THE IMPACT OF SCHOOL-BASED GROUP ADLERIAN PLAY THERAPY ON INTERNALIZING BEHAVIORS AND ACADEMIC ACHIEVEMENT

by

KELLY OWEN

(Under the Direction of Jolie Ziomek-Daigle)

ABSTRACT

The urgent need to address the mental health needs of students in the United States has recently gained significant attention in the aftermath of the Coronavirus pandemic and recent school shootings. Alarmingly, studies show that only one-third of the children suffering from mental health behaviors will receive mental health services, and 80% of these students receive these services in the school setting (Lin & Bratton, 2015). Unfortunately, students struggling with internalizing behaviors often go unnoticed, leading to missed opportunities for early intervention, which can have adverse lasting impacts social-emotionally and academically. School counselors, often the primary source of counseling services, play a critical role in removing obstacles to academic achievement through developmentally appropriate and evidence-based interventions. Group Adlerian Play Therapy (GAdPT) is a developmentally appropriate, feasible, and efficient intervention for engaging students simultaneously, rooted in Alfred Adler's Theory of Individual Psychology.

This randomized control trial examined the impact of Group Adlerian Play Therapy (GAdPT) compared to the waitlist control group (WG) with 94 fourth and fifth-grade students who qualified with clinical levels of internalizing behaviors. Forty-eight

students were randomly assigned to GAdPT (treatment group), and forty-six were assigned to WG (waitlist group). The students in the treatment group received two 30-minute play therapy sessions per week for six weeks.

Results from a two (group) by two (repeated measures) split plot ANOVA indicated that compared to the WG, the GAdPT group demonstrated statistically significant improvements on (a) internalizing behaviors at home, as reported by parents, (b) internalizing behaviors in the classroom, as reported by teachers, (c) reading scores, as recorded by a standardized reading assessment, and (b) math scores, as recorded by a standardized math assessment. GAdPT demonstrated a large effect size on all measures, indicating the clinical significance of the intervention. In summary, 73% of parents and 91% of teachers reported improvements in internalizing behaviors revealing clinical significance of the results. The standardized assessments reported that 65% of students improved in reading and 67% in math, moving from below to on-grade level from pretest to posttest.

INDEX WORDS: Play Therapy, Internalizing behaviors, Academic achievement, School counseling, Elementary students, Group play therapy, Childhood mental health

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DEDICATION

"Be still and know that I am God" (Psalm 46:10). When it seemed as if all hope was lost, this psalm resonated with my soul, radiating assurance that God would make everything alright. Through dark valleys and over unrelenting mountains, He provided a peace during this journey that surpassed all understanding. This dissertation stands as a testament that miracles and tender mercies do happen, in His way and on His timetable. I humbly dedicate this dissertation to a loving Heavenly Father who taught me to "Be still and know that He is God."

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CHAPTER 1

INTRODUCTION

In the aftermath of relentless school shootings and the aftershock of the Coronavirus Pandemic, children are facing a mental health crisis in the United States, and the need for mental health services has reached a record high (Abramson, 2022). The U.S. Secret Service and the U.S. Department of Education (2022) report that a substantial number of students who engage in acts of violence in schools exhibit evidence of being victims of internalizing behaviors, including depression, low self-esteem, and social isolation. The global pandemic has exasperated these problems and has created multifaceted and unexpected burdens on children, including isolation, insecurity, uncertainty, increased fears, loss of family members, and financial instability (Sethy & Mishra, 2020). Before the pandemic in 2020, suicide rates among children and youth were the second leading cause of death (Leeb et al., 2020). Amid the pandemic in 2020, emergency department visits for mental health needs such as anxiety, trauma, and suicidality sky-rocketed by 24% for children ages 5-11 and 31% for youth ages 12-17 (Leeb et al., 2020). Lurie Children's Hospital in Chicago surveyed 1,000 parents from across the Nation. The survey revealed that 71% of parents said the pandemic negatively impacted their child's mental health, 69% of parents noted that the pandemic was the worst thing to happen to their child, and 64% believed the pandemic would have lasting effects on their child (Children's Mental Health During Covid-19 Pandemic, 2021). For

more than a decade, children's mental health has declined, with 20% of children experiencing a diagnosable mental, emotional, or behavioral disorder (Abramson, 2022).

Alarmingly, studies show that only one-third of the children suffering from mental health behaviors will receive mental health services (Lin & Bratton, 2015). The research shows that the unmet mental health needs of children last into adulthood, resulting in increased violence, suicidality, substance use, incarceration, higher dropout rates, and risk of homelessness (Carbonneau et al., 2016). Of the children who receive counseling services, 80% receive these services within the school setting. Regrettably, schools typically overlook students suffering from internalizing behaviors, such as depression, social isolation, peer relationships, anxiety, and low self-esteem, as these behaviors do not disrupt the learning environment (Cunningham & Suldo, 2014). The consequences of untreated mental health have lasting and sometimes devastating consequences and are just as detrimental as externalizing behaviors such as defiance, aggression, and blurting out (Merrell, 2011).

Students struggling with mental health often show symptoms through both internalizing and externalizing behaviors. Disruptive or externalizing behaviors are directed outwardly at others, such as aggression, destruction of property, conduct problems, and hyperactivity-impulsivity (American Psychiatric Association, 2013). In comparison, internalizing behaviors can be challenging to detect and less often disrupt classroom instruction. Characteristics of internalizing behaviors include behaviors directed at the self, such as excessive worrying, withdrawal, depression, inattention, and somatic complaints (Achenbach & Rescorla, 2001). Commonly, students receive school counseling services through teacher or parent referrals to school counselors. While

internalizing behaviors are as problematic as externalizing, students exhibiting these symptoms are less likely to receive a school counseling referral since the behaviors do not often disrupt classroom instruction (Cunningham & Suldo, 2014). The disproportionate focus on students with disruptive behaviors permits schools to overlook students with internalizing behaviors preventing mental health support (Perryman & Bowers, 2018).

