

Adlerian Play Therapy with Students with Externalizing Behaviors and Poor Social Skills

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Government reports emphasize the dire need for counseling services to be accessible and effective for children in need in the United States. We employed a single case exploratory design and used group and individual Adlerian play therapy (AdPT) as the independent variable to examine its effects on children with disruptive classroom behaviors and poor social skills. Results for each participant revealed effective to very effective treatment effects during the intervention and follow-up phases of the designs.

Keywords: Adlerian theory, play therapy, externalizing behaviors, single-case design

Government reports have emphasized the need for accessible mental health services for children for over a decade. The American Academy of Pediatrics Committee on School Health (Taras & American Academy of Pediatrics Committee on School Health, 2004) has deemed the current state of children's mental health, a crisis. Estimates predict that one in five children have an emotional disturbance significant enough to warrant a mental health diagnosis, and less than one third of these children will receive mental health care (Mental Health America, 2009). The President's New Freedom Commission on Mental Health (2003) and Mental Health America (2009) charge schools and school administrators with providing children access to such services. In this way, children will have access to mental health services, and care providers can collaborate with parents and teachers of the children in need.

Students are most often referred to the school counselor for disciplinary actions related to their off-task or externalizing classroom behaviors (Abidin & Robinson, 2002). Such behaviors may include aggression, impulsivity, rule breaking, yelling or calling out, or other behaviors that interfere with teachers' ability to teach

and students' ability to learn. These behaviors tend to be disruptive in nature and create a nuisance in the classroom. Externalizing behaviors are often an indicator of underlying, more serious emotional difficulties happening for the child and may later result in greater personal and social problems, such as drug abuse, school dropout, and criminal activity (Barkley, 2007; Mental Health America, 2009; Webster-Stratton & Ried, 2003). Reef, Diamantopoulou, van Meurs, Verhulst, and van der Ende (2011) recommend early intervention to alleviate the internal distress and mitigate additional negative consequences associated with externalizing behaviors. Thus, when teachers or other school staff can reframe the problem behavior as a potential indicator for emotional difficulty, children may be more likely to receive supportive care.

Play therapy is developmentally responsive and an empirically supported intervention that uses children's natural mode of communication, play, as the therapeutic language for change (Kottman & Meany-Walen, 2016; Landreth, 2012). Many of the published studies use elementary schools as the intervention location and find promising results with statistical significance and moderate to large treatment effect sizes when compared with no-treatment or active control groups (Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015). To date, the majority of play therapy research uses child-centered play therapy (CCPT) as the independent variable. CCPT is the most widely used

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theoretical approach to play therapy (Lambert et al., 2007), developed by Axline (1974) and later refined by Landreth (2012). This approach is based on Carl Rogers's person-centered theory. Research published in the last decade using CCPT has been found to be effective at improving children's academic achievement (Blanco & Ray, 2011; Blanco, Ray, & Holliman, 2012), reducing externalizing behaviors (Bratton et al., 2013; Dougherty & Ray, 2007; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Ray, 2007, 2008; Ray, Blanco, Sullivan, & Holliman, 2009; Ray, Henson, Schottelkorb, Brown, & Muro, 2008; Schottelkorb & Ray, 2009; Schottelkorb, Swan, Jahn, Haas, & Hacker, 2015; Schumann, 2010; Tsai & Ray, 2011), reducing internalizing behaviors (Baggerly & Jenkins, 2009; Cheng & Tsai, 2014; Muro et al., 2006; Ray, 2008; Ray, Stulmaker, Lee, & Silverman, 2013; Stulmaker & Ray, 2015; Tsai & Ray, 2011), improving teacher-child relationship (Ray, 2007; Ray et al., 2008), reducing trauma symptoms (Schottelkorb, Dumas, & Garcia, 2012), reduction in somatization (Schottelkorb et al., 2015), and improvement in functioning for children with developmental delays or intellectual disabilities (Garofano-Brown, 2012; Swan & Ray, 2014; Ware Balch & Ray, 2015).

Whereas the previous list of research is impressive, and certainly supports the use of play therapy to improve children's functioning in a number of areas, it identifies only a narrow scope of play therapy practiced today. Research that explains and/or supports other theoretical orientations of play therapy is limited. For example, Adlerian play therapy (AdPT) is the third most widely used approach to play therapy (Lambert et al., 2007) and has only a developing body of published research with the first research article published in 2014. AdPT was developed by Kottman (Kottman & Meany-Walen, 2016) and is based on the theoretical tenets of Adler's individual psychology. Meany-Walen, Bratton, and Kottman (2014) conducted a randomized control trial in which children with disruptive behaviors were randomly assigned to AdPT treatment group or an active control group, where they received reading mentoring. Participants in either group received sixteen 30-min sessions of AdPT or reading mentoring. Results were statistically significant with moderate and large treatment effect sizes for reducing externalizing behav-

iors, increasing on-task classroom behaviors, and improving teacher-child relationships. Other AdPT published research used single case experimental designs (SCED). Findings showed moderate to strong support for individual sessions of AdPT as an effective intervention for improving on-task behaviors (Dillman Taylor & Meany-Walen, 2015; Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015) and reducing overall total problems as identified by the assessment tool (Meany-Walen, Bullis, Kottman, & Dillman Taylor, 2015). Research that explored the effectiveness of group AdPT also showed favorable results for improving children's on-task classroom behaviors (Dillman Taylor, Nelson, Gungor, & Meany-Walen, 2015; Meany-Walen, Bullis, et al., 2015). Findings among the published studies are similar: AdPT showed a moderate to high treatment effect at improving children's on-task classroom behavior for children who receive individual or group counseling sessions.

