatment is needed.
4. The present study did not include parent consultations or parent assessments. Consistent with the philosophy of AdPT, research should examine parent involvement in the process, as well as include parent data as an additional source of measurement to assess the impact of AdPT on children's disruptive behavior.

Implications and Conclusions

The need for early mental health intervention has been well noted over the past decade in government reports targeting the needs of children (President's New Freedom Commission, 2003; U.S. Public Health Service, 2000). However, a lack of services to meet the needs of children remains an on-going problem (MHA, 2009). Children who display disruptive behaviors at home or in the classroom are at particular risk for a trajectory of increased behavioral problems without early intervention (Barkley, 2007; Bratton, 2010; Brinkmeyer & Eyeberg, 2003; MHA, 2009; Persson, 2005; Webster-Stratton & Reid, 2003).

The critical need for early intervention services that are made available in accessible settings such as schools has been emphasized repeatedly by researchers and experts in child mental health (Bratton, 2010; Ray et al., 2008; Satcher, 2000) as well as acknowledged in the aforementioned government reports on child mental health issues. Schools have the resources and the means to assess and identify children in need of

mental health assistance. Additionally, since children spend several hours a day at the school, children are available to receive services that they might not otherwise be able to access due to issues of poverty, low parental involvement, and cultural barriers (Ceballos & Bratton, in press; Sheely & Bratton, 2010).

AdPT, based on Adlerian theory, is a developmentally responsive intervention that uses play and metaphor, the child's natural mode of communication (Kottman, 2003, 2009). Moreover, Adlerian theory has historically been used in the school settings by counselors and teachers to create an atmosphere conducive to healthy development (Adler, 1927/1998; Dinkmeyer, 1965; Dreikurs, 1950/1964; Kottman, 2003, 2009; Muro & Dinkmeyer, 1977; Muro & Kottman, 1995; Nelsen, 2000; Watts, 2006). Although this was an initial study investigating the effectiveness of AdPT, the statistical, practical, and clinical significance of the present study's findings provide strong support for its use in school settings with early elementary-aged children who exhibit disruptive behaviors in the classroom.

The findings in this study indicate that AdPT can significantly reduce stress in the teacher-student relationship for teachers of students who exhibit behavior problems in the classroom. Teachers reportedly experience high levels of stress in relation to students with disruptive behaviors (Abidin & Robinson, 2002). This stress creates tension between the student and teacher, which can lead to teacher burn-out. Furthermore the relationship between student and teacher can be critical to a child's social and academic success (Abidin & Robinson, 2002; Hamre et al., 2007; Myers & Pianta, 2008; Persson, 2005).

The significance of the present study's results regarding AdPT's treatment effects on children's disruptive behaviors is especially encouraging in light of reports on the importance of early intervention for externalized behavior problems (Barkley, 2007; Brinkmeyer & Eyeberg, 2003; MHA, 2009; Persson, 2005; Sheely & Bratton, 2010; Webster-Stratton & Reid, 2003). A strength of the present study is that data was obtained from multiple sources and that assessors (teachers and independent evaluators) were deliberately uninformed of children's treatment group assignment. An additional strength is that the intervention was delivered in a format that fits within the school-schedule with minimal interruptions. Consistent with play therapy literature (Bratton & Ray, 2000; Bratton et al., 2005; Kottman, 2003; Landreth et al., 2009; Ray, 2007; Ray et al., 2007; Ray et al., 2008), results from the present study support that play therapy provided twice per week for 30-minutes is an appropriate format for delivering school-based counseling interventions.

The effects of AdPT on children's behavior and teachers' stress is particularly important in light of literature that suggests children's development is correlated with the quality of the student-teacher relationship. Moreover, children exhibiting disruptive behaviors have an increased risk of continued problems in personal and social development (Baggerly & Jenkins, 2009; Hamre et al., 2007; Myers & Pianta, 2008; Persson, 2005; Ramos et al., 2005; Ray et al., 2007; Sanson et al., 2004; Teisl & Cicchetti, 2008; Webster-Stratton & Reid, 2003; Wood, Repetti, & Roesch, 2004). Children need relationships with adults who view them positively in order to practice and develop healthy adjustment and social functioning (Hartup, 1989; Myers & Piana, 2008).

Because children displaying disruptive behaviors are often the most stressful for teachers, school-based interventions targeting this issue as early as possible are of particular importance.

Interventions that demonstrate a reduction in teacher stress have the potential to benefit all students in the classroom. Adlerian theory and the AdPT protocol emphasize the importance of teacher inclusion in the process of AdPT when working with students in a school setting (Dinkmeyer, 1965; Kottman, 2003, 2009). Based on teachers' feedback following the study and the current literature, it appears that teacher consultations might have enhanced the study's findings (Barkley, 2007; Bratton et al., 2005; Kottman, 2003, 2009, Kottman et al., 2009; Landreth et al., 2009; Morrison & Bratton, 2010; Paone & Douma, 2009; Raman & Kapur, 1999; Ray, 2007; Shaski et al., 1999).

This study answers the call to conduct outcome research to investigate that can credible treatment modalities for children (APT, 2009; Baggerly & Bratton, 2010; Frick-Helms & Drewes, 2010; Ray, 2006; Urquiza, 2010) and contributes to the evidence base for play therapy's effectiveness as an early mental health intervention. In addition, the fact that this study was conducted in a school setting with children in kindergarten through third grade responds to the need for identifying effective early mental health services for children in accessible settings (New Freedom Commission on Mental Health, 2003). It also increases its utility for school counselors and other school-based mental health professionals. Further, study procedures suggest that partnerships between

elementary schools and universities are an efficient method for expanding research while providing effective services to underserved populations in the schools.