In addition, students suffering from mental health needs or trauma often find it challenging to process academic information and actively engage in instruction (Denham et al., 2012). Students who need help with social and emotional behaviors also struggle with academic achievement, self-esteem, happiness, social skills and peer relationships (Kendall et al., 2010; Blanco et al., 2011; Weiner et al., 2015). These concerns highlight the importance of early intervention to improve students' mental health needs and academic achievement.

Never has the service of school counselors been so important. Since students spend more than seven hours per day at school, school counselors have the unique opportunity to provide mental health support to children. Often, school counselors are the only social support accessible, and students are more likely to turn to the school for support than outside mental health services (Carlson & Kees, 2013). Children who receive counseling support in schools complete treatment at 96%, as compared to only 13% of students who complete treatment in the clinical mental health setting (CSMH, 2012). Recognizing symptoms or presenting concerns of internalizing behaviors and effective interventions for students increases the probability of lifelong success. Given the national attention to children's mental health crisis, there is an urgent need for school

counselors to effectively screen, assess, and provide evidence-based services to students in the school setting (Center for Disease Control, 2021).

Empirically supported data demonstrates that play therapy is an age-appropriate and effective intervention for young students because it utilizes children's natural language- play (Landreth, 2012). When offered in the school setting, play therapy provides opportunities for students to overcome emotional struggles that interfere with academic achievement (Blanco, 2010). Even though play therapy is considered the oldest and most famous intervention in counseling children, there remains criticism over the lack of scientific support for the efficacy of play as therapy (Kottman, 2011). Research investigating group play therapy also demonstrates the same trend (Ray, 2011). Critics blame a lack of researched outcome data for the research gap in play therapy (Bratton, 2010). School systems depend on rigorous research designs with an explicit treatment protocol to guide classroom and counseling instruction. An evidence-based approach will provide schools with the knowledge to help students overcome internalizing behaviors to increase their academic success. Despite the extensive research examining individual play therapy modalities, there remains a need for more empirical research on group play therapy.

Research investigating Adlerian Play Therapy (AdPT) follows the same pattern. Empirical support for AdPT shows only one randomized control trial (Meany-Walen et al., 2014) and several single-case experimental designs (Dillman et al., 2015; Meany-Walen et al., 2015a; Meany-Walen et al., 2015b; Meany-Walen & Teeling, 2016). In addition, despite the documented benefits of group play therapy (Sweeney, 2014), the studies examining group play therapy in school are non-existent. The literature also needs

more research studies involving students with internalizing behaviors, as this population proves challenging to detect and is susceptible to being overlooked. The disproportionate research on students with disruptive behaviors creates a gap in internalizing behaviors and effective interventions (Perryman & Bowers, 2018). There remains a considerable need to identify students struggling with internalizing behaviors and identify effective interventions to meet the mental health needs of students so they can be successful academically, socially, and emotionally. This dissertation is unique because it contributes to the literature concerning the effects of internalizing behaviors and the application of Group Adlerian Play Therapy (GAdPT) as an evidence-based intervention. This study provides valuable insights school counselors can utilize to address the substantial mental health needs of students in an effective manner.

Statement of the Problem

The Center for Disease Control and other government agencies have brought national attention to the pressing need to find effective interventions for students who endure mental health needs (Mental Health America, n.d.; O'Neal & Cotten, 2016; Center for Disease Control, 2021). A recent study on post-traumatic stress disorder showed that quarantined children scored four times as high on the post-traumatic stress scores than children who did not (Sethy & Mishra, 20220). The most common symptoms of traumatic events like a worldwide pandemic or vicarious trauma of active shooters include internalizing behaviors, including depression, behavioral problems, panic disorder, and anxiety (Sethy & Mishra, 2020). The Data Resource Center for Child and Adolescent Health (2005) reports that only 40% of students with mental health disorders graduate from high school, although the national graduation average is 76%. More than

any other population with disabilities, 50% of students with behavioral or emotional disorders drop out of high school. Furthermore, school safety is compromised when students do not receive adequate mental health care risking tragedies such as Columbine or Sandy Hook (Goff, 2019; Rasberry et al., 2020).

Since school counselors are often the only social support accessible, students are more likely to turn to the school for support than outside mental health services (Carlson & Kees, 2013). A crucial component of a professional school counselor's role is to alleviate obstacles that prevent students' academic achievement (American School Counselor Association, 2019). At the same time, expectations are high for students to meet academic standards; many who suffer from mental illness fight to access the standards due to the emotional barriers to learning (Perryman et al., 2020). The American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents was created to stimulate evidence-based interventions in schools for mental health professionals to find effective interventions to address the growing mental health crisis in our schools (Kratochwill et al., 2012).

Studies reveal that the prevalence of internalizing behaviors is high, illuminating the data that almost half of the children will experience a diagnosable disorder before adulthood (Merikangas et al., 2010). Since students' internalizing behaviors are not always observable to others, adults might overlook their needs, resulting in missed opportunities to receive interventions for mental health needs (Merrell & Gueldner, 2010). Furthermore, internalizing behaviors are a considerable concern for classroom teachers since they have adverse social-emotional and academic impacts on the student (Meany-Walen, Bullis, et al., 2015). Research supports findings that students' ability to

process emotions can improve academic achievement (Zin et al., 2004; Blanco et al., 2012, 2019; Elias, 2006). Students' social-emotional skills are critical and are predictive of student academic and social success (Denham et al., 2012). In addition, most research studies also focus on externalizing behaviors which creates a gap in the research regarding internalizing behaviors and effective interventions (Perryman & Bowers, 2018). Consequently, there is a significant need for evidence-based interventions to improve internalizing behaviors for students to succeed academically (Perryman & Bowers, 2018).

