International Journal of Play Therapy
2017, Vol. 26, No. 1, 1–11
© 2017 Association for Play Therapy
1555-6824/17/$12.00 http://dx.doi.org/10.1037/pla0000041

Treating the Tiers: Play Therapy Responds to Intervention in the Schools

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This article explores the potential of play therapy as a school-based intervention for children who are experiencing behavioral difficulties within the K-12 school setting. A model is presented describing the use of play therapy within the Response to Intervention (RtI) model at the Tier 2 and Tier 3 level. This article explores the RtI model and how play therapy can be incorporated by school counselors or school-based play therapists using individual and small group sessions.

Keywords: behavioral interventions, response to intervention, school counseling

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Research and practice support the notion that play therapy fits well within the school environment. Play therapy helps students develop a positive self-concept, assume personal responsibility, become more self-directed and self-accepting, create an internal source of evaluation, and enhance coping skills (Landreth, 2012). These life tasks parallel the lessons and goals of early childhood education. Through the use of play therapy in schools, students can problem-solve, motivate themselves, and improve social skills (Schaefer & Drewes, 2012). Because play therapy fosters responsibility, emotional awareness, and communication, it is a useful tool for school counselors and teachers (Perryman & Doran, 2010). In addition, play therapy aligns well with the American School Counseling Association's (ASCA) national model because it is developmentally appropriate, multiculturally sensitive, and empirically supported.

Developmentally Appropriate

Children play naturally and spontaneously for sheer enjoyment. They play without prompting or goal direction. As they play, they can address their feelings about themselves, others, and the world through metaphors and the manipulation of toys, rather than with words (Landreth, 2012). Because young children lack abstract reasoning skills and the verbal ability to articulate thoughts and feelings, it is through play that they express themselves early in life. Play provides children with a nonthreatening means of bridging the gap between their experiences and cognitions, thereby providing opportunities for learning.

Kottman and Meany-Walen (2016) outlines how using play therapy with children provides empowerment and self-understanding and also improves self-control and responsibility. This Adlerian approach outlines how counselors can work with children through active and direct engagement and promotes a partnership of equal power and responsibility between the counselor and child. According to Kottman (2011), the goal of this approach is to provide a sense of personal power to the child and support the child to choose how to interpret situations, events, and relationships.

Multiculturally Sensitive

Children from diverse backgrounds with different types of distress and dysfunction all attend school together. They bring with them a variety of mental health and social issues needing attention. It is imperative school counselors be aware, knowledgeable, skillful, and effective as they serve a diverse student body (American

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School Counselor Association, 2010, E.2.d). Because play therapy accepts each student as a unique individual and does not attempt to reshape their life or alter them in definitive ways (Axline, 1947; Landreth, 2012), it is a multiculturally sensitive approach to counseling. Additionally, "play is an integral component of most cultures, and mental health professionals must determine the role of play therapy for children from multicultural backgrounds" (Coleman, Parmer, & Baker, 1993, p. 68). Play is a voluntary action without a specified goal that assists children in addressing their feelings about themselves, others, and the world through the manipulation of toys. Particularly in Child Centered Play Therapy (CCPT), the relationship between the child and the counselor is the catalyst for therapeutic healing and development, further emphasizing that children are the best resources about themselves and are capable of directing their own growth (Axline, 1947). For the counselor, the focus is on being present with the child, as opposed to the application of specific procedures. It is that freedom to attend to the unique needs of the client that makes play therapy universal across cultures (Drewes, 2005). The counselor recognizes and respects children's innate capacity to grow, heal, and make choices that will help them flourish without direct intervention on the part of the counselor, who may have a completely different background and worldview.

Empirically Supported

Play therapy draws on decades of research. In the field's history it has evolved to include numerous theoretical frameworks and treatment modalities. Axline (1947) was among the first to study the effects of play therapy to validate her work and outcomes with children. Her research was rudimentary especially on issues of reliability compared with today's methodological standards. However, she was key in broadening the acceptance of play therapy.