Group sessions might be particularly ideal in the school settings due to limited resources such as time and professionals trained in providing counseling interventions to children (Hess, Post, & Flowers, 2005). A second benefit to group sessions is the ability for children to develop or refine social skills, build interpersonal relationships, gain insight, and be provided with immediate feedback from fellow group members and the group leader (Sweeney, Baggerly, & Ray, 2014). A limitation with group-only intervention is the one-on-one time that might be advantageous for children who have significant underlying emotional difficulties. Children who only participate in group sessions might miss out on the valuable opportunity to individually process their emotions, thoughts, attitudes, and experiences that is a typical part of individual play therapy sessions (Kottman & Meany-Walen, 2016).

Purpose of Study

The purpose of this study was to explore the effects of a mixed treatment approach on children's on-task behaviors. We wanted to know if there was benefit for children to receive individual and group play therapy sessions. Our primary research question was: is a mixed treatment approach of individual and group AdPT

sessions effective at increasing children's classroom on-task behavior?

Method

A single-case experimental design (SCED) was used to examine the effects of mixed treatment AdPT on off-task behaviors of early elementary-aged children. Several experts in the field of counseling have encouraged that SCEDs be used in clinical research conducted by helping professionals because of challenges in providing services to multiple participants (Foster, 2010; Lundervold & Belwood, 2000; Ray, Barrio Minton, Schottelkorb, & Garofano Brown, 2010). SCED also allows for researchers and interested parties to observe the weekly behavioral data throughout the process within the phases of the study, rather than comparing only pre- and posttest data (Morgan & Morgan, 2003; Purswell & Ray, 2014). Integrating design recommendations from several researchers, we ensured a rigorous design by using a treatment protocol (Lundervold & Belwood, 2000), multiple base lines (Lundervold & Belwood, 2000; Morgan & Morgan, 2003; Rubin, 2008), multiple treatment phases (Lundervold & Belwood, 2000; Ray & Schottelkorb, 2010; Rubin, 2008), at least three data points within a given phase of treatment (Lundervold & Belwood, 2000; Ray & Schottelkorb, 2010; Rubin, 2008), and a control group. Although unnecessary with SCED, we included the use of a control group to assess other participants' trajectory of behavioral outcomes during the phases of the intervention.

Participants

This study consisted of five elementary aged students from a public school in the Midwest region of the United States. The school district (K–12) has approximately 5,200 students with the following demographics: 84% Caucasian, 5% African American, 4% multiracial, 3% Hispanic, 3% Asian American, less than 1% Native American and Pacific Islander; 22% of students qualify for free and reduced lunch. The elementary school (K–6) in which the study was conducted has approximately 275 students with the following demographic make-up: 88% Caucasian, 6% multiracial, 3% Hispanic, 2% African American, and less than 1% Native American;

44% of students qualify for free and reduced lunch. In 2001, this school was identified by the state department of education as a *school in need of assistance* (SINA) due to declining proficiency in testing scores: less than 46% of 4th grade students met reading comprehension benchmarks.

Qualified participants met the following criteria: (a) referred to the study by classroom teachers based on poor social skills; (b) enrolled in grades kindergarten, 1st, or 2nd; (c) scored in the borderline or clinical range of on-task scale of the *Direct Observation Form* (DOF; McConaughy & Achenbach, 2009); and (d) received parental consent and child assent prior to the start of data collection. Participants were randomly assigned to the waitlist control group ($n = 2$) or the AdPT treatment group ($n = 3$).

Instrument/Direct Observation Form

The DOF (McConaughy & Achenbach, 2009) is a standardized observational instrument used to objectively assess behavior in children's natural settings, such as in a classroom, lunchroom, or recess. The DOF was completed by an observer, who tracked behaviors using standardized observations that took place during a 10-min segment of time. The sole observer observed each child throughout the duration of the study period to ensure consistency of rating. The DOF provides scores on the total problems scale, the on-task scale, and six syndrome subscales: nervous/obsessive, withdrawn/inattentive, depressed, hyperactive, attention/demanding, and aggressive.