The secondary problem is that even though play therapy was introduced initially in the early 1900s, it has only recently gained more attention due to the increasing empirical data showing its effectiveness (Association for Play Therapy, 2018). School systems depend on evidence-based strategies to guide classroom and counseling instruction. The research reiterates the dire need for randomized control trials in play therapy to understand better the impact and effectiveness of interventions used in schools.

Research on play therapy has historically supported the tested interventions to determine efficacy, and which treatment modality is most effective (Lampropoulous, 2011). The discussion over therapeutic approaches has heightened as insurance companies, and school systems require evidence-based interventions (Kazdin, 2008). When examining play therapy research, the Association of Play Therapy provides a hierarchy of research designs for practitioners to evaluate the credibility and reliability of standard research designs (APT, 2019). The top of the pyramid recognizes literature review and meta-analyses as the most reliable and credible of all research designs (Paynter, 2009). Literature reviews and meta-analyses can pinpoint relationships across

multiple research studies (Rubin & Babbie, 2001). Next, randomized control trials (RCT) are considered the gold standard of intervention research design due to their rigor (Paynter, 2009). RCT's randomly assigns participants to either treatment or control groups, utilize pre- and post-assessments, use a manualized treatment intervention, and analyze data to determine the effectiveness of the intervention (Paynter, 2009). The trademark element of RCT is the use of randomly assigning participants to treatment or control groups. Random assignment helps control threats to validity and compares the investigated treatment with another form of treatment, methodologically dispersing these sources of unpredictability across groups and less impact on the outcome (Johnson & Christensen, 2017). Successfully implemented RCT designs attribute the differences in groups to the tested intervention (Johnson & Christensen, 2017). Despite the benefits, RCT's require large sample sizes to calculate statistical significance, which makes them challenging for school counselors to conduct. Next, observational studies such as single-case, single group experimental, and quasi-experimental designs are popular interventions designs when RCTs are not feasible (Johnson & Christensen, 2017). The disadvantage of these designs includes the limiting interpretations of outcomes due to confounding variables.

The strength of a randomized control trial offers insight into development of vigorous research interventions that produce positive outcomes for students struggling with internalizing behaviors. Since only two RCT's have been published using AdPT (Meany-Walen et al., 2016 & Dickinson, 2021) which are considered the gold standard of research design, more evidence providing evidence for AdPT is needed. While AdPT seems to be a promising approach to helping students in the school setting, more rigorous

research designs are needed to claim generalizability across various cultures and dependent variables to inform school counselors of the usefulness of AdPT or GAdPT (Meany-Walen, 2020).

Counselors are most effective when they use developmentally appropriate interventions with children. In Landreth's (2012) words, "Children learn through play; therefore, play therapy is adjunct to the learning environment, an experience that helps children maximize opportunities to learn in the classroom" (p. 86). The brain of a child develops until about the age of 25, limiting the ability of most children to verbalize thoughts and feelings effectively (Perry, 2009). According to the Association of Play Therapy, play therapy has shown effective results for many presenting concerns and across theoretical approaches (Association of Play Therapy, 2018). Play therapy has evolved to use various theoretical approaches, including psychoanalytic perspectives, nondirective approaches such as child-centered, cognitive-behavioral, and Adlerian approaches (Kottman, 2011).

With more than 2,200 play therapy publications in the past thirty years, the empirical studies confirming its effectiveness remain sparse (Landreth, 2012). These empirical studies looking at play therapy (Bratton & Ray, 2000; Bratton, Ray, Rhine, & Jones; Leblanc & Richie, 2001) show many gaps in the literature regarding the effectiveness of play therapy using different theoretical orientations and documenting the impact play therapy has on various mental health problems (Bratton, 2010). Regardless, better-designed studies are needed to investigate the effectiveness of the different theoretical play therapy approaches on various presenting concerns (Bratton et al., 2005). Since Adlerian Play Therapy (AdPT) was developed in the 1980s, AdPT has become one

of the most utilized play therapy approaches (Meany-Walen & Kottman, 2019). The Substance Abuse and Mental Health Services, which identifies evidence-based interventions, considered AdPT as an evidence-based practice due to its demonstration of empirical support on a targeted issue (SAMHSA, 2019).

Even though more than ten evidence-based published research articles use AdPT, only two of these studies use a randomized control trial (RCT), considered the "gold standard" of research. (Meany-Walen, 2020). The two RCTs using AdPT examined disruptive behaviors in the clinical and school settings (Dickinson, 2021; Meany-Walen, 2010).

Group counseling easily integrates with AdPT as it provides opportunities to express creativity, develop a social connection, observe students holistically, and reinforce personal responsibility (Ziomek-Daigle et al., 2008). Allowing school counselors to access more students, group play therapy is ideal in the school setting. Group therapy empowers children to generalize new skills in the group setting to compare to real-world scenarios (Yalom, 1995). During group play therapy sessions, children use their natural language of play to communicate with other children, forming healthy relationships (Meany-Walen &Kottman, 2019). Sweeny et al. (2014) reviewed group play therapy studies and discovered no studies on group play therapy for more than 13 years between 1988-2001. Since then, group play therapy research has accelerated for child-centered play therapy approaches, but not for other modalities (Sweeney et al., 2014).

Despite the research supporting the use of AdPT in schools, no known randomized control trials use GAdPT as an evidence-based intervention for school

counselors. There are no studies to date examining how AdPT or GAdPT impacts internalizing behaviors in children. A randomized control trial will provide schools with the knowledge to help students overcome internalizing behaviors and increase academic success. Research adhering to rigorous research standards is critical to finding interventions to address children's mental health crises.

Even though many randomized control trials show promising results looking at internalizing behaviors using Child-Centered Play Therapy (CCPT) and Group Child-Centered Play Therapy (GCCPT) (Stulmaker & Ray, 2015; Blanco et al., 2015; Naderi et al., 2010; Ojiambo & Bratton, 2014; Morrison & Bratton, 2011; Siu, 2009; Cheng & Ray, 2016), there are no studies used GAdPT as the treatment. Furthermore, very few randomized control trials found significance for play therapy and academic achievement when using CCPT (Blanco et al., 2015; Blanco et al., 2019; Perryman, 2020; Massengale, 2020; Holliman et al., 2022). To date, there are no studies examining the impact of Adlerian Play Therapy on academic achievement.