Over the last 15 years, four meta-analyses have been conducted (Leblanc & Ritchie, 2001; Bratton, Ray, Rhine, & Jones, 2005; Ray, Armstrong, Balkin, & Jayne, 2015; and Lin & Bratton, 2015) to examine the effectiveness of play therapy. According to Lin and Bratton (2015), these four meta-analytic findings clearly confirm the effectiveness of play therapy, specifically CCPT approaches including filial therapy. ASCA's National Model calls for accountability and inherently requires empirically supported evidence for school-based interventions, such as play therapy. Behavioral, social, and emotional issues have been successfully addressed through various forms of play therapy (Bratton, Ray, Rhine, & Jones, 2005), such as reduced stress and more positive interactions with teachers (Ray, Schottelkorb, & Tsai, 2007). Further, when reviewed across more than 20 studies, CCPT has been found effective specifically in the elementary school setting (Ray et al., 2015), which includes benefits in the area of academic achievement (Blanco & Ray, 2011).

Response to Intervention and School-Based Play Therapy

Clements and Sabella (2010) state that once a counselor becomes familiar with the Response to Intervention (RtI) process, he or she can begin to understand that the foundation of RtI highly correlates to the components of a comprehensive counseling program. Specifically, the model stipulates that counseling programs work to identify specialized services, such as play therapy, based on the child's level of risk (2012). According to the U.S. Department of Education (2005), counselors should have a comprehensive knowledge and understanding of how to recognize barriers to equal educational opportunities for students. These early interventions are critical to a child's success, and school counselors play an integral part in identifying children's needs and assisting teachers with differentiated instruction. School counselors who are trained in play therapy can use the modality to intervene with students who are at risk of failure. These school-based play therapy interventions can be employed individually or in a small group setting.

Emergence of Response to Intervention

In 1975, the Education for all Handicapped Children Act (PL 94–142) was passed, and since that time, there has been endless debate about how to best serve students with disabilities. According to Ysseldyke, Algozzine, and Thurlow (1998), special education has been a controversial topic since the Education for all

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Handicapped Children was first mandated. This controversy directly contributed to debates regarding the diagnostic procedures used to identify students with possible disabilities. The 1975 legislation included the discrepancy model, which only labeled children as learning disabled if there was significant gap in achievement compared with the student's score on the intelligence scale.

The discrepancy model has come under tremendous criticism. Bradley, Danielson, and Doolittle (2007) found that the model was not useful in enhancing services for students, particularly in the area of early intervention. These authors continued their criticisms by calling it a "wait-to-fail" model, stating that students did not receive services when first observed, but had to wait until there was a wide enough gap between achievement and intelligence scores to qualify for special education services.

Carbo (2010) claimed, "The use of the discrepancy model meant teachers could not help students with learning until they had fallen substantially behind and were struggling" (p. 121). Other critics of the model have identified it as culturally insensitive with its use being to overidentify minority students for special education services (De Valenzuela, Copeland, Qi, & Park, 2006; MacMillan & Reschly, 1998). In response to these critics, leaders within the field of education proposed changes to the way students are identified for special education services.

The National Research Council's study conducted by Heller, Holtzman, and Messick (1982) marked the emergence of Response to Intervention (RtI). As a result, researchers found that the quality of instruction and the organization of special education services have an impact on the effectiveness of student outcomes. In 1983, The U.S. Department of Education published the A Nation at Risk report. This report once again spurred debate about the nation's education system, stressed the need for educational reform, and increased discussion of accountability measures (Ravitch, 1999).

In 2001, The No Child Left Behind Act (NCLB) required the measuring of every student's educational skills and academic progress. This act included students who fell within the subgroup of special education and led to the Individuals with Disabilities Education Improvement Act (IDEIA; 2004) reauthorization law, which specified that students could not be labeled as eligible for special education until "the child fails to achieve a rate of learning to make sufficient progress to meet state-approved results" (P.L. 108–446, 300.309). These two laws have established new guidelines for student identification as well as new accountability measures for students and teachers in both the general and special education classroom.