In this study, we were interested in participants' disruptive classroom behaviors, and thus observations were only done in the classroom setting. According to the DOF manual, the trained observer tracks on-task and off-task behaviors, in 1-min intervals, over a 10-min period. Following the observation period, the observer completes an 89-item checklist designed to measure disruptive classroom behaviors such as fighting, speaking out of turn, fidgeting, avoiding tasks, and bullying. In accordance with the DOF procedures, a minimum of two observations and a maximum of six observations within an observation set are required to obtain a single score on an individual child. This allows for a more global picture of children's behavior, rather than getting a single

point in time in which a child has exceptionally poor or good behavior. [McConaughy and Achenbach \(2009\)](#) reported a mean interrater reliability for classroom observations of .97 for on-task/off-task score. They also reported they had evaluated and established validity of the DOF by comparing the assessment results of referred and nonreferred children, and by the strong correlation with other assessment instruments that measure behavior such as the child behavior checklist and the caregiver–teacher report form ([Achenbach & Rescorla, 2001](#)).

Procedure

The principle investigator (PI), and first author of this study, has an ongoing relationship with the identified school administration including the school counselor. The school principal approved the study and study procedures. After obtaining Institutional Review Board (IRB) approval, teachers were notified of the research study and asked to refer students who exhibited disruptive classroom behaviors and had poor social or relationship skills. Referrals for the study were initiated in the beginning of October. We believed that this provided teachers and students ample time to settle into the routine of school and for typical, ongoing behaviors to emerge. Disruptive classroom behaviors included, but were not limited to, aggressiveness, swearing, verbal or behavioral outbursts, hyperactivity, inability to sit still, oppositional behaviors, attention seeking, or rule breaking. Consent and assent forms were sent home with identified children and were returned to the school counselor upon receiving guardian and child signatures. This process allowed for children to maintain their privacy in the event that a parent opted to not let his or her child participate in the study. Only after receiving consent and assent forms, was the PI informed of potential participants, and qualifying instrumentation began.

A research assistant, responsible for observing the children using the DOF, completed initial rounds of assessments that were scored and evaluated for inclusion in the study. The research assistant was an advanced master's level mental health counseling student who had more than 3 years experience providing behavioral services to children in schools. She was trained in using the DOF by the PI and conducted

practice sessions that allowed her to ask questions and clarify procedures prior to starting the data collection. Students who scored in the borderline or clinical range of the on-task scale of the DOF were allowed to participate. Participants then were randomly assigned to the treatment group or the waitlist control group. The research assistant was not aware of the students' group assignments, study procedures, or intervention start dates for the participants. She continued to collect data points on a weekly basis throughout the phases of the study. Each participant received a minimum of three baseline data points prior to starting the intervention.

AdPT. The study lasted 16 weeks, which allowed for 3 weeks of baseline data collection, 8 weeks of the intervention period and data collection, and up to 5 weeks of postintervention data collection. Because of unforeseen absences, as is typical in a school setting, participants did not receive an equal number of group or individual AdPT sessions. The 3 participants in the treatment group received 10–12 sessions. Consistent with previous school-based play therapy research, sessions were conducted twice weekly (e.g., [Landreth & Bratton, 2009](#); [Meany-Walen et al., 2014](#); [Meany-Walen, Kottman, et al., 2015](#); [Schottelkorb & Ray, 2009](#)). Participants engaged in 30-min, individual sessions at the beginning of the week and a 45-min group session later in the week, in which the 3 participants made up the group membership. The play therapy procedures followed the *Treatment Manual for Adlerian Play Therapy* ([Kottman, 2009](#)), with considerations and adjustments made for the group process. Adjustments included using group counseling skills such as linking, drawing out, or engaging in group discussion and activities.

Pseudonyms for each of the participants have been created to disguise participants' identity. Demographics of the treatment group participants were as follows: first grade ($n = 1$); second grade ($n = 2$); girls ($n = 1$), boys ($n = 2$); Caucasian ($n = 3$). Anna was a first grade, Caucasian girl at the time of this study. Her teacher described her as impulsive, rude, and bossy, with few friends. According to Anna's teacher, she was intrusive in peer relationships and turned-off other kids from wanting to play. She stated that Anna was able but unwilling to follow classroom rules and often spoke out of turn. Anna participated in 3 weeks of no-

intervention baseline, five individual AdPT sessions, and seven group AdPT sessions. Six follow-up data points were collected. Christoph was a second grade, Caucasian boy at the time of the study. His teacher described his classroom behavior as unruly. He was impulsive and unpredictable; at times he would physically leap across the room. She stated that he was friendly and desired relationships but had limited interpersonal skills and self-control, and other students were disinterested in being his friend due to his big and loud behaviors. Christoph had three baseline data points and participated in five individual AdPT sessions and five group AdPT sessions. Five follow-up data points were collected for this participant. Geoffrey was a second grade, Caucasian boy. His teacher described his social and classroom behavior as chaotic and bossy. She stated that he demanded to be in control, and he regularly refused to follow classroom directions. She further stated that he routinely disrupted the entire class and was not liked by his peers. Geoffrey had three baseline data points and participated in five individual AdPT sessions and six group AdPT sessions. His follow-up data consisted of five data points.