Purpose of the Study

The purpose of this study is designed to establish the effectiveness of GAdPT in decreasing internalizing behaviors for referred students while also investigating the impact on academic achievement. This study is to equip school counselors with an evidence-based intervention to meet the dire needs of students struggling with mental health in schools. This study utilizes a randomized waitlist control group design with two treatment conditions (experimental/waitlist group) and two points of measurement (pretest/posttest) to examine the effectiveness of GAdPT compared with a waitlist treatment group. The two research questions are as follows:

RQ1: Does participation in GAdPT decrease internalizing behaviors among referred elementary students?

RQ2: Does participation in GAdPT increase academic achievement among elementary students referred for internalizing behaviors?

Significance of the Study

This study will empower school counselors with research-based interventions to alleviate the internalizing behaviors that disrupt the learning for an increasing number of students with sometimes tragic consequences. School counselors have incredibly full schedules, and the mental health needs of students since the pandemic have multiplied. Therefore, school counselors often lack time to meet the overwhelming needs of every student. Group play therapy is advantageous in a school setting because it empowers school counselors to serve more students in less time using developmentally appropriate methods. The results of this study will provide the school counseling profession with evidence of an effective intervention to decrease internalizing behaviors for students so they may learn without barriers and experience childlike happiness. By researching the possible effects of GAdPT using a randomized control trial, school systems can create a foundation for utilizing group play therapy within the school setting. Direct evidence linking the relationship between emotional health and academic achievement will empower school systems to teach students holistically to maximize student success.

Brief Overview of the Study

In this quantitative study, the use of GAdPT will be examined through a randomized control trial with a waitlist comparison group. Treatment providers will utilize a twelve session GAdPT curriculum based on the Adlerian Play Therapy

Treatment (AdPT) manual. For ethical purposes, students in the waitlist control group will receive the same intervention as students in the treatment group after completion of the posttest assessments. Treatment providers, who are school counselors or social workers in public elementary schools, will each conduct play therapy groups for students in their schools referred for internalizing behaviors. Thus far, there have been no Randomized Control Trials (RCT) investigating Group Adlerian Play Therapy in the school setting.

Additionally, there are gaps in the research investigating AdPT and internalizing behaviors and academic achievement in the school setting. Data will be collected using a pretest prior to the intervention and a posttest after the intervention. Most play therapy studies only use assessments from a single source; this study involves teachers and parents as informants to the student's behavior. Furthermore, this study is the first study to adhere to parent consultation, a crucial construct of AdPT, during a research study using Adlerian Play Therapy. This study adds to the research supporting Group Adlerian Play Therapy in the school setting by evaluating its effects on academic achievement and students struggling with internalizing behaviors. A robust research design using generalizable data adds credibility to the intervention, empowering school counselors to access more students using evidence-based interventions.

Theoretical Framework

In 1987, Terry Kottman created Adlerian play therapy using the fundamentals outlined in Adler's Individual Psychology to be developmentally applicable to children in counseling (Kottman, 2011). The founder of Adlerian therapy, Alfred Adler, believed that it is essential to become familiar with the person's social context by exploring birth

order, lifestyle, and parental education (Adler, 1976). The Adlerian theory assumes people are creative and unique; people feel the need to belong and create lifestyles to help them manage life (Adler, 1976). Childhood experiences are essential to developing these lifestyles, and human behavior is goal oriented (Kottman, 2011). Kottman (2003) acknowledges Adler as one of the first theorists to recognize the importance of children's perceptions of their experiences and how personality impacts behavior. According to Adler (1976), "Play should be seen as educational aids and stimuli for the child's psyche, imagination, and life skills. Every game is a preparation for the future. In observing children during play, we can see their whole attitude towards life; Play is of the utmost importance to every child" (p. 42).

GAdPT, based on the same philosophical underpinnings as Adlerian Theory, follows the same phases as Adlerian play therapy with individual children: building an egalitarian relationship with members of the group, investigating the children's lifestyles, helping the children to gain insight, and reorienting/re-educating the children. Group Adlerian Play therapist merges theoretical concepts of play therapy skills, leadership roles, responsibilities to the goals of each phase of Adlerian play therapy (Dickinson, 2021). When applied in the group setting, Adlerian Play Therapy shows numerous benefits such as interpersonal learning, catharsis, and accessing more children in a limited amount of time which is critical for school counselors today (Meany-Walen & Kottman, 2019).

During GAdPT, Meany-Walen and Kottman recommend the play therapist meet individually with the child for the first few sessions (2019). The individual time spent with the child and the parents will help build a relationship built on trust and become

familiar with play therapy. The play therapist then selects more children to join the play therapy group, irrelevant of the child's therapy goals. Once Group Adlerian Play Therapy sessions begin, the group follows the four phases of Adlerian Play Therapy.

Within each phase of GAdPT, treatment providers practice Adlerian Play Therapy skills such as tracking behavior, restating content, reflecting feelings, encouraging, asking questions, metacommunication, and giving insight. Furthermore, treatment providers may return the responsibility, actively play with the child, clean the playroom with the child, and set limits (Kottman, 2019). GAdPT encompasses directive and nondirective play activities to allow students to develop insight, take appropriate risks, and interact with peers. Play activities include expressive arts, movement, games, and play. Each activity or game is purposeful for the specific phase of Adlerian Play Therapy. School counselors evaluate the appropriateness of each student in the play therapy group through lifestyle assessments, collaboration with teachers and caregivers, and interaction with the potential group members (Kottman, 2019). Group AdPT shows positive results when conducted twice a week for 30-minute sessions in the school setting (Meany-Walen &Kottman, 2019).