With these new guidelines, researchers and educational leaders have greatly enhanced the knowledge base from which educators now practice. Research on student learning and effective interventions have dramatically increased over the last two decades, and meta-analytic research has been able to identify best practices for learners (with and without disabilities) who are struggling with core curriculum (Kavale & Forness, 1999; Swanson, Hoskyn, & Lee, 1999).

RtI was developed as an early intervention for children who continue to fail to meet basic standards within the school system. Several national studies, such as the Common Ground Report (Roundtable, 2002), have made recommendations regarding identification, eligibility, and intervention for students who are experiencing difficulties. Researchers such as Marston (2005) studied national reports such as the Common Ground Report to see whether RtI standards fulfilled the requirements outlined in the report. Marston found that RtI positively corresponded to each of the recommendation statements; thus, the research study concluded that RtI is a valid option for identifying whether a student has a barrier to success.

In 2004, reauthorization of IDEIA took place and continued to spur the debate about best practices. The law states that a local education agency "must use a process that determines if a child responds to scientific, research-based interventions as a part of the evaluation process" (P.L. No. 108–446 614 b 6 A). This law is the basis for a great deal of change and continued debate within the educational system (Burns & Gibbons, 2008).

In the reauthorization of IDEIA, the federal government outlined objectives to improve special education services within the United States, and, while RtI is not federally mandated, IDEIA does include RtI approaches within its regulations and guidelines. This suggests a systematic framework for screening, intervening, and mon-

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itoring to help determine a student's response to evidenced-based interventions (Burns & Gibbons, 2008). In 2015, the Every Student Succeeds Act (ESSA) was authorized by President Obama. This most recent education legislation expands upon No Child Left Behind and adds flexibility to the previous policies. The ESSA legislation focuses not only on academic standards but also place emphasis on college and career readiness.

Response to Intervention

Carbo (2010) defines RtI services as an approach that serves as a safety net to catch students at risk of failure early and immediately provide carefully monitored interventions to ensure academic and behavioral improvements. Simply put, RtI is a process of implementing high quality instructional practices that are based on students' needs, monitoring progress, and then adjusting instruction based upon the data collected from the students' responses.

Moores (2008) states that the goal of RtI is to prevent failure and ensure success for all students using early identification and progress monitoring, along with research-based instruction. RtI focuses on evidenced-based interventions and proven data to drive instructional decisions that align with the goals of early intervention. Effectively used, RtI will allow teachers, counselors, and administrators to know how to identify students who are at-risk for failure using interventions grounded in research and shown to be valid and reliable. According to Vaughn, Fuchs, and Fuchs (2008), if these research-based interventions are introduced to students in the early stages of their education when struggles are initially identified, no longer will students have to "wait to fail."

Howard (2010) states that the tiered system is designed to offer instructional support at increasing levels of intensity according to the student's needs along with specific attributes. Models for RtI are divided into a three-tier system; each tier varies and is used to support the needs of all learners. The three tiers provide a framework for best practices.

Tier 1 serves as a universal foundation for student learning and focuses on quality instructional strategies. This tier contains core curriculum standards which help determine the effectiveness of instructional delivery of core content to students. Allington, (2011) states that Tier 1 interventions are the most critical. Students who experience difficulties at the Tier 1 level and are not growing at a pace equal to their peers should be provided with additional differentiated instruction. According to Justice (2006), Tier 1 instruction should provide school personnel with the opportunity to provide direct services with a concentration on high-priority targets for academic or behavioral development. Other strategies include small groups or other best practice interventions.

Tier 2 is for students who continue to demonstrate difficulty with academic and behavioral performances after receiving additional differentiated instruction. Tier 2 interventions are supplemental to Tier 1 instruction (Vaughn & Roberts, 2007). Tier 2 interventions provide small group experiences for those students who were unable to experience success at the Tier 1 level. The Tier 2 groups are generally small so that school personnel can attend to the needs of the students while explicitly focusing on the skill in need of development. Fuchs et al. (2008) states that Tier 2 interventions should be executed in small groups of four to six students and should be designed to provide a strong focus on skills that the students need to become proficient.