The treatment provider was a Caucasian woman, doctoral-level, licensed, mental health counselor, and registered play therapist, with experience in school-based interventions. Several integrity measures were used to ensure a great degree of treatment fidelity and research rigor. The provider has advanced training in play therapy, specifically in using the AdPT treatment protocol (Kottman, 2009). Sessions were recorded and compared with the AdPT Skills Checklist. Ten percent of all recordings were randomly selected and reviewed by Kottman who is the developer of AdPT and the treatment manual, to confirm the treatment followed the protocol. Because the treatment manual is specific to individual therapy, the reviewer was sure to assess for the elements necessary to be considered AdPT and for group process skills. To ensure client care and fair treatment to children who are research participants, and people in need of counseling, the treatment provider received ongoing supervision and consultation from Kottman.

All sessions were conducted at an elementary school. Because the school did not have a designated playroom, the counselor used one of

two spare rooms for a playroom. The rooms were private and allowed a confidential space for participants to engage in the AdPT process. Toys from each of Kottman and Meany-Walen's (2016) categories were supplied throughout the sessions: aggressive, expressive, family/nurturing, pretend/fantasy, and scary toys. During particular phases of AdPT, the treatment provider brought in specific materials such as books, games, or puppets with which to target particular goals such as to help the child gain insight or practice new skills.

The AdPT treatment followed the four phases of AdPT: building an egalitarian relationship; investigating the child's lifestyle; helping the child gain insight; reorientation/reeducation (Kottman & Meany-Walen, 2016). During the first phase, the child(ren) and play therapist work together to build a relationship in which power and decision making are shared, trust is established, and general relationship rules are created. Therapist skills used during this phase might include reflecting feelings, asking and answering the child's questions, demystifying the counseling process, and playing actively together. In the second phase, the Adlerian play therapist gathers information about the child and his or her lifestyle. The play therapist can learn this information from a variety of means. He or she might ask questions of the child's teacher or parent(s); observe the child in the classroom, lunchroom, or recess; ask the child questions; and observe the child in session. Specific interventions might include art activities, sandtray play, doll play, game play, and interactions with group members or the play therapist. The Adlerian play therapist is interested in learning lifestyle information that help the counselor to conceptualize the client in order to effectively and responsively treatment plan. Particular areas of interest are the child's goals of misbehavior (Dreikurs & Soltz, 1964), Crucial Cs (Lew & Bettner, 1996), personality priorities (Kfir, 1981; Kottman & Ashby, 2015), mistaken beliefs about self, others, and the world, and the child's assets. During the third phase of AdPT, the play therapist works to help the child gain insight into his or her lifestyle (that which was uncovered during the previous phase). Strategies to help the child gain insight include *spiting in the client's soup*, metacommunicating, mutual storytelling, dance or movement techniques, doll play or sandtray play,

puppet shows, bibliotherapy, or custom-created interventions. In the final phase of AdPT, reorientation/reeducation, the counselor teaches the child new skills through play activities, role plays, or other approaches. Here, the child has the “opportunity to practice socially useful behaviors and experiment with new thoughts and feelings all within the safety of a secure and supportive relationship” (Meany-Walen, Kottman, et al., 2015, p. 419).

Control group. The two students assigned to the waitlist control group received no treatment through the course of the study. One participant, Robert, was a second grade, Caucasian boy who was described to have erratic behavior, poor social skills, and a limited ability to keep to himself in class. The other participant, Scott, was a first grade, African American boy who was described as funny and energetic. His teacher further described his behaviors as impulsive, aggressive, and inattentive. She stated that he did not have many friends because of his rude and sometimes reckless classroom and recess behavior.

Data Analysis

Observational data using the DOF were gathered several times throughout the three phases of the study: baseline, intervention, and follow-up. The DOF was used to strengthen the objectivity of the assessment process. A research assistant who was blinded to the grouping of study participants, and start time of the intervention period, completed the observations. She observed each child two times in the classroom to get a single data point. The majority of the observations took place in the middle of the school week (Tuesday or Wednesday). At times, due to student or observer illness/absence, make-up observations were conducted at the beginning or end of the week. The baseline phase lasted at least 3 weeks as identified by Lundervold and Belwood (2000) as adequate for a baseline. As indicated by Ray and Schottelkorb (2010), it can be difficult for teachers or children to wait several weeks for a stable baseline before starting the intervention. Because the teachers of the participants in this study were eager to start the intervention due to the children’s challenging classroom behaviors, we started the intervention after three data points were obtained.

Visual analysis was used to determine the likelihood that change is a result of the AdPT treatment intervention (Lundervold & Belwood, 2000; Rubin, 2008). Visual analysis and the calculation of the percentage of nonoverlapping data (PND) are the most utilized and accepted methods of analyzing SCED data (Morgan & Morgan, 2003; Rubin, 2008). Using Kennedy’s (2005) recommendations, we graphed all of the data points to compare the treatment results over time. Level (mean) and variability (degree of difference between the trend and each data point), within each of the phases, were calculated and analyzed.