In summary, AdPT shows strong promise as an effective intervention to positively impact children's problem behavior and teaching stress. After an exhaustive review of the literature, the present study appears to represent the first controlled AdPT study to date. As such, the study contributes to the broader field of play therapy by adding to its evidence base, particularly related to theoretical applications of play therapy. Because Adlerian theory is among the most identified theories of counselors who practice play therapy (Lambert et al., 2007), these findings hold particular importance to a large segment of practicing counselors. Additionally, the use of a treatment protocol and fidelity checks ensures confidence in the integrity of the treatment and allows practitioners and researchers to replicate the intervention. Study limitations exist with all research; however, adherence to stringent research methods, along with the statistical, practical, and clinical significance of the findings, adds to the confidence of the findings and supports AdPT as a viable intervention for children exhibiting disruptive behavior problems in the classroom.

APPENDIX A

INFORMED CONSENT: ENGLISH VERSION

University of North Texas Institutional Review Board Informed Consent Form

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Comparison of a Non-Directive and Directive Humanistic Play Therapy Intervention: Effect on Disruptive Behaviors of Early Elementary School-Aged Children

Principal Investigator: Dr. Sue Bratton, associate professor at the University of North Texas (UNT) Department of Counseling and Director of the Center for Play Therapy. Co-investigator is Kristin Meany-Walen, Ph.D. candidate in counseling at UNT, and assistant director of the Center for Play Therapy.

Purpose of the Study: You are being asked to allow your child to participate in a research study which involves your child participating in school-based play therapy services. The purpose of the study is to help children who have behavior difficulties such as aggression, fighting, attention problems, hyperactivity, conduct problems, rule-breaking, etc to reduce their behavior problems. Experts in child development suggest that children who have less behavioral problems at school do better academically.

Study Procedures: Your child will be asked to participate in 16 individual play therapy sessions or reading mentoring sessions that will take about 30 minutes, 2 times each week over the course of 8 weeks. All sessions will take place during regular school hours at a time determined by the teacher. Sessions will be video taped and turned into the researchers to ensure the treatment (play therapy or reading mentoring) is being conducted as planned.

Foreseeable Risks: The potential risks involved in this study are minimal. As with any counseling intervention, children may become more aware of emotional difficulties. In the event a child has a difficult time adjusting to emotional insight, the parent will be contacted and a referral will be made to a local counseling center.

Benefits to the Subjects or Others: We expect the project to benefit your child by allowing him or her an opportunity to learn self-control and socially acceptable behaviors which can then be transferred to the classroom.

Procedures for Maintaining Confidentiality of Research Records: Children will be assigned a random code to be used in place of their name. Names will be removed from all collected materials including assessments, videos, and notes to ensure participant anonymity and confidentiality. Consent forms will be stored in a location separate from coded materials. All data, notes, records and videos will be kept in a locked cabinet

within the researcher's office. Only the researchers will have access to video recordings. Collected information will be kept for a period of 3 years following the conclusion of this study. At that time, all records will be properly destroyed. The confidentiality of your child's individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact *Kristin Meany-Walen* at email Kristin.Meany-Walen@unt.edu or telephone number 940-565-3864; or *Dr. Sue Bratton*, UNT Department of Counseling, at telephone number 940-565-3864.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Dr. Sue Bratton, Kristin Meany-Walen, or your child's school counselor has explained the study to you and your questions have been answered. You have been informed of the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow your child to take part in this study, and your refusal to allow your child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your child's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your child's participation in this study.
- You have been told you will receive a copy of this form.

_____ Y / N _____ Y/N _____ Y/N
Cell phone – ok to leave msg Home phone - ok to leave msg Work phone - ok to leave msg

Email address Printed Name of Parent or Guardian

Signature of Parent or Guardian Date

For the Principal Investigator or Designee: I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

Signature of Principal Investigator Date

Child Assent Form

You are being asked to be part of a research project being done by the University of North Texas Department of Counseling.

This study involves you participating in a special play time or reading time for 30 minutes, 2 times each week for a total of 16 times. You will be asked to go to the special play room or reading area at your school.

If you decide to be part of this study, you can stop participating any time you want to.

If you would like to be part of this study, please sign your name below.

Printed Name of Child

Signature of Child

Date

Signature of Principal Investigator

Date

Waiver of Assent

The assent of (_____) was waived due to:

_____ Age

_____ Maturity

_____ Psychological State

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

APPENDIX B

INFORMED CONSENT: SPANISH VERSION

University of North Texas Institutional Review Board Formulario de Consentimiento

Antes de aceptar que su niño participe en este estudio de investigación, es importante que usted lea y comprenda la explicación siguiente acerca del propósito, los beneficios y los riesgos del estudio y cómo será realizado.

El título del Estudio de Investigación: Comparación entre una Intervención de Juego basada en Terapia Humanística No-Directa y una Intervención de Juego basada en Terapia Humanística Directa: Efectos de las Intervenciones en los Problemas de Conducta de los Niños que están en educación primaria.

Principal Investigadora: La Dra. Sue Bratton, es profesora en el departamento de “counseling” en la “University of North Texas” (UNT) y Directora del Centro para la Terapia del Juego. La co-investigadora es Kristin Meany-Walen, candidata del Doctorado de “counseling” en UNT, y asistente de la directora del Centro para la Terapia del Juego.

El propósito del Estudio: A usted se le está pidiendo permitir la participación de su niño en un estudio de investigación que requiere que su niño reciba servicios de terapia de juego en la escuela. El propósito del estudio es ayudar a niños que tienen problemas de conducta como por ejemplo agresión, falta de atención, hiperactividad, o dificultades siguiendo reglas, a reducir sus problemas de conducta. Los expertos en el desarrollo de niño sugieren que los niños que tienen menos problemas de conducta en las escuelas salen mejor académicamente.

Procedimientos del Estudio: Su niño participara en 16 sesiones individuales de terapia de juego o en 16 sesiones individuales de lectura con un mentor. Estas sesiones serán llevadas a cabo 2 veces cada semana sobre el curso de 8 semanas y duraran aproximadamente 30 minutos. Todas las sesiones se llevaran a cabo durante el día escolar a una hora determinada por el maestro del niño. Las sesiones serán grabadas y los videos serán entregados a las investigadoras para asegurar que el tratamiento (terapia de juego o lectura) es realizado de acuerdo a como se han planeado.