Limitations

In this study, several limitations need to be considered when interpreting results. Participants in the study represent a limited area from a selected area near Atlanta, Georgia. Use of limited range from the specific geographic location limits possible generalizations for future studies. While the natural world setting of this intervention supports AdPT applications in the school setting, it also comes with limitations. While it is impossible to control for some extraneous variables such as students receiving

additional support in gifted classes, school clubs, differences in teacher effectiveness, or school culture, conducting the study in a natural world school setting allows the researcher to generalize findings to other schools with different school cultures and discipline policies.

Using a waitlist control group opens the possibility of student improvements based on the use of an intervention rather than results precisely due to GAdPT. The researcher believed it was ethically essential to provide full disclosure to parents and teachers regarding their child's placement in the waitlist group. Creating an active control group without parent or teacher knowledge might lead to a loss of trust and misconception and among parents that their child was receiving services. The time constraints in the school setting are critical and the ethical implications of removing students from class for a group that does not yield educational benefits are questionable. Additionally, Adlerian play therapist utilize parent consultation, a fundamental principle of Adlerian play therapy, that would not be unfeasible with an active control group. To adhere to the highest ethical standards, the researcher opted to use a waitlist control group as the most appropriate option and benefit for students in this study.

Definition of Terms

For this study, the following terms have been operationally defined as indicated below:

Group Adlerian Play Therapy

Group Adlerian Play Therapy is based on the same philosophical underpinnings and follows the same phases as Adlerian play therapy with individual children: building an egalitarian relationship with members of the group, investigating the children's lifestyles, helping the children to gain insight, and reorienting/re-educating the children.

Group Adlerian Play therapist merges theoretical concepts of play therapy skills, leadership roles, responsibilities, and goals of each phase of Adlerian play therapy with group counseling skills, goals, and benefits (Dickinson, 2021). Two or more children are joined together in a group and move through the four phases of Adlerian Play Therapy using group skills and processes. Group interventions align well with Adlerian Play Therapy and Adlerian Theory since social embeddedness is the cornerstone of the theory (Meany-Walen & Kottman, 2019). Dr. Kottman published a Treatment Manual specifically for research for Adlerian Play Therapy and revised the treatment manual to include Group Adlerian Play Therapy in 2019 (Dickinson, R. 2021). The Treatment Manual's Group Adlerian Play Therapy section outlines specific recommendations for working with groups during each phase, appropriate play materials, spacing, group size, and recommendations for inclusion into the group (Dickinson, R. 2021).

Internalizing Behaviors

Internalizing behaviors refer to the difficulties that involve inner distress or difficulties within the self-such as anxiety, depression, withdrawal, and somatic symptoms. In this study, internalizing behavior problems are operationally defined using the internalizing behavior subscale scores on the CBCL or the TRF. T scores between 60 and 63 are considered within the borderline range, and those above 63 are considered within the clinical range (Achenbach & Rescorla, 2001). The TRF mirrors the CBCL for scoring students with internalizing behaviors. Students scoring in between 60 and 63 on the TRF are also considered within the borderline range, and those above 63 on the TRF are considered within the clinical range (Achenbach & Rescorla, 2001). Students scoring

in the borderline or clinical range on either the CBCL or the TRF are considered to have internalizing behaviors.

Academic Achievement

For this study, *academic achievement* is defined as increased scores, Quantile or Lexile, on the standardized Reading Inventory (MI) and Math Inventory (RI). Cobb County School District administers the MI and RI to all students in grades K-9 three times per year. MI and RI inventories are research-based, adaptive diagnostics that meet each student where they are. RI measures reading comprehension skills and longitudinal progress (Scholastic, Inc., 2011) and MI tracks math readiness progression (Scholastic, Inc., 2014). This study utilizes data points taken at the beginning of the six-week intervention and after the intervention will be used for this study. Achievement will be measure by Lexile's on the Reading Inventory and by Quantiles on the Math Inventory. For this study, the researcher will analyze scores for fourth and fifth grades, using grade level expected scores documented in the RI and MI Manuals.

Reading Inventory Scores below 539 (4th Grade) and 619 (5th Grade) are considered below basic grade level (Scholastic, 2011). Scores from 540 to 739 (4th Grade) and 620 to 829 (5th Grade) are considered basic. Scores between 740 and 940 (4th grade) and between 830 and 1010 (5th grade) are proficient. Scores above 941(4th grade) and 1011 (5th grade) are considered advanced on the Reading Inventory.

Math Inventory Scores below 389 (4th Grade) and 539 (5th Grade) are considered below grade level (Scholastic, 2014). Scores between 390 and 533 (4th grade) and between 540 and 644 (5th grade) are considered basic. Scores between 534 and 629 (4th

grade) and between 645 and 771 (5th grade) are proficient. Scores above 630 (4th grade) and 772 (5th grade) are considered advanced on the Math Inventory.

Chapter Summary

This chapter presents a brief overview regarding the focus of this quantitative research study regarding the current state of mental health of children, how their mental health impacts their academic achievement, and how evidence-based interventions such as GAdPT need research studies to solidify their effectiveness. The research reiterates the dire need for a randomized control trial to understand better the impact and effectiveness of Group Adlerian Play Therapy and how it can empower students to succeed academically. Randomized Control Trials are considered experimental research that compares groups and random assignment of participants. The overarching goal of RCT is to explore interventions while controlling for variables to find evidence-based interventions that can be generalized to the population.

CHAPTER 2

LITERATURE REVIEW

The following review of literature begins with a brief overview of children's mental health, specifically internalizing behaviors in the school setting as recognized by anxiety, depression, inattention, social withdrawal, and somatic complaints. The relationship between internalizing behaviors and academic achievement is explored and connected to play therapy research. In addition, this section includes a review of the history of play therapy and literature supporting its effectiveness for children with mental health needs and literature on group play therapy with supporting literature. Finally, this review highlights the theoretical underpinnings and constructs of Adlerian Theory and the general process of Adlerian Play Therapy. Group Adlerian Play Therapy is considered an effective intervention for addressing the mental health needs of children regarding internalizing behaviors in the contexts of parent collaboration, social justice, the roles of school counselors, and supporting research.