PND is a pragmatic approach for school counselors and mental health counselors (Lenz, 2013; Ray & Schottelkorb, 2010). The PND statistic is analyzed by calculating the percentage of data in the treatment phase that overlaps with the highest or lowest data point during the baseline phase (Lenz, 2013; Morgan & Morgan, 2003; Ray & Schottelkorb, 2010). The highest or lowest data point used for analysis depends on the desired outcome of the intervention. The goal of treatment in this study was to increase on-task behaviors, thus we used the highest data point during the baseline phase as our comparison value. To analyze the change in each participant’s on-task scores, a line was drawn from the highest baseline data point through the treatment phase and follow-up phase data points. Any points in the treatment phase that plotted higher than the baseline phase comparison data point were added and divided by the total number of data points in that phase (e.g., Lenz, 2013; Ray & Schottelkorb, 2010). The calculated percentage provides the effect size statistic. Because the statistic relies on a single data point, PND is vulnerable to Type II error in which a treatment effect size is reduced because of an outlier in the baseline phase (Lenz, 2013). We visually assessed our baseline data prior to determining the treatment effect size statistic we would use. While the baselines are not necessarily stable, we do not anticipate Type II error due to a baseline outlier. PND equal or greater than 90% indicates a “very effective” treatment, 70–90% indicates an “effective” treatment, 50–70% indicates “questionable” effectiveness, and less than 50% is considered “ineffective” (Scruggs & Mastropieri, 1998).

Results

Anna

Figure 1 represents the behavioral observations for Anna. Visual analysis for on-task behavior scores on the DOF revealed an improvement in desired behaviors over the course of the study period. During the baseline phase, Anna scored in the clinical range of behavioral concern for off-task behaviors. Her scores remained relatively stable during the first three observations following the start of the intervention with marked improvement starting around the fourth observation, followed by a strong and steady increase in scores. At the follow-up phase, Anna's scores remained out of the borderline or clinical concern range and had a steady trend during the six points of observation following the conclusion of the intervention, indicating that Anna's behaviors maintained the improved change when the independent variable was removed. The levels for each phase are as follows: baseline phase, 1.8; intervention phase, 4.3; follow-up phase, 7.6. The levels for the on-task scores demonstrated an improvement in desired behaviors from baseline to intervention phase and maintenance of desired behaviors from intervention phase to follow-up observations. Anna's behavior demonstrated slight variability over the course of each phase.

We also calculated the PND statistic across each phase to estimate the effectiveness of each treatment phase. The highest data point on the on-task scale during the baseline phase was 2.5. This value was used for comparison for the treatment and follow-up phases. In the AdPT treatment phase, the PND statistic was 86%,

indicating the treatment was effective for increasing Anna's on-task behaviors. During the follow-up phase, the PND statistic was 100%, which suggests the intervention was very effective in improving this participant's on-task behaviors. Teacher report supports the statistical and observational data. Her teacher stated that it was evident when Anna started therapy because her behaviors seemed to settle, and she was better behaved in the classroom. The school counselor also approached the treatment provider to offer supportive feedback implying that there was a notable difference in Anna's social behavior as seen in areas such as lunch, recess, and less structured classes (i.e., art and PE).

Christoph

Figure 2 represents the behavioral observations for Christoph. Visual analysis for on-task behavior scores on the DOF revealed an improvement in desired behaviors over the course of the study period. During the baseline phase, Christoph scored in the clinical range of behavioral concern for on-task behaviors. His scores remained relatively stable during the first three observations following the start of the intervention with marked improvement starting around the fourth observation, followed by a strong and steady increase in scores. At the follow-up phase, Christoph's scores initially reduced by 1.5 points, but remained out of the borderline or clinical concern range and improved to scores only .5 points below his highest point during the intervention phase. During the six-point follow-up period, Christoph's scores remained relatively stable, indicating that Christoph was able to maintain the desired behaviors following

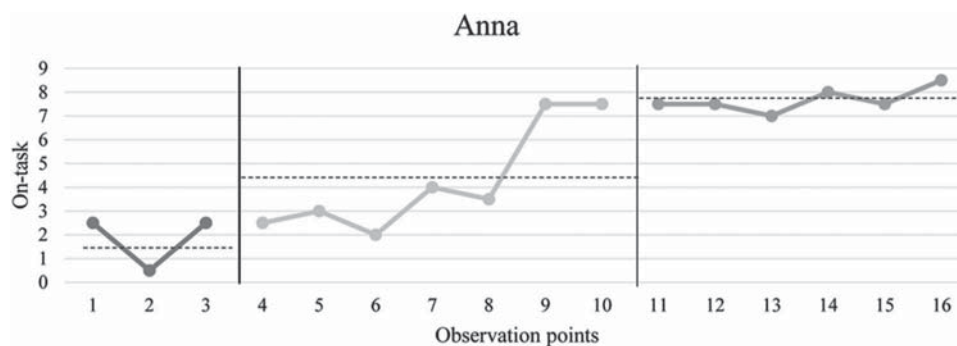


Figure 1. Anna's on-task scores. An increase in scores indicates improvement.