Los Riesgos Previsibles: El potencial de riesgo por participación en el estudio es mínimo. Al igual que con cualquier intervención de terapia, los niños pueden desarrollar un entendimiento más profundo acerca de sus dificultades emocionales. En el caso de que un niño presente dificultades emocionales intensas durante el trabajo de investigación, el padre será contactado y será referido a sitio local donde se provee terapia para niños.

Los Beneficios a los Participantes y a Otros: Esperamos que el proyecto beneficie a su niño al permitirle una oportunidad de aprender el auto-control y conductas socialmente aceptables que pueden ser transferidas al aula.

Los procedimientos para Mantener la Confidencialidad de Investiga Registros: Los niños serán asignados un número de código para que no sean identificados. Los nombres serán quitados de todos los materiales que sean recolectados incluyendo evaluaciones, videos, y notas acerca de las sesiones para asegurar el anonimato de participante y confidencialidad. Los formularios de consentimiento al igual que todos los materiales que sean recolectados serán guardados en un gabinete cerrado con llave al que solamente las investigadoras van a tener acceso. Sólo las investigadoras tendrán acceso para observar las grabaciones de las sesiones. La información que se recolecte será mantenida por un período de 3 años después de que el estudio haya terminado. Una vez que se cumplan los tres años, todos registros serán destruidos apropiadamente. La confidencialidad de la información individual de su niño será mantenida en cualquier publicación o presentaciones que se hagan con respecto a este estudio.

Las Preguntas Acerca del Estudio: Si usted tiene cualquier pregunta acerca del estudio, usted puede contactar a Kristin Meany Walen por medio del correo electrónico: Kristin.Meany-Walen@unt.edu o por teléfono llamando al siguiente numero 940-565-3864. Usted también puede comunicarse con la Dra. Sue Bratton, en el Departamento de “Counseling” de UNT llamando al 940-565-3864.

Revisión Proveído para la Protección de los Participantes: Este estudio de investigación ha sido revisado y aprobado por el “UNT Review Board (IRB).” Si usted tiene cualquier pregunta acerca de los derechos de los participantes en este trabajo de investigación, usted puede contactar la oficina del IRB llamando al (940) 565-3940.

Research Participants’ Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

Derechos de los Participantes en Esta Investigación: Su firma debajo indica que usted ha leído o ha tenido a alguien que le ha leído toda la información que se encuentra en esta forma de consentimiento y que usted confirma todo lo siguiente:

- La Dra. Sue Bratton, Kristin Meany-Walen, o el consejero de la escuela de su niño le ha explicado el estudio a usted y sus preguntas han sido contestadas. Usted ha sido informado de los posibles beneficios y de los posibles riesgos o molestias que pueden suceder por participar en el estudio.

- Usted comprende que usted no tiene obligación de tener que permitir la participación de su niño en este estudio, y si usted se niega a permitir que su niño participe o usted decide retirar a su niño del estudio en cualquier momento, estas decisiones no resultara en ninguna penalidad o ninguna pérdida de derechos o beneficios. El personal del estudio puede decidir parar la participación de su niño en cualquier momento durante el trabajo de investigación.

- Usted comprende por qué el estudio de investigación es realizado y cómo será realizado.
- Usted comprende sus derechos como padre/guardián legal del niño usted voluntariamente consiente a que su niño participe en este estudio.
- A usted le han dicho que usted recibirá una copia de este formulario de consentimiento.

_____ S/ N
Teléfono Celular – ¿se puede dejar mensaje?

_____ S/N
Teléfono de la Casa - ¿se puede dejar mensaje?

_____ S/N
Teléfono del trabajo ¿se puede dejar mensaje?

Dirección de correo electrónico

El Nombre Impreso del Padre o Guardián Legal

La firma de Padre o Guardián Legal

Fecha

Para el Investigador Principal o Designado: Certifico que he revisado el contenido de este formulario de consentimiento con el padre o el guardián legal que firman arriba. He explicado los posibles beneficios y los posibles riesgos o molestias que pueden ser ocasionados por el estudio. Es mi opinión que el padre o guardián legal comprendió la explicación que se le fue dada.

La firma del Investigador Principal

Fecha

Formulario de Consentimiento del Niño

Se te está pidiendo formar parte de un proyecto de investigación que será dirigido por el departamento de “Counseling” de la “University of North Texas”.

Este estudio implica que participaras en un tiempo especial de juego o en un tiempo de leer durante 30 minutos, 2 veces cada semana por un total de 16 veces. Se te pedirá que vayas al cuarto especial de juego o a una área especial para leer dentro de la escuela.

Si tú decides participar en este estudio, tú puedes decidir no seguir participando en cualquier momento durante el proyecto de investigación.

Si te gustaría participar en este estudio, por favor firma tu nombre abajo.

El Nombre impreso de Niño

La firma de Niño

Fecha

La firma del Investigador Principal

Fecha

Formulario de Exoneración del Consentimiento del Niño

La aprobación de (_____) fue exonerada debido a:

_____ Edad

_____ Madurez

_____ Estado psicológico

El Nombre impreso del padre/ Guardián Legal

La firma de Cría/Guardián

Fecha

APPENDIX C

ADLERIAN PLAY THERAPY SKILLS CHECKLIST

Adlerian Play Therapy Skills Checklist (APTSC)

Therapist: _____ Child/age: _____

Observer: _____ Date/session #: _____ Phase #: _____

| Therapist's Visual Attitude | Too Much | Appropriate | Need More | Not Observed | Examples of Therapist Responses |
|---|----------|-------------|-----------|--------------|---------------------------------|
| Active involvement | | | | | |
| Appears interested | | | | | |
| Relaxed/comfortable | | | | | |
| Tone & affect congruent with child's affect | | | | | |
| Tone and affect congruent with therapist's response | | | | | |

| Skills Phase 1 Building a Relationship | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|---|--|---|---|--|
| <i>With every child:</i> | | | | | |
| Meeting the child* | | | | | |
| Asking child, "What did your parents say about coming here?"* | | | | | |
| Demystifying p. t. process | | | | | |
| Tracking behavior | | | | | |
| Restating content | | | | | |
| Reflecting feelings | | | | | |
| Encouraging | | | | | |
| Asking questions | | | | | |
| Metacommunicating | | | | | |
| Giving explanations and answering questions | | | | | |

| Skills Phase 1 Building a Relationship (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|--|--|---|
| <i>With selected children:</i> | | | | | |
| Returning responsibility to the child | | | | | |
| Using the child's metaphor | | | | | |
| Interacting actively with the child | | | | | |
| Cleaning the room together | | | | | |
| Setting limits | | | | | |

* Generally only happens once in a counseling relationship.