By design, Tier 2 is are highly structured requiring consistent application. Recommendations for Tier 2 interventions are that each intervention be provided within a 30-min time frame and be monitored on a biweekly schedule (Marston, 2005). As cited in Marston (2005), Tilly states that Tier 2 instruction is a combination of core instruction and supplemental instruction. These interventions should include structured tasks and be executed within an allotted amount of time. Previously conducted research suggests that, for Tier 2 instruction to be effective, the interventions should reinforce the learning goals and materials used in the Tier 1 instruction (Speece, Case, & Molloy, 2003; Vellutino, 2003).

If students are still underperforming at the Tier 2 level, they are then referred to Tier 3 instruction. Only a small minority of the student population needs this level of instruction (Coyne et al., 2004). Tier 3 is a much more intensive set of instructional interventions. This level of instruction should provide more strategic planning and direct interventions than the

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previous two tiers. The frequency and intensity of the Tier 3 interventions should increase from the Tier 2 model.

Tier 3 interventions are the most intensive level of intervention available within general education. These interventions should center directly on the needs of the child (Stecker, 2007). At the Tier 3 level, students generally receive personalized interventions in individual sessions or in smaller groups (no more than three students). The length of interventions and frequency of progress monitoring typically are longer and more intensive than at the Tier 2 level. General education teachers often find the detail and involvement that is required with Tier 3 interventions to be overwhelming; therefore, additional school personnel can be instrumental at this level to help provide additional services to these Tier 3 students.

While Tier 3 instruction does not automatically qualify a student for special education services, it may indicate the possibility for additional testing and exploration of special education services. According to Kashi (2008) after a student has participated in Tier 3 instruction for several weeks without any documented progress, the student is then in a situation for referral to special education services.

Tier 2 Group Play Therapy

Students may be referred for Tier 2 intervention when Tier 1 support has not been effective in changing behavior adversely impacting academics. There are various factors that may lead to challenging behavior. For example, the behavior may be related to symptoms of attention-deficit/hyperactivity disorder (ADHD), which can affect academic achievement and overall functioning in the school environment (McConaughy, Volpe, Antshel, Gordon, & Eiraldi, 2011; Voogd, 2014). Other behavioral factors that may lead to Tier 2 intervention are aggressive and disruptive behaviors, which can cause difficulty in developing positive peer relationships (Powers & Bierman, 2013). At an early age, lack of quality friendships can affect school adjustment and academic motivation (Vitaro, Boivin, Brendgen, Girard, & Dionne, 2012). Additionally, students who show aggressive behaviors may experience peer rejection, which is important to address as peer acceptance can be crucial to academic achievement and increased school engagement (De Laet et al., 2015; Powers & Bierman, 2013).

Group-centered interventions can be effective in addressing deficiencies prohibiting students from reaching their full academic potential (Harpine, 2008). Play therapy is a developmentally appropriate intervention for young children shown to be effective in treating ADHD, aggression, anger management, and disruptive behavior (Barzegary & Zamini, 2011; Fischetti, 2010; Meany-Waley, Bratton, & Kottman, 2014; Ray, Blanco, Sullivan, & Holliman, 2009; Swan & Ray, 2014). Group-centered play therapy is one approach for school counselors to use when combining group-centered interventions and play therapy for Tier 2 interventions (Harpine, 2008). In small groups, students can work through behavior and emotional issues while increasing positive peer relationships.

Group-centered play therapy allows children to work through challenges in a positive, supportive environment (Harpine, 2008). The environment is primarily established through the school counselors' use of empathy and acceptance, modeled through interactions with students (Allen & Barber, 2015). The school counselor's unconditional positive regard within a safe environment is a form of modeling for students participating in the behavior intervention group. Expressing genuine acceptance and teaching this to students helps them build relationships and develop empathy for others. Group counseling with children in schools takes much preparation and planning (Kestly, 2010). Therefore, planning for Tier 2 group play therapy should be done deliberately (see Figure 1). Tier 2 group play therapy ideally consists of up to 6 students in accordance with RtI recommendations (Pierangelo & Giuliani, 2008). The group is structured so the school counselor can actively focus on the students' goals (Kottman, 2011). Time should also be a consideration, as the frequency and duration of Tier 2 interventions are limited based on district or state regulations.