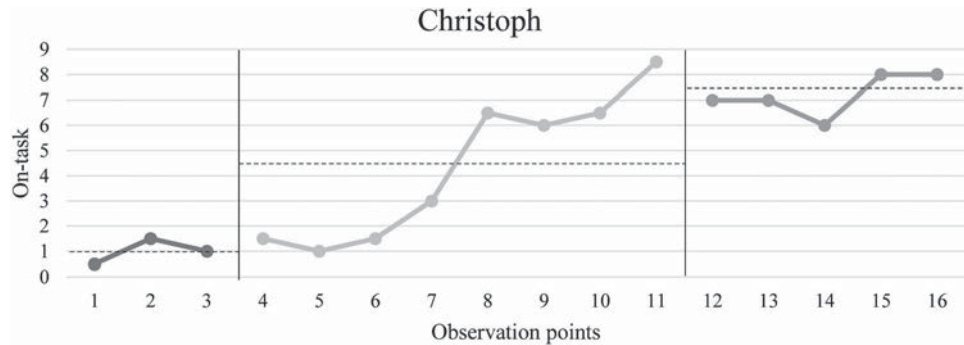


Figure 2. Christoph's on-task scores. An increase in scores indicates improvement.

the conclusion of the independent variable. The levels for each phase are as follows: baseline phase, 1; intervention phase, 4.3; follow-up phase, 7.2. The levels for the on-task scores demonstrated an improvement in desired behaviors from baseline to intervention phase and maintenance of desired behaviors from intervention phase to follow-up observations. Christoph's behavior demonstrated slight variability with an upward trend over the course of each phase.

We also calculated the PND statistic across each phase to estimate the effectiveness of each treatment phase. The highest data point on the on-task scale during the baseline phase was 1.5. This value was used for comparison for the treatment and follow-up phases. In the AdPT treatment phase, the PND statistic was 86%, indicating the treatment was effective at increasing Christoph's on-task behaviors. During the follow-up phase, the PND statistic was 100%, which suggests the intervention was very

effective in improving this participant's on-task behaviors. The teacher's report of Christoph's behavior after the study was complimentary but was not as positive as the observational data. The teacher reported that his classroom and social behaviors had improved but were still not at levels that she considered on-target for his age. She commented that he was able to sit for longer periods of time, improved his ability to focus and maintain attention on a single task, and required less attention after the intervention period than as compared with prior to receiving treatment. She also thought that a longer treatment period or additional services such as family therapy or testing for additional needs might be helpful.

Geoffrey

Figure 3 represents the behavioral observations for Geoffrey. Visual analysis for on-task behavior scores on the DOF revealed an im-

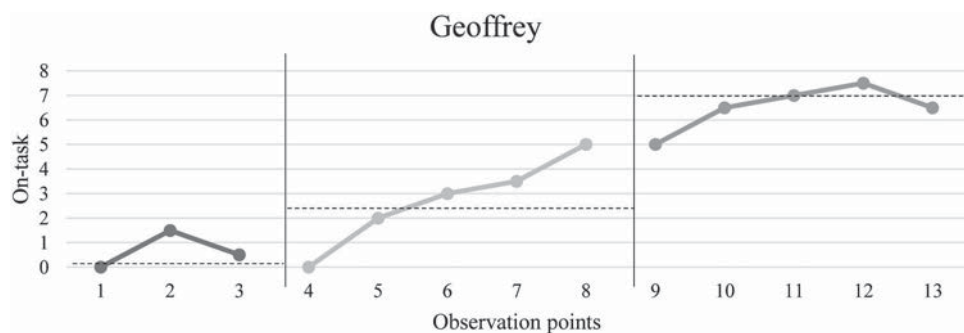


Figure 3. Geoffrey's on-task scores. An increase in scores indicates improvement.

provement in desired behaviors over the course of the study period. During the baseline phase, Geoffrey scored in the clinical range of behavioral concern for off-task behaviors. His scores steadily improved starting at the second observation during the intervention phase. This trend continued throughout the follow-up phase as well. During the 5-point follow-up phase, Geoffrey's scores moved out of the borderline or clinical range of concern, indicating that Christoph was able to maintain the desired behaviors following the removal of the independent variable. The levels for each phase are as follows: baseline phase, .7; intervention phase, 2.7; follow-up phase, 6.5. The levels for the on-task scores demonstrated an improvement in desired behaviors from baseline to intervention phase and an additional improvement of desired behaviors from intervention phase to follow-up observations. Geoffrey's behavior demonstrated slight variability with an upward trend over the three phases.

We also calculated the PND statistic across each phase to estimate the effectiveness of each treatment phase. The highest data point on the on-task scale during the baseline phase was 1.5. This value was used for comparison for the treatment and follow-up phases. In the AdPT treatment phase, the PND statistic was 80%, indicating the treatment was effective at increasing Geoffrey's on-task behaviors. During the follow-up phase, the PND statistic was 100%, which suggests the intervention was very effective in improving this participant's on-task behaviors. Anecdotal evidence from Geoffrey's teacher supported the observational findings of this study. His teacher saw notable differences in his classroom behavior. She described him as being more respectful and having less need for

control or power. She also shared that he was building friendships with other boys in his classroom and was occasionally sought after by peers when assigned to do group or partner activities. These were notable changes from prior to the intervention.