Adlerian Play Therapy Skills Checklist (APTSC)

Therapist: _____ Child/age: _____

Observer: _____ Date/session #: _____ Phase #: _____

| Skills Phase 2 Exploring the Child's Lifestyle | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|--|--|---|
| <i>With every child:</i> | | | | | |
| Tracking behavior | | | | | |
| Restating content | | | | | |
| Reflecting feelings | | | | | |
| Encouraging | | | | | |
| Asking questions | | | | | |
| Metacommunicating | | | | | |
| Giving explanations & Answering questions | | | | | |
| Exploring functioning at life tasks through using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |

| Skills Phase 2 Exploring the Child's Lifestyle (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|--|--|---|
| Exploring family atmosphere through using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |
| Exploring family constellation through using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |
| Examining goals of misbehavior through using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |

| Skills Phase 2 Exploring the Child's Lifestyle (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|--|--|---|
| Exploring Crucial Cs through using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |
| Exploring personality priorities through using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |
| Exploring lifestyle convictions, mistaken beliefs, and private logic using questioning strategies, art techniques, metaphoric & storytelling techniques, and/or sand tray | | | | | |

| Skills Phase 2 Exploring the Child's Lifestyle (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|--|--|---|
| <i>With selected children:</i> | | | | | |
| Returning responsibility to the child | | | | | |
| Using the child's metaphor | | | | | |
| Interacting actively with the child | | | | | |
| Cleaning the room together | | | | | |
| Setting limits | | | | | |
| Soliciting early recollections | | | | | |

Adlerian Play Therapy Skills Checklist (APTSC)

Therapist: _____ Child/age: _____

Observer: _____ Date/session #: _____ Phase #: _____

| Skills Phase 3 Helping the Child Gain Insight | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|--|--|---|
| <i>With every child:</i> | | | | | |
| Tracking behavior | | | | | |
| Restating content | | | | | |
| Reflecting feelings | | | | | |
| Encouraging | | | | | |
| Asking questions | | | | | |
| Giving explanations & answering questions | | | | | |
| Metacommunicating (as a way to get insight) about: | | | | | |
| • a single event, behavior, or interaction | | | | | |
| • meaning of a specific event, behavior, or interaction | | | | | |
| • pattern within a session | | | | | |
| • pattern across sessions | | | | | |

| Skills Phase 3 Helping the Child Gain Insight (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate, and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|--|--|---|---|--|---|
| • pattern that extends to other situations or relationships outside playroom | | | | | |
| • pattern that extends to other situations or relationships outside playroom | | | | | |
| • lifestyle theme or conviction, mistaken beliefs, or private logic | | | | | |
| • assets & strengths | | | | | |
| • functioning at life tasks | | | | | |
| • Crucial Cs | | | | | |
| • goals of misbehavior | | | | | |
| Metacommunicating (as a way to get insight) about: | | | | | |
| • purposes of behavior | | | | | |
| • personality priorities | | | | | |
| • impact of family atmosphere on the child | | | | | |
| • impact of family constellation on the child | | | | | |

| Skills Phase 3 Helping the Child Gain Insight (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate, and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|---|--|---|
| • self-defeating behavior patterns | | | | | |
| • play themes | | | | | |
| Using custom- designed therapeutic metaphors, mutual storytelling, Creative Characters, and/or bibliotherapy | | | | | |
| <i>With selected children:</i> | | | | | |
| Returning responsibility to the child | | | | | |
| Interacting actively with the child | | | | | |
| Cleaning the room together | | | | | |
| Setting limits | | | | | |
| Using the child's metaphor | | | | | |
| Inviting the child to do art techniques to help him/her gain insight | | | | | |

Adlerian Play Therapy Skills Checklist (APTSC)

Therapist: _____ Child/age: _____

Observer: _____ Date/session #: _____ Phase #: _____

| Skills Phase 4 Reorienting & Reeducating the Child | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|--|--|---|--|--|---|
| <i>With every child:</i> | | | | | |
| Tracking behavior | | | | | |
| Restating content | | | | | |
| Reflecting feelings | | | | | |
| Encouraging | | | | | |
| Asking questions | | | | | |
| Giving explanations & answering questions | | | | | |
| Metacommunicating | | | | | |
| Spitting in the client's soup about mistaken beliefs, private logic, or self-defeating behaviors | | | | | |
| Using custom-designed therapeutic metaphors, mutual storytelling, Creative Characters, and/or bibliotherapy | | | | | |
| Using brainstorming, discussion, storytelling and metaphoric techniques, art techniques, puppet play, didactic teaching, modeling, and/or role- playing to help child generate ideas for at least 1 of the following: | | | | | |

| Skills Phase 4 Reorienting & Reeducating the Child (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate, and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|--|--|---|---|--|---|
| • capitalizing on assets | | | | | |
| • improving functioning at life tasks | | | | | |
| • fostering improvement on Crucial Cs | | | | | |
| • moving toward healthy functioning in personality priorities | | | | | |
| • shifting from goals of misbehavior to more positive goals | | | | | |
| • substituting positive convictions for mistaken beliefs and common sense for private logic | | | | | |
| • reducing self-defeating behaviors and learning positive behaviors | | | | | |
| • Increasing skills such as social skills, negotiation skills, communication skills, assertiveness, taking responsibility for behavior, etc. | | | | | |