The most incredible tool school counselors embody for making systemic change is knowledge. A thorough literature review allows school counselors to make decisions based on proven theoretical orientations and evidence-based interventions to advocate for the students they serve. This review of research points to this study as the logical next step in the progression of research on play therapy and the overall mental health of students in elementary schools to improve academic achievement.

The Mental Health of Children

An increasing number of students each year struggle with mental health needs, and communities are struggling to keep up (Zyromski et al., 2018). Following series of alarming school shootings coupled with the lasting effects from the Coronavirus Pandemic, many children are grappling with diminishing coping skills amid a mental health crisis.

Prior to the worldwide pandemic caused by COVID-19, the mental health needs of children were increasing at alarming rates, with more than 20% of children experiencing mental health problems (Merikangas et al., 2010). The global pandemic introduced unexpected changes to our children and society, such as social isolation, government lockdowns, unexpected sickness, and loss of loved ones. Emerging evidence suggests worsened emotional and behavioral health among children and adolescents during the pandemic, including internalizing and externalizing behaviors (Hawke et al., 2020). Emergency room visits for children battling mental health have increased by 25% since the pandemic (Leeb et al., 2020). London & Ingram (2019) conducted a longitudinal study among elementary-aged students and discovered increased rates of loneliness and depression. Suicidality, trauma, technology addiction, and substance abuse have also increased among children (Gallo, 2017; Hou et al., 2019; Wan, 2020).

These unexpected changes have put pressure on children and forced many into isolation, resulting in increased mental health struggles that are too often overlooked (Fergert et al., 2020). Furthermore, during a crisis, many students who have never dealt with mental health issues before may find themselves experiencing anxiety or externalizing and internalizing behaviors for the first time (Fergert et al., 2020). The

researchers predict that students' mental health problems forecast future anxiety and depression into adulthood (London & Ingram, 2019).

Young students express their mental health needs through behaviors, internal and external, and show signs of psychological distress (Achenbach & Rescorla, 2001). Most behavior problems are classified as either externalizing or internalizing. Externalizing behaviors include conduct problems, aggression, hyperactivity, and defiance (Merikangas et al., 2010). Internalizing problems involve behaviors such as social withdrawal, somatic complaints, loneliness, inattention, and depression (Merikangas et al., 2010). Externalizing and internalizing behaviors differ in those externalizing behaviors typically involve defiance, disruptions, aggression, hyperactivity, and impulsivity, while internalizing behaviors involve anxiety, depression, low self-esteem, attention problems, and anxiety (Masten et al., 2012). Unlike externalizing behaviors, internalizing behaviors are directed toward the self and indicate a student's mental health needs. Internalizing behaviors manifest differently in children, and each student's experience does not necessarily look the same (Achenbach & Rescorla, 2001). Children demonstrating these behaviors often struggle with coping with negative or stressful situations or emotions. These negative behaviors directed within often contribute to the silent suffering descriptions of internalizing behaviors.

Students exhibiting disruptive behaviors typically demand attention, leaving students with internalizing behaviors to be overlooked and not given the support needed emotionally or academically (Perryman & Bowers, 2018). Untreated mental health disorders in children with internalizing behaviors are alarmingly high compared to students with externalizing behavior problems, illuminating the data that almost half of

children will experience a diagnosable disorder before adulthood (Merikangas et al., 2010). Shockingly, a recent study suggests that students suffering from symptoms of internalizing behaviors receive the same treatment as non-symptomatic students (Bradshaw et al., 2008). Since students' internalizing behaviors (anxious/depressed, withdrawn, inattention) are not always observable to others, adults might overlook their needs, resulting in missed opportunities to receive interventions for mental health needs (Merrell & Gueldner, 2010).

Lack of treatment for students with mental health concerns has serious consequences. Students struggling with internalizing behaviors have an increased risk of psychiatric disorders as adolescents and adults, including panic attacks, depression, conduct disorder, and attention-deficit/hyperactivity disorder (Denham et al., 2012). Children suffering from these problems risk jeopardizing their academic success and emotional well-being if their needs remain unmet (Merikangas et al., 2010). Struggling with internalizing behaviors often leads to lifelong consequences such as impaired relationships, lower academic achievement, and withdrawal symptoms (Bayer et al., 2011). Without interventions, students with internalizing behaviors risk facing social, emotional, and academic challenges.

Currently, most research investigates the impact of interventions on externalizing or disruptive behaviors, while research investigating internalizing problems has yet to be published (Horner et al., 2010). The assessment used to measure internalizing behaviors in this study, the Child Behavior Checklist Subscale of Internalizing Behaviors, includes anxious/depressed, withdrawn-depressed, and somatic complaints (Achenbach & Rescorla, 2001). The categories of internalizing behaviors, such as anxiety, depression,

social withdrawal, inattention, and somatic complaints, are described in the following paragraphs (Merrell & Gueldner, 2010).

Anxiety

The most documented internalizing behavior among children is anxiety, impacting one in eight children (Blanco et al., 2015). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) defines *anxiety* as "the apprehensive anticipation of future danger or misfortune accompanied by a fear of dysphoria or somatic symptoms of tension. The focus of danger may be internal or external" (p. 189). According to the typical onset age, the DSM-5 lists the different categories of anxiety in developmental order, with excessive fear and related behavioral disturbances as the standard features. Fear portrays an emotional response to a real or perceived imminent threat, and anxiety is the anticipation of the fear. While anxiety disorders are highly comorbid, they show differences in the types of feared or avoided situations. The categories of anxiety in developmental order include separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder, panic disorder, panic attack specifier, agoraphobia, generalized anxiety disorder, substance/medication-induced anxiety disorder, anxiety disorder due to another medical condition, other specified anxiety disorder, and unspecified anxiety disorder. Excessive fear and worry can impede student learning and mental health (Thompson et al., 2013). Anxiety can show up during certain situations, such as testing, or can be more generalized.