An Adlerian Approach to Group Play Intervention

In consideration of an effective theoretical framework for group play therapy, an Adlerian approach is supportive of developing positive

Group Focus	Behavior Objective	Replacement Behavior	Intervention Method	Expected Behavior Outcomes	Duration	Assessment of Progress
Increasing positive peer interaction; developing social skills	Student will engage in cooperative play without aggression toward peers during free play activities at least 4 days a week.	Appropriately express needs; engage in acceptable social interaction with peers.	Adlerian Group Play Therapy	Students will reduce behavior incidents by 60% within the next 9 weeks.	9 weeks, 3 times a week, 30-45 minutes per session	Child Behavioral Check List (CBCL); Teacher & Parent report; daily behavior report

Figure 1. Group play therapy plan summary. In this sample plan summary, a goal-focused, directive approach to group play therapy is chosen as the best method for a small group of students who collectively struggle in the class environment. The desire is to help students develop a positive sense of play and healthy feelings expressions.

relationships, gaining insight into students' perceptions, and understanding the purposes for misbehavior (Kottman, 2011). In addition, Adlerian play therapy acknowledges that all behavior is purposeful (Kottman, 2001, 2011). This view aligns with the use of functional behavior assessments in determining reasons for students' behavior, and an Adlerian approach in Tier 2 intervention supports the information-gathering process. Studies have shown the effectiveness of Adlerian play therapy in decreasing hyperactive, aggressive, and defiant behaviors and increasing social skills (Meany-Walen, Bratton, & Kottman, 2014; Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015; Meany-Walen & Teeling, 2016). More specifically, Adlerian group play therapy has been researched and found to be effective in improving on-task behaviors (Meany-Walen, Bullis, Kottman, & Dillman Taylor, 2015).

An Adlerian approach to group play therapy allows the school counselor to strategically implement directive and nondirective techniques throughout the process (Kottman, 2011). The school counselor begins phase one with a nondirective approach with a focus on student empowerment and relationship-building. The relationship is essential in this approach because of its recognition as a catalyst for encouraging change (Kottman, 2001). The second phase is more directive as the school counselor works to understand how students perceive the world and themselves, which may give insight to underlying causes of behavior. In the third phase, the school counselor alternates between a supportive, nondirective role to a challenging role. Because of emphasis on supporting students in making changes, this phase could be conducive to working with the students in goal-setting for behavior improvement. The final phase focuses on actively helping students learn and practice new skills and gain new perceptions. In the small group play environment, students can practice appropriate classroom behaviors and engage in positive peer and adult interactions.

Limit Setting in Adlerian Group Play Therapy

Limits are set to maintain safety in the play environment (Kottman, 2011). For instance, limit setting is important in working with children with aggressive behaviors. Because group play therapy can help foster positive peer relationships, limits should be set and maintained for protection of all children in the group. In addition, limit setting can allow the school counselor to redirect inappropriate behaviors, which may be an issue experienced in the larger classroom setting.

The four-step process of limit-setting in Adlerian play therapy aims to support students in redirecting their own behavior (Kottman, 2011). The school counselor sets the limit, makes a guess about the students' feelings and purpose of behavior, supports students in redirecting their own behavior, and discusses consequences for continued limit violations (Kottman, 2001). In determining behavioral growth, an assessment of progress could be the students'

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ability to acknowledge feelings and purpose for behavior, as well as a decrease in defying limits.

Tier 3 Individual Play Therapy

Intervention at the Tier 3 level is more intensive and individually focused (Burns & Gibbons, 2008; Pierangelo & Giuliani, 2008). As with Tier 2, play therapy should be used as remediation for the student's presenting problems. However, work with the student at this level is now one-on-one instead of whole class or small group. The school counselor's approach with Tier 3 intervention still centers on the child's behavior goals or objectives outlined in the behavior improvement plan (see Figure 2). The goal of Tier 3 therapy should be to show adequate progress (Burns & Gibbons, 2008) by eliminating or decreasing the severity of problematic behaviors. At this level, the student's progress is more closely monitored to determine if a special education ruling is necessary.