| Skills Phase 4 Reorienting & Reeducating the Child (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate, and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|---|--|---|---|--|---|
| Using brainstorming, problem solving techniques, discussion, storytelling and metaphoric techniques, art techniques, puppet play, didactic teaching, modeling, and/or role-playing to teach child ideas and/or skills for at least 1 of the following: | | | | | |
| • capitalizing on assets | | | | | |
| • improving functioning at life tasks | | | | | |
| • fostering improvement on Crucial Cs | | | | | |
| • moving toward healthy functioning in personality priorities | | | | | |
| • shifting from goals of misbehavior to more positive goals | | | | | |
| • substituting positive convictions for mistaken beliefs and common sense for private logic | | | | | |

| Skills Phase 4 Reorienting & Reeducating the Child (continued) | No opportunity or not appropriate to do | Had opportunity, appropriate, but did not do | Had opportunity, appropriate and did adequately | Had opportunity, appropriate, and did very well | Had opportunity, did adequately, but needed more |
|--|--|---|--|--|---|
| • reducing self-defeating behaviors and learning positive behaviors | | | | | |
| • Increasing skills such as social skills, negotiation skills, communication skills, assertiveness, taking responsibility for behavior, etc. | | | | | |
| Using storytelling and metaphoric techniques, art techniques, puppet play, role-playing and/or homework assignments to set up ways for the child to practice at least 1 of the following: | | | | | |
| • capitalizing on assets | | | | | |
| • improving functioning at life tasks | | | | | |
| • fostering improvement on Crucial Cs | | | | | |
| • moving toward healthy functioning in personality priorities | | | | | |
| • shifting from goals of misbehavior to more positive goals | | | | | |
| • substituting positive convictions for mistaken beliefs and common sense for private logic | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| <ul style="list-style-type: none"> reducing self-defeating behaviors and learning positive behaviors | | | | | |
| <ul style="list-style-type: none"> increasing skills such as social skills, negotiation skills, communication skills, assertiveness, taking responsibility for behavior, etc. | | | | | |
| <i>With selected children:</i> | | | | | |
| Returning responsibility to the child | | | | | |
| Interacting actively with the child | | | | | |
| Cleaning the room together | | | | | |
| Setting limits | | | | | |
| Using the child's metaphor with children who use metaphors | | | | | |
| Inviting the child to do art techniques to help him/her move toward more constructive patterns of thinking, feeling, & behaving | | | | | |

APPENDIX D
READING MENTORING PROTOCOL

Reading Mentor Protocol

Reading mentoring is an intervention for children who have a variety of concerns. Mentoring provides children with extra attention they may not receive in other areas of their lives. As a mentor you will spend undivided scheduled time with a randomly assigned elementary-aged child. The children will be between kindergarten and 3rd grade. For each child you are assigned, you will facilitate 16, 30 minute sessions (2x each week for 8 weeks).

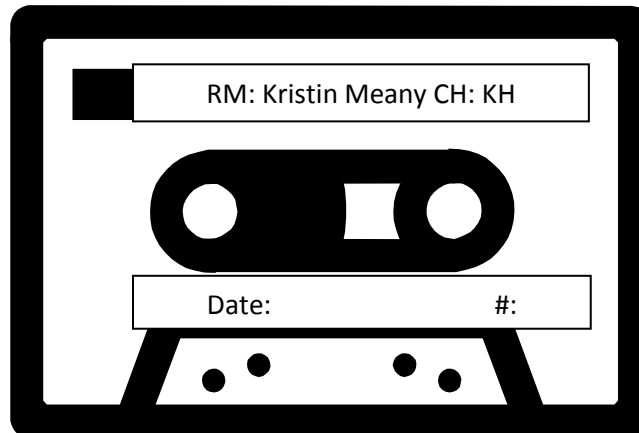
During the sessions

You will be given a kit which consists of a variety of age-appropriate children's books. The kit needs to go with you each time you have a session with a child. The books range in topics and are not specifically selected for each child. In an assigned area of the school you will spend time with a child. The child may choose to read or talk with you. The child or you can choose which book(s) to read.

- 1) Arrive at the school 15 minutes prior to your session. Dress appropriately for elementary school environment (no shorts, tank tops, or low cut shirts).
- 2) Check in at the computer located near or in the main office.
- 3) Set up your mentoring area so you are ready for the child to join you.
- 4) The office assistant or school counselor can show you which room(s) the child(ren) are in.
- 5) Go to the classroom to get the child – wait for the teacher to acknowledge you and let him/her know that you are here for (child's name). DO NOT SAY, "I'm here for (child's name) reading mentoring time." It is VERY important that the teachers do not know which group the children are assigned.
- 6) RECORD THE SESSION (see specific instructions)
- 7) Go directly to the mentoring area and have your mentoring session
- 8) Return the child to his/her classroom.
- 9) Make sure the teacher acknowledges his/her return.
- 10) After your final session, clean/straighten your area.
- 11) Sign out
- 12) Track your session on the Mentor Tracking Form. Turn in your weekly sheets and tapes to Kristin Meany-Walen at the Center for Play Therapy.

Taping Procedures

1. Make sure to have the recorder with you each time you see a child.
2. Record on the 1st side for session 1 and 2nd side for session 2; 1st side for session 3 and 2nd side for session 4, etc.
3. Do not rewind your tape. Record from the position you are in.
4. Write the date on the tape, on the side that you are recording on.



5. At the end of each week, turn in your recorded session tape in your assigned box at the Center for Play Therapy.
6. You will then get a new tape for the following week.

REFERENCES

- Abidin, R., Greene, R., & Konold, T. (2004). *Index of teacher stress: Professional manual*. Lutz, FL: Psychological Assessment Resources.
- Abidin, R. R., & Robinson, L. L. (2002). Stress, biases, or professionalism: What drives teachers' referral judgments of students with challenging behaviors? *Journal of Emotional and Behavioral Disorders*, 10(4), 294-212.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington: University of Vermont, Research Center for Children, Youth, & Families.
- Adler, A. (1964). *The individual psychology of Alfred Adler: A systemic presentation in selections from his writings*. H. L. Ansbacher & R. R. Ansbacher (Eds). New York, NY: Harper Perennial. (Original work published in 1956).
- Adler, A. (1998). *Understanding human nature*. England: Oneworld Oxford. (Original work published in 1927).
- Allen, J. (1997). Jungian play therapy. In K. J. O'Connor & L. M. Braverman (Eds.). *Play therapy theory and practice: A comparative presentation* (pp. 100-130). New York, NY: Wiley.
- American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: American Counseling Association.