Many students respond to anxiety psychosomatically, and researchers agree that children's physical responses can be intense and involve the entire body (Hanie &

Stanard, 2009). Psychosomatic symptoms of anxiety include blurred vision, headaches, tense muscles, cold hands and feet, chest pain, rapid heartbeat, dry mouth, digestive problems, phobias, fears, behavioral problems, sleep problems, or unusual sweating (Hanie & Stanard, 2009). Children might become restless, withdraw, lose interest in usual activities, struggle to concentrate, struggle to maintain relationships with peers, increase absenteeism, become hyperactive, become aggressive, or show excessive worry (Thompson et al., 2013). Children suffering from high anxiety in primary grades are significantly more likely to drop out of high school than those with moderate or low anxiety (Duchesne et al., 2007).

Children suffering from anxiety typically focus on noninstructional stimuli rather than academic instruction (Wood et al., 2003). Additionally, research shows that anxiety limits academic performance because children with anxiety struggle to encode and process relevant information. As a result, cognitive functioning and processing decrease attention and concentration (Thompson et al., 2013). Several studies also demonstrate that high anxiety impedes the ability to retain information, reducing learning and causing children to perform lower on IQ and achievement tests than their peers (Merikangas et al., 2010). In recent years, the rise of anxiety has led many to refer to our time as the "Age of Anxiety" (Twenge, 2000). In addition to the recent surge in anxiety and childhood suicide rates, many students express heightened concerns about the possibility of school shooting (Pew Research Center, 2018). These concerns are associated with increased anxiety levels and a prevailing sense of fear among students (O'Brien & Taku, 2022). One study reveals that children today, compared to children in the 1950s, experience anxiety at increasingly higher rates. The same study found a direct link

between increased environmental dangers and a lack of social connectedness (Twenge, 2000). Researchers have warned that school officials might expect to see worsened mental health in students from the pandemic due to a combination of social isolation, economic recession, and a public health crisis (Fergert et al., 2020).

Depression

Depression is a mental health disorder that embodies internalizing symptoms like irritable mood, difficulty focusing, irregular sleeping patterns, fatigue, and feelings of worthlessness (American Psychiatric Association, 2013). Approximately 3.9% of children ages three to 17 have a diagnosis of depression (Perou et al., 2013). Features of depression include low self-esteem, sadness, guilt, mood variation, and social and interpersonal difficulties. Children who suffer from depression risk developing suicidal ideation diminished cognitive functioning, and academic delays (Perou et al., 2013).

Symptoms of depression in children might go unnoticed since undepressed children have similar behaviors (Merikangas et al., 2010). Social withdrawal, anger, eating difficulties, and sleep disturbances are symptoms of depression in children that are often expressed nonverbally (Merikangas et al., 2010). Essential features of depression include low self-esteem, sadness, guilt, diurnal variation of mood, loss of interest, fatigue, irritability, and agitation. Depression is a disorder that includes major depression, dysthymia, bipolar disorder, and depressive disorder not otherwise specified (American Psychiatric Association, 2013). Depressed children have social and interpersonal difficulties in that they suffer from poor peer relations, go into self-isolation, and concentrate on negative cognitions (Perou et al., 2013). There are also high comorbidity rates between depression and conduct disorder/oppositional defiant disorder and

attention-deficit/hyperactivity disorder (ADHD) (Merikangas et al., 2010). Often, students struggling with symptoms of depression find it hard to concentrate in school, which negatively affects reading and math achievement (Breslau et al., 2010).

A dangerous factor for children suffering with depression is the onset of suicidal ideation. A striking statistic reveals 85% of children who tragically die by suicide have a chronic history of depression, anxiety, and other diagnosable mental disorders (Perou et al., 2013). According to the Centers for Disease Control claims that death by suicide is the second leading cause of death among 10–24-year-olds, and many more children attempt but fail to complete suicide. In a comprehensive meta-analysis investigating internalizing behaviors, symptoms, and suicide discovered that students with these behaviors are at a higher risk of suicide attempts and death by suicide. Notably, the presence of depressive symptoms emerged as the most prominent risk factor for suicide attempts (Piqueras, 2019).

Inattention

Inattention or attention/hyperactivity disorder (ADHD) is among the most common diagnoses of students with evidence-based long-term problems. Problems associated with inattention and off-task behaviors predict low academic achievement and lower graduation rates (Swank & Smith-Adcock, 2018). These problems often continue into adulthood, with about 50% of adolescents and adults struggling with high school GPA, workplace performance, and arrests (Robinson et al., 2017). Early interventions help reduce the long-term adverse effects of inattention or ADHD and off-task behaviors in children. Empirical data reveal that play therapy has significant positive effects on students who struggle with inattention.

Students with attention-deficit/hyperactivity disorder (ADHD) or inattention problems often exhibit behaviors that interfere with learning. According to the DSM-5, ADHD is a neurological disorder characterized by inattention, hyperactivity, and impulsivity that interferes with daily functioning and development (American Psychological Association, 2013). Children with ADHD struggle to concentrate and listen, exhibit off-task behaviors, and struggle with maintaining positive relationships. Academic struggles related to inattention can lead to increased anxiety, frustration, stress, low motivation and depression. As students with inattention continue to underperform, their self-esteem and social relationships are also impacted. These off-task behaviors can negatively influence how peers and teachers view them, risking academic and mental health difficulties. Literature reports that off-task behaviors can include externalizing behaviors that interfere with others' learning and internalizing behaviors that interfere with the student's learning. Students who exhibit internalizing behaviors might daydream, struggle to finish assignments or become easily distracted. In contrast, students with externalizing behaviors might show aggression, act impulsively, and refuse to follow the rules (Meany-Walen, Bullis, et al., 2015).