Determining a play therapy approach is dependent on the child's individual goals. Understanding the child's needs is integral to utilizing an approach that encourages progress through play therapy. In addition, this understanding helps the school counselor measure progress inside the playroom and, with parents' and teacher's help, outside of therapy. Whether the behavioral challenges result from defiance, impulsivity, or poor relational skills, the school counselor should consider what approach works best for the child. For example, a nondirective approach may be considered if the focus is on using the therapeutic relationship to help students develop healthy communication and feelings expression (Kottman, 2011). This may also be considered for students who have trouble with aggression toward others. If the student needs more structure with attention to specific behavior goals as determined by the intervention plan, then the school counselor may consider a directive approach necessary. Directive play therapy may be more efficient at this level because Tier 3 intervention is time-limited and goal-oriented.

School counselors should still be deliberate in planning with students at the Tier 3 level. Consideration should be given to best intervention approaches to address presenting problems (Burns & Gibbons, 2008). Research-based approaches can assist school counselors in deciding what approaches are beneficial for decreasing the unwanted behaviors. School counselors should also be reflective of goals in the behavior improvement plan and ways to assess progress. This is pertinent to determining the next steps in the special education referral process.

Application of Play Therapy: Brandon

The following is a presentation of how play therapy can be applied as a tiered behavior intervention. Brandon is a first grader at Davis Elementary. Brandon has exhibited behavioral challenges since the beginning of the school year that have affected his academic progress. Although he is capable of performing at-level academically, he struggles behaviorally in the classroom environment. Initially, Brandon had trouble following directions and obeying classroom rules. His teacher worked with his parents throughout the beginning

Current Behavior or Summary	Behavior Objective	Replacement Behavior	Intervention Method	Expected Behavior Outcomes	Duration	Assessment of Progress
Difficulty engaging in positive social interactions with classmates.	Student will engage in positive social interaction during play at least 3 out of 5 school days.	Sharing with peers during center time; playing without pushing or taking items from peers without asking.	Child-Centered Play Therapy	Participate in group/center play without incident during 70% of the school day.	Twice a week, 30-45 minutes per session	Child Behavior Checklist (Parent and Teacher Report); behavior referrals reduced by 50%

Figure 2. Behavior improvement plan summary for kindergartner. This sample plan focuses on intervention for a kindergarten student struggling with peer interactions. Child-Centered Play Therapy has been shown to be effective for children with aggressive behaviors and for improving social skills. By emphasizing an accepting, supportive relationship, it is hoped that the student builds self-confidence and vocabulary to aid in feelings expression.

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of the semester to implement a positive reinforcement system to help Brandon improve his behavior. Brandon continued to have problems, which affected his relationships with peers. He became aggressive toward classmates, refusing to wait his turn and often pushing or hitting others when he did not get what he wanted. Brandon was suspended twice during the first half of the first semester for displaying aggressive behavior. After additional suspensions and lack of improvement with Tier 1 classroom-based interventions, the RtI team and Brandon's parents decided to move Brandon to Tier 2 intervention with a 9-week progress check date.

The RtI team decided on interventions to implement to assist Brandon with engaging in positive peer interactions during free play and following instructions without redirection during instructional time. In addition to specific interventions implemented in the classroom, it was decided that Brandon would receive intervention from the school counselor, also a member of the RtI team. The school counselor met with Brandon's teacher and parents to gather more information about his behavior and requested they complete the Achenbach Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). The school counselor also observed Brandon's interactions with his peers during class activities. With this information gathered, the school counselor decided to implement group play therapy as an evidence-based behavior intervention.

The school counselor relied on previous play therapy training to begin the process of group play intervention. Prior to forming the play group, the school counselor screened for students who functioned at similar developmental levels and who could model target behaviors for Brandon (Reddy, 2012). After receiving parental consent to involve selected students in group play, Brandon was placed in a small group with two other students. Because of Brandon's difficulty functioning in the classroom setting, sessions were structured with a routine that was manageable for the school counselor and easy for students to follow. Also considered were the group rules. These rules were written on a chart to be reviewed with students before each group play session. The school counselor was sure to limit the number of rules and understood to phrase them in "positive, proactive language" (Reddy, 2012, p. 33).