- American Psychiatric Association. (1995). *The task force on promotion and dissemination of psychological procedures*. Retrieved from <http://www.apa.org/divisions/div12/est/chamble2.pdf>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American School Counseling Association (2009). *The role of the professional school counselor*. Retrieved from <http://www.schoolcounselor.org/content.asp?pl=325&sl=133&contentid=240>
- Amplo, J. E. (1980). *Relative effects of group play therapy and Adlerian teacher training upon social maturity and school adjustment of primary grade students* (Doctoral dissertation). University of Mississippi, Mississippi. Retrieved from Dissertation Abstracts International. (Order No. 8029220)
- Association for Play Therapy (2009). Retrieved from <http://www.a4pt.org/ps.aboutapt.cfm?ID=1212>
- Axline, V. (1974). *Play Therapy*. New York, NY: Ballantine Books.
- Baggerly, J. (2004). The effects of child-centered group play therapy on self-concept, depression, and anxiety of children who are homeless. *International Journal of Play Therapy*, 12(2), 31-51.
- Baggerly, J., & Bratton, S. (2010). Building a firm foundation: Response to Phillips 2009. *International Journal of Play Therapy*, 19(1), 26-38.

- Baggerly, J., & Jenkins, W. W. (2009). The effectiveness of child-centered play therapy on developmental and diagnostic factors in children who are homeless. *International Journal of Play Therapy, 18*(1), 45-55. doi: 10.1037/a0013878
- Barkley, R. (2007). School interventions for attention deficit hyperactivity disorder: Where to from here? *School Psychology Review, 36*(2), 279-286.
- Bettner, B. L., & Lew, A. (2005). *Raising kids who can*. Newton Centre, MA: Connexions.
- Blanco, P. J. (2009). *The impact of child-centered play therapy on academic achievement, self concept, and teacher-child relationship stress*. (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3381780)
- Bratton, S. (2010). Meeting the early mental health needs of children through school-based play therapy: A review of outcome research. In A. A. Drewes & C. E. Schaefer (Eds.), *School-based play therapy* (2nd ed., pp. 17-59). Hoboken, NJ: Wiley
- Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 9*(1), 47-88.
- Bratton, S., Ray, D., & Landreth, G. (2008). Play therapy. In A. Gross & M. Hersen (Eds.), *Handbook of clinical psychology Vol. 2: Children and adolescents*. New York, NY: Wiley.
- Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional*

Psychology: Research and Practice, 36(4), 376-390. Doi: 10.1037/0735-7028.36.4.376

- Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 204-223). New York, NY: Guilford.
- Brody, V. A. (1997). Developmental play therapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 160-183). New York, NY: Wiley.
- Brown, C. H, Costigan, T. E., & Kendziora, K. (2008). Data analytic frameworks: Analysis of variance, latent growth and hierarchical models. In Nezu & Nezu (Eds.), *Evidence-based outcome research: A practical guide to conducting randomized clinical trials for psychosocial interventions* (pp. 285-313). London: Oxford University Press, 285-313.
- Carlson, J., Watts, R. E., & Maniaci, M. (2006). (Eds.), *Adlerian therapy: Theory and practice*. Washington, DC: American Psychological Association.
- Cavell, T. A., Elledge, C. Malcolm, K. T., Faith, M. A., & Huges, J. N. (2009). Relationship quality and the mentoring of aggressive, high-risk children. *Journal of Clinical Child & Adolescent Psychology*, 38(2), 158-198.
- Ceballos, P., & Bratton, S. (in review). School based child parent relationship therapy (CPRT) with low income first generation immigrant Hispanic parents: Effects on child behavior and parent-child relationship stress. *Psychology in the Schools*.

- Chambless, D. L., Baker, M., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Woody, S.R. (1998). Update on empirically validated therapies, II. *Clinical Psychologist*, 51(1), 3–16.
- Cohen, J. (2003). Things I have learned (so far). In A. Nezu & C. Nezu (Eds.), *Evidence-based outcome research* (3rd ed., pp. 407-436). New York, NY: Oxford University Press.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New York, NY: Academic Press.
- Dinkmeyer, D. C. (1965). *Child development: The emerging self*. Englewood Cliffs, NJ: Prentice-Hall.
- Dreikurs, R. (1950). *Fundamentals of Adlerian psychology*. New York, NY: Greenberg.
- Dreikurs, R. & Soltz, V. (1964). *Children: The challenge*. New York, NY: Hawthorn Books.
- Erikson, E. H. (1977). *Toys and reasons: Stages in the ritualization of experience*. New York, NY: Norton.
- Fall, M., Balvanz, J., Johnson, J., & Nelson, L. (1999). A play therapy intervention and its relationship to self-efficacy and learning behaviors. *Professional School Counseling*, 2(3), 194-204.
- Fall, M., Navelski, L. F., & Welch, K. K. (2002). Outcomes of a play intervention for children identified for special education services. *International Journal of Play Therapy*, 11(2), 91-106.