Robert

Figure 4 represents the observational behavioral data for Robert who did not receive intervention. Throughout the study period, the observer blinded to the treatment group observed Robert for two reasons. First, this deterred the observer from knowing which students received the AdPT intervention. This also created an observational timeline to see how a child might fair if he or she did not receive intervention during the same period in time that other students did receive intervention. Robert's scores indicated that he consistently scored in the clinical or borderline range of concern for classroom behaviors. His highest data point was 3.5 and lowest data point was 0. Robert's scores showed moderate variability, and his level was 1.6.

Scott

Figure 5 represents the observational behavioral data for Scott who did not receive intervention for the same reasons as Robert. Scott's scores indicated that he consistently scored in the clinical or borderline range of concern for classroom behaviors. His highest data point was 4 and lowest data point was 0. Robert's scores showed moderate variability, and his level was 2.5. Scott had less data points due to starting the study after the others and occasional absences.

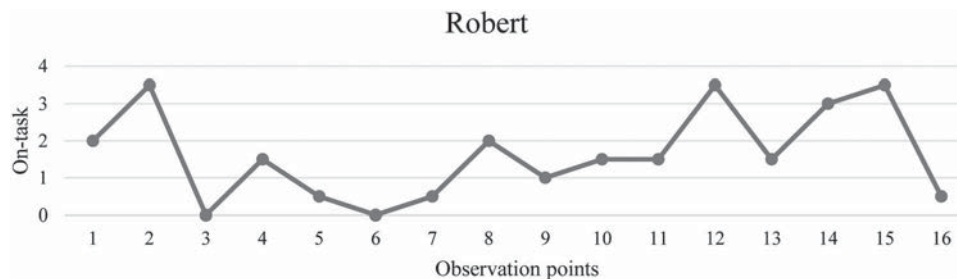


Figure 4. Robert's on-task scores. An increase in scores indicates improvement.

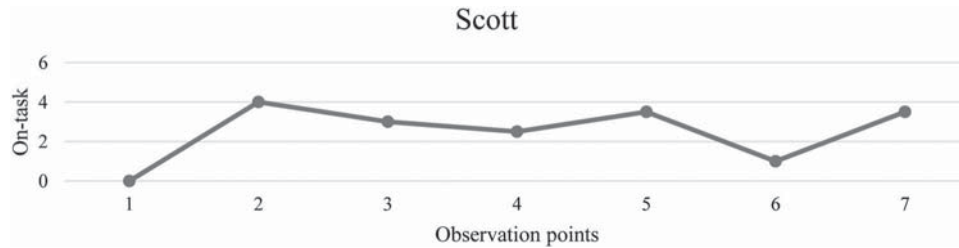


Figure 5. Scott's on-task scores. An increase in scores indicates improvement.

Discussion and Implications

A strong emphasis for accessible and effective interventions for children in the United States has been well-documented (President's New Freedom Commission on Mental Health, 2003; Taras & American Academy of Pediatrics Committee on School Health, 2004). We aimed to explore a mixed approach of individual and group AdPT with children who were referred to counseling for disruptive classroom behaviors and poor social skills. The results of this study revealed that AdPT was effective at improving behavior of the 3 participants during the intervention period and very effective at maintaining the desired behavior change following the intervention period, which is of particular importance with counseling-type interventions.

The results were relatively consistent for each of the participants who received AdPT. They showed an improvement in behaviors after a few AdPT sessions, which might indicate that the effects of AdPT are not immediate but rather, the changes become apparent in children's behaviors after a couple of sessions. This might be a response to the process of AdPT. The first session or more is dedicated to building relationships with subsequent sessions focused on helping children change their attitudes and behaviors (Kottman & Meany-Walen, 2016). Another treatment consideration is that the children received individual and group sessions at different intervals due to their absences. For each of the participants, the positive behavioral changes occurred immediately following their first group session, which could indicate that group sessions are more impactful at bringing about positive classroom change for the participants of this study. Waitlist participants did not show change over the time period, which might further support that change in the

three treatment participants was due to the intervention.

Previous SCEDs that investigated AdPT found that children's results from individual sessions ranged from ineffective to very effective treatment effect sizes (Dillman Taylor & Meany-Walen, 2015; Meany-Walen, Bullis, et al., 2015), and individuals who participated in group sessions revealed ineffective to very effective treatment effects (Dillman Taylor et al., 2015; Meany-Walen, Bullis, et al., 2015). The mono-treatment design showed various results whereas the blended treatment design showed more favorable outcomes for all of the children who participated in this design. These results might indicate that the combination of the individual and group AdPT was a benefit for the children of this study. Of the previously listed SCEDs that did use control groups, each found that participants who did not receive treatment did not show improvement, which is similar to the results of the control group participants in this study.