Each group play session began with a review of the routine and group rules. Group play included interventions that supported cooperative peer interactions and social skills building. The school counselor used behavior management strategies such as positive reinforcement, corrective feedback, and verbal prompts to support Brandon as he engaged in interactions with the group (Reddy, 2012). The school counselor reiterated these strategies with the other group members so they could serve as models for Brandon. Appropriate behavior and positive interactions were also modeled by the school counselor. There were moments when a less directive approach was taken to allow the group to problem-solve on their own, with specific attention to Brandon's role in these interactions. At times, he struggled with cooperative group play. Brandon sometimes pretended not to hear when the school counselor set limits and ignored reminders of group rules. When this occurred, the school counselor would give corrective feedback and allowed Brandon an opportunity to change his behavior. If this did not work, the school counselor would deliver an effective command, being specific and using a positive, encouraging tone.

At Brandon's 9-week target monitoring update, the RtI team reconvened to discuss Brandon's progress based on group play observations and classroom monitoring reports. Brandon's progress was further assessed using follow-up CBCL reports. It appeared that Brandon's classroom behavior was not improving. His aggression toward classmates was still an issue. The RtI team and Brandon's parents agreed to involve Brandon in Tier 3 intervention as he needed a more targeted, individualized intervention. A functional behavior assessment (FBA) was completed by the RtI coordinator, which consists of "methods and procedures that are used to identify associations between the behavior and variables in the environment" (Dunlap et al., 1993, p. 275). A behavior improvement plan was created, and further interventions included weekly individual play therapy sessions with the school counselor.

The school counselor began sessions with a nondirective approach to establish a trusting relationship and to transition Brandon from group play therapy. By using a child-centered approach, the school counselor wanted to help Brandon to understand the time in the playroom was for him. Initially, sessions consisted of a lot of aggressive play. Brandon often directed aggression at the

school counselor by throwing balls or attempting to hit with the play sword. To ensure a safe environment, the school counselor set limits on aggressive behavior (Kottman, 2011). Observation of Brandon's actions during sessions allowed the school counselor to recognize when a limit needed to be set prior to aggressive behavior. The school counselor engaged in the session by tracking and reflecting, making attempts to identify Brandon's feelings and emotions.

After six weeks of biweekly individual play therapy, Brandon began talking more and inviting the school counselor to play with him during sessions. His aggression occurred less frequently. Because Brandon sometimes struggled with expressing feelings or emotions, the school counselor incorporated activities to help Brandon create feelings statements. In class, Brandon's teacher noticed him engaging in more frequent positive interactions with adults and demonstrating less aggression toward classmates. During the 9-week Tier 3 progress monitoring meeting, reported observations and weekly behavior assessments revealed a decrease in adverse classroom behaviors. However, the teacher recognized that Brandon still needed support as he continued to have occasional challenges in group activities. Based on Brandon's progress and ongoing needs, the RtI team decided to continue with Tier 3 support. Brandon's behavior improvement plan was modified to include weekly individual play therapy sessions and small group therapy. An additional progress monitoring date was set for continued evaluation of Brandon's behavior.

Conclusion

If utilized properly, the RtI model offers numerous opportunities for counselors to work and act with students on both individual and group levels. School counselors can promote the integration of school-based play therapy and the RTI model to advocate for and empower students to achieve greater success. Through consultation, collaboration, and direct services, school counselors can be at the center of a successful RtI program that advocates for the needs of all students. The mission of the RtI model and of play therapy align naturally with a comprehensive school guidance program. Counselors who engage in school-based play therapy are in a unique position to work simultaneously within the goals of each to facilitate an agenda that dynamically works to meet the needs of children.

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Received December 9, 2015
Revision received September 6, 2016
Accepted September 12, 2016 ■

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