- Flahive, M., & Ray, D. (2007). Effect of group sandtray therapy with preadolescents. *Journal for Specialists in Group Work, 32*(4), 362-382.
- Frick-Helms, S. B., & Drewes, A. A. (2010). Introduction to play therapy research theme issue. *International Journal of Play Therapy, 19*(1), 1-3.
- Garza, Y., & Bratton, S. C. (2005). School-based child-centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy, 14*(1), 51-79.
- Hamre, B. K., Pianta, R. C., Downer, J. T., & Mashburn, A. J. (2007). Teachers' perceptions of conflict with young students: Looking beyond problem behaviors. *Social Development, 17*(1), 115-136. doi: 10.1111/j.1467-9507.2007.00418.x
- Hartup, W. W. (1989). Social relationships and their developmental significance. *American Psychologist, 44*(2), 120-126.
- Janosz, M., Le Blanc, M., Boulerice, B., & Tremblay, R. E. (2000). Predicting different types of school dropouts: A typology approach with two longitudinal samples. *Journal of Educational Psychology, 92*(1), 171-190.
- Josefi, O., & Ryan, V. (2004). Non-directive play therapy for young children with autism: A case study. *Clinical Child Psychology and Psychiatry, 9*(4), 533-551. doi: 10.1177/1359104504046158
- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Counseling and Clinical Psychology, 67*, 332-339.

- Kazdin, A. (2003). Clinical significance: Measuring whether interventions make a difference. In A. Nezu & C. Nezu (Eds.), *Evidence-based outcome research* (3rd ed., pp. 601-719). New York: Oxford University Press.
- Knell, S. M. (1997). Cognitive-behavioral play therapy. In K. J. O'Connor & L. M. Braverman (Eds.). *Play therapy theory and practice: A comparative presentation* (pp. 79-99). New York, NY: Wiley.
- Kottman, T. (1987). *An ethnographic study of an Adlerian play therapy training program*. Unpublished doctoral dissertation, University of North Texas.
- Kottman, T. (1997). Adlerian play therapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 310-340). New York, NY: Wiley.
- Kottman, T. (2001a). Adlerian play therapy. *International Journal of Play Therapy*, 10(2), 1-12.
- Kottman, T. (2001b). *Play therapy: Basics and beyond*. Alexandria, VA: American Counseling Association.
- Kottman, T. (2003). *Partners in play* (2nd ed.). Alexandria, VA: American Counseling Association.
- Kottman, T. (2009). *Treatment manual for Adlerian play therapy*. Unpublished manuscript.
- Kottman, T., Bryant, J., Alexander, J., & Kroger, S. (2009). Partners in the schools: Adlerian school counseling. In A. Vernon & T. Kottman (Eds.). *Counseling*

- theories: Practical application with children and adolescents in school settings.*
(pp. 47-84). Denver, CO: Love.
- Lambert, S. F., LeBlanc, M., Mullen, J. A., Ray, D., Baggerly, J., White, J., & Kaplan, D. (2007, Winter). Learning more about those who play in session: The national play therapy in counseling practices project (phase 1). *Journal of Counseling & Development*, 85, 42-46.
- Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York, NY: Brunner Routledge.
- Landreth, G. L., Ray, D. C., & Bratton, S. C. (2009). Play therapy in elementary schools. *Psychology in the Schools*, 46(3), 281-289. doi: 10.1002/pits.20374
- Landreth, G. L., & Sweeney, D. S. (1997). Child-centered play therapy. In K. J. O'Connor & L. O. Braverman (Eds.). *Play therapy theory and practice: A comparative presentation*, (pp. 17-45). New York, NY: Wiley.
- LeBlanc, M., & Ritchie, M. (1999). Predictors of play therapy outcomes. *International Journal of Play Therapy*, 8(2), 19-34.
- Lee, A. C. (1997). Psychoanalytic play therapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 46-78). New York: Wiley.
- McConaughy, S. H., & Achenbach, T. M. (2009). *Manual for the ASEBA Direct Observation Form*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

- Mental Health America. (2009). *Factsheet: Recognizing mental health problems in children*. Retrieved from <http://www.mentalhealthamerica.net/farcry/go/information/get-info/children-s-mental-health/recognizing-mental-health-problems-in-children>
- Morrison, M., & Bratton, S. C. (in press). Effects of child teacher relationship training (CTRT) on disadvantaged preschool children's behavior problems: Pilot study of an early mental health intervention for head start programs. *Psychology in the Schools*.
- Mosak, H. & Maniaci, M. (1998). *A primer of Adlerian psychology*. New York, NY: Brunner-Routledge.
- Mosak, H. H., & Maniaci, M. (2008). Adlerian psychotherapy. In R. J. Corsini & D. Wedding (Eds.). *Current psychotherapies* (8th ed., pp. 63-106). United States: Thomson Brooks/Cole.
- Muro, J. J., & Dinkmeyer, D. C. (1977). *Counseling in the elementary and middle schools: A pragmatic approach*. Dubuque, IA: W. C. Brown.
- Muro, J. J., & Kottman, T. (1995). *Guidance and counseling in the elementary and middle schools*. Dubuque, IA: Brown & Benchmark.
- Muro, J., Ray, D., Schottelkorb, A., Smith, M. R., & Blanco, P. J. (2006). Quantitative analysis of long-term child-centered play therapy. *International Journal of Play Therapy*, 15(2), 35-58.
- Myers, S. S., & Pianta, R. C. (2008). Development commentary: Individual and contextual influences on student-teacher relationships and children's early

- problem behaviors. *Journal of Clinical Child & Adolescent Psychology*, 17(3), 600-608. doi: 10.1080/15374410802148160
- Nathan E., & Goreman, J. M. (2002). *A guide to treatments that work*. New York, NY: Oxford University Press.
- Nelsen, J., Lott, L. S., & Glenn, H. S. (2000). *Positive discipline in the classroom: Developing mutual respect, cooperation, and responsibility in your classroom* (3rd ed.). Roseville, CA: Prima Publishing.
- Oaklander, V. (1988). *Windows to our children*. Highland, NY: Center for Gestalt Development.
- O'Connor, K. (1997). Ecosystemic play therapy. In K. J. O'Connor & L. M. Braverman (Eds.) *Play therapy theory and practice: A comparative presentation* (pp. 234-284). New York, NY: Wiley.
- Packman, J., & Bratton, S. (2003). A school-based group play/activity therapy intervention with learning disabled preadolescents exhibiting behavior problems. *International Journal of Play Therapy*, 12(2), 7-29.
- Pallant, J. (2007). *SPSS survival manual: A step by step guide to data analysis using SPSS for Windows* (3rd ed.). New York, NY: McGraw-Hill.
- Paone, T. R., & Douma, K. B. (2009). Child-centered play therapy with a seven-year-old boy diagnosed with intermittent explosive disorder. *International Journal of Play Therapy*, 18(1), 31-44. doi: 1555-6824/09