The blended treatment design might be a benefit to school counselors and school-based counselors who have several students in need of mental health services and a lack of time or personnel resources to provide such services (Hess et al., 2005). The group sessions allow for students to receive counseling services at the same time while reducing the amount of time that it takes out of the counselor's already busy schedule. As is suggested with AdPT, the individual sessions allow children the space necessary for personal disclosure, processing, and connection with the counselor (Kottman & Meany-Walen, 2016), and the group format creates opportunities for children to receive immediate feedback from peers and the counselor as well as the platform to practice new ways of

connecting with others and building relationships (Meany-Walen, Bullis, et al., 2015). The results of this study showed greater strength and outcomes of treatment effects as compared with research that used individual AdPT or group AdPT (e.g., Dillman Taylor & Meany-Walen, 2015; Meany-Walen, Bullis, et al., 2015; Meany-Walen, Kottman, et al., 2015).

A review of sessions with Anna revealed that she showed a one- or two-point improvement in scores following each of her group sessions with less improvement or even a reduction in scores following individual sessions. Definitive explanations and implications cannot be determined based on this research, but might suggest that whereas the individual sessions were important for stabilization, the group sessions were impetus for noticeable classroom behavioral changes. Christoph showed different results. During his treatment phase, he started his upward trend following his participation in group sessions and continued to improve after individual sessions. Again, for Christoph, the group sessions might have been the impetus for noticeable change, but his results did not stagnate following individual sessions. In fact, his greatest improvement in scores occurred after an individual session. Geoffrey's results were similar to Christoph's outcomes. He showed improvements following individual and group sessions, with greatest gains in on-task scores following group sessions. Occasionally, due to illness or absence, children were not able to maintain the individual-group session rotation as originally intended. The shift in rotation did alter the type of session that happened before the observation and the length of time between session and observation. A review of the data did not provide us with patterns that might account for the differences in the children's observational data but should be considered when interpreting results.

A final explanation and implication for the results is that AdPT is designed to respond to the individual needs of each client (Kottman & Meany-Walen, 2016). As children build collaborative relationships with peers and the counselor and reveal parts of their lifestyle, the Adlerian play therapist responds with interventions specifically designed to target the unique characteristics and needs of the children. An AdPT trained therapist respects that children will respond differently to interventions and will pace

themselves in a fashion that meets their development, lifestyle, and life circumstances (e.g., divorce, adult substance abuse, grief, birth of a sibling). Consistent with research strategies, the treatment design was determined prior to working with the children of this study. Had the counselor had freedom to manipulate the session type (individual or group) for each of the children, which is at the heart of AdPT, the results might have looked different.

Despite minor outcome differences between the three children, the results for each of the children showed strong evidence to suggest that AdPT was the cause of positive behavioral change. During the intervention phase, each child showed significant improvement in on-task behavior scores, and each child maintained or improved classroom behavior following the intervention. More research is needed to make greater reaching claims for AdPT, yet we believe the results of this study adds to the body of literature that supports the use of AdPT with children with disruptive or off-task behaviors.

Limitations and Future Research

Consistently, AdPT research touts the challenges with enlisting teachers to partake in regular teacher consultations (Dillman Taylor & Meany-Walen, 2015; Dillman Taylor et al., 2015; Meany-Walen, Bullis, et al., 2015; Meany-Walen, Kottman, et al., 2015). That existed with this research as well. The counselor attempted to meet with teachers during recess or via email. Teachers were pleasant and typically responded or interacted with the counselor. However, teachers did not wish to schedule time to meet with the counselor or process ideas for classroom behavior management. This might be in part due to their busy schedules and demands. A second, and similar limitation to this research is that parents were not contacted to do consultation with the treatment provider. Teacher and parent consultation is an important component of AdPT and future research that investigates teachers' reluctance to participate in AdPT consultations or research that makes a focused point of teacher and/or parent consultations being an essential part of the treatment plan is needed to explore the implications and potential benefits of including these important adults in the therapeutic process.

To date, the body of literature that explores AdPT uses a SCED (e.g., Dillman Taylor & Meany-Walen, 2015; Dillman Taylor et al., 2015; Meany-Walen, Bullis, et al., 2015; Meany-Walen, Kottman, et al., 2015) save for one randomized control trial (Meany-Walen et al., 2014). SCED provides important information about children's process during the intervention and can give researchers information about the treatment design and effectiveness. However, results cannot be generalized beyond that of the individual clients. More research that uses greater numbers of participants and pretest posttest designs, specifically randomized control trials, are needed to gain a better grasp of the impact and effectiveness of AdPT.

Similarly, the AdPT research that has been conducted uses AdPT as the independent variable and some variation of externalizing behaviors (i.e., off-task, disruptive) as the dependent variable. Because AdPT is the third most used play therapy intervention (Lambert et al., 2007), it would behoove researchers to explore the treatment effect of AdPT with children who present with internalizing behaviors or other symptoms such as somatization, trauma, or academic challenges.

Conclusion

AdPT demonstrated effective to very effective treatment results for the 3 participants of this study. Each participant showed the desired behavioral changes during and following the intervention. The intervention was relatively short and employed an individual and group format that might make this an attractive intervention for busy professionals such as school counselors. Whereas this research adds to the growing body of research that supports AdPT, more research is needed to make greater claims about its effectiveness.

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