- Persson, G. E. B. (2005). Young children's prosocial and aggressive behaviors and their experiences of being targeted for similar behaviors by peers. *Social Development, 14*(2), 206-228.
- Piaget, J. (1962). *Play, dreams, and imitation in childhood*. New York, NY: Routledge.
- Post, P. (1999). Impact of child-centered play therapy on the self-esteem, locus of control, and anxiety of at-risk 4th, 5th, and 6th grade students. *International Journal of Play Therapy, 8*(2), 1-18.
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America final report* (DHHS Publication N. SMA-03-3832). Rockville, MD: Department of Health and Human Services.
- Raman, V., & Kapur, M. (1999). A study of play therapy in children with emotional disorders. *National Institute of Mental Health and Neuro Sciences Journal, 17*(2), 93-98.
- Ramos, M. C., Wright Guerin, D., Gottfried, A. W., Bathurst, K., & Oliver, P. H. (2005). Family conflict and children's behavior problems: The moderating role of child temperament. *Structural Equation Modeling, 12*(2), 278-298.
- Ray, D. (Ed.). (2004). From the editor. *International Journal of Play Therapy, 13*(2), 7.
- Ray, D. (2006). Evidenced-based play therapy. In C. E. Schaefer & H. G. Kaduson (Eds.). *Contemporary play therapy: Theory, research, and practice* (pp. 136-157). New York, NY: The Guilford Press.
- Ray, D. (2007). Two counseling interventions to reduce teacher-child relationship stress. *Professional School Counseling, 10*(4), 428-440.

- Ray, D., Armstrong, S. A., Warren, E. S., & Balkin, R. S. (2005). Play therapy practices among elementary school counselors. *Professional School Counseling*, 8(4), 360-366.
- Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, 10(1), 85-108.
- Ray, D., Henson, R. K., Schottelkorb, A. A., Garofano Brown, A., & Muro, J. (2008). Effect of short- and long-term play therapy services on teacher-child relationship stress. *Psychology in the Schools*, 45(10), 994-1009. doi: 10.1002/pits.20347
- Ray, D., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy*, 16(2), 95-111. doi: 1555-6824/07
- Rubin, A. (2008). *Practitioner's guide to using research for evidence-based practice*. Hoboken, NJ: Wiley.
- Sanson, A., Hemphill, S. A., & Smart, D. (2004). Connections between temperament and social development: A review. *Social Development*, 13(1), 142-170.
- Satcher, D. (2000). Mental health: A report of the Surgeon General. *Professional Psychology: Research and Practice*, 31(1), 5-13.
- Sattler, J. M., & Hodge, R. D. (2006). *Assessment of children: Behavioral, social, and clinical foundations* (5th ed.). La Mesa, CA: Author.
- Schafer, C. (2001) Prescriptive play therapy. *International Journal of Play Therapy*, 10(2), 57-73.

- Schottelkorb, A. A. & Ray, D. (2009). ADHD symptom reduction in elementary students: A single-case effectiveness design. *Professional School Counseling, 13*(1), 11-22.
- Shapiro, E. S., & Heick, P. (2004). School psychologist assessment practices in the evaluation of students referred for social/behavioral/emotional problems. *Psychology in the Schools, 41*, 551-561.
- Shashi, K., Kapur, M., & Subbakrishna, D. K. (1999). Evaluation of play therapy in emotionally disturbed children. *National Institute of Mental Health and Neuro Sciences Journal, 17*(2), 99-11.
- Sheely-Moore, A. I., & Bratton, S. (2010). A strengths-based parenting intervention with low-income African American families. *Professional School Counseling, 13*(3), 175-183.
- Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression, and adjustment. *International Journal of Play Therapy, 11*(1), 43-63.
- Society of Clinical and Child and Adolescent Psychology and Network on Youth Mental Health. (n.d). *Evidence-based treatments for children and adolescents*. Retrieved August 24, 2009, from <http://sccap.tamu.edu/>
- Substance Abuse and Mental Health Services Administration. (2009). *National registry of evidenced-based programs and practices*. Washington, DC: U.S. Department of Health and Human Services.

- Teisl, M., & Cicchetti, D. (2008). Physical abuse, cognitive and emotional processes, and aggressive/disruptive behavior problems. *Social Development, 17*(1), 1-23. doi: 10.1111/j.1467-9507.2007.00412
- Thompson, B. (2002). "Statistical," "practical," and "clinical": How many kinds of significance do counselors need to consider? *Journal of Counseling and Development, 80*, 64-71.
- U.S. Public Health Service. (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda*. Washington, DC: U.S. Department of Health and Human Services.
- Urquiza, A. J. (2010). The future of play therapy: Elevating credibility through play therapy research. *International Journal of Play Therapy, 19*(1), 4-12.
- Volpe, R. J., DiPerna, J. C., Hintze, J. M., & Shapiro, E. S. (2009). Observing students in classroom settings: A review of seven coding schemes. *School Psychology Review, 34*(4), 454-474.
- Watts, R. (2006). Play therapy. In J. Carlson, R. E. Watts, & Maniaci, M. (Eds.), *Adlerian therapy: Theory and practice* (pp. 227-249). Washington, DC: American Psychological Association.
- Webster-Stratton, C., & Ried, M. J. (2003). The incredible years parents, teachers, and children training services: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York, NY: Guilford.

- Wood, J. J., Repetti, R. L., & Roesch, S. C. (2004). Divorce and children's adjustment problems at home and school: The role of depressive/withdrawn parenting. *Child Psychiatry and Human Development*, 35(2), 121-142.
- Yura, M., & Galassi, M. (1974). Adlerian usage of children's play. *Journal of Individual Psychology*, 30, 194-201.