Social Withdrawal

The definition of social withdrawal includes shyness based on fear of new situations or social experiences and a preference for isolation (Storey & Smith, 2008). Children who socially withdraw avoid social companionship, fail to reciprocate social invitations from peers and struggle to develop friendships. Social withdrawal might be temporary or long-term, depending on the child's state of mental health. Social withdrawal symptoms mirror symptoms of other disorders like depression and anxiety rather than a specific disorder

(Merrell, 2008). Students who socially withdraw are linked to lower academic achievement and a higher chance of dropping out of school (Serbin et al., 2010). Low self-esteem also contributes to students' avoidance of social interactions due to negative beliefs regarding social abilities. Even though students know how to socialize with their peers, they will avoid social situations due to their anxieties (Serbin et al., 2010).

Somatic Complaints

Somatic complaints parallel social withdrawal and are commonly viewed as a symptom of disorders rather than a diagnosis (Storey & Smith, 2008). Somatic complaints include physical pain or discomfort, such as headaches, abdominal pain, nausea, and gastrointestinal symptoms. Like social withdrawal, somatic complaints research shows that problems are a unique element of internalizing behaviors. Data on somatic complaints remains sparse since it is not understood as a specific disorder, even though somatic problems are prevalent in children. Most children with somatic complaints report stomachaches, nausea, headaches, skin problems, or breathing problems. Students who report high somatic complaints due to anxiety typically have poor academic achievement (Hughes et al., 2007).

Internalizing Behaviors Link Academic Achievement

Historically, the research investigating internalizing behaviors and academic achievement has been minimal even though academics is a prominent influence in students' lives. In recent years, studies have begun to examine the roles of internalizing and externalizing behaviors on academic achievement (Masten et al., 2012). Research shows that students with healthy social-emotional behaviors improve academic achievement and increase prosocial behaviors, such as kindness, sharing, and empathy,

have improved attitudes toward school, and demonstrate reduced depression and stress (Durlak et al., 2011).

Furthermore, internalizing behaviors are a considerable concern for school districts since they have adverse social-emotional and academic impacts on the student (Meany-Walen, Bullis, et al., 2015). Students with internalizing behaviors also struggle with academic achievement, self-esteem, happiness, social skills, and peer relationships (Weiner et al., 2015). These behaviors often lead to reduced class engagement, incomplete assignments, and decreased motivation to learn. Depression, anxiety, and other internalizing behaviors studied in a meta-analysis found that these behaviors are indicative of lower academic achievement, and students who were academically high achieving were less likely to suffer from internalizing behavior symptoms (Arslan et al., 2021b; Chen et al., 2013; Mychailyszyn et al., 2010). One longitudinal study found a strong relationship between inattention and achievement in math and reading by examining internalizing behaviors and achievement. Essentially, the higher the inattentive symptoms, the lower the levels of achievement for students (Merrell, 2010). A study involving students with depressive behaviors and self-criticism noted a significant relationship between the behaviors and academic achievement (Preiss & Franova, 2006). Two concurrent studies found that academic achievement on standardized tests and report cards showed a significant relationship to internalizing behaviors such as depression and anxiety (Durbrow et al., 2000).

Children battling internalizing behaviors cannot learn effectively in the school environment and risk lifelong consequences. These mental health concerns highlight the importance of early intervention to improve future success for students. There is a need to

utilize an evidence-based methodology to explore the efficacy of play therapy on students with internalizing behaviors and how this intervention impacts student achievement in school.

Internalizing Behaviors and School Counselors

There is a growing realization that students with internalizing behaviors might experience lifelong consequences if their needs remain unmet. Estimates show that up to 20% of school children struggle with behavioral, social, or academic achievement due to internalizing behaviors (Walker et al., 2000). Of these students struggling with mental health needs, 70–80% receive their care in schools (Hoagwood & Johnson, 2003). School counselors have the knowledge, insight, and specialized training to address students' mental health needs. Today, school counselors are essential workers as they face the daunting challenges of meeting children's social, emotional, and academic needs while battling systemic educational issues. Optimistically, students spend their time in school engaged in instruction, but too often, internalizing behaviors disrupt the learning of many students. Since school counselors are often the only social support accessible, students are more likely to turn to the school for support than outside mental health services (Carlson & Kees, 2013). A crucial component of a professional school counselor's role is to alleviate obstacles that prevent students' academic achievement (American School Counselor Association, 2019).

Consequently, recognizing symptoms of presenting concerns and effective interventions for students increases the probability of lifelong success. The critical role of school counselors emerged mainly during a worldwide pandemic that has increased the mental health problems for many children; school counselors are responsible for being

leaders, advocates, and change agents within the educational setting. Counselors are most effective when they use developmentally appropriate interventions with children. Empirically supported data demonstrates that play therapy is an age-appropriate and effective intervention for young students because it utilizes children's natural language-Play (Landreth, 2012).

An Overview of Play Therapy

Play therapy is a unique medium that facilitates children's therapeutic processes in a developmentally appropriate manner. Children under the age of 11 communicate, reason, and process information differently than individuals fully capable of abstract reasoning and verbal processing (Bratton et al., 2005). Young students typically lack the cognitive ability to express themselves through language; therefore, play therapy removes the barriers to communication that meet the needs of students. Play is the natural language of children that developmentally connects experiences to thoughts, empowering children to make meaning and express emotions in a developmentally appropriate manner (Ray, 2011). Opening doors to communication by using toys and play, play therapy meets students on their developmental level with appropriate therapeutic interventions. According to Ray (2011), "Play therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." Despite theoretical orientation, counselors utilize play and activities in therapeutic interventions to build positive relationships, improve behaviors, and help children express feelings, explore experiences, and enhance their self-view (Kottman, 2003). The essential part of the therapeutic process occurs when

children express their thoughts and feelings through play in the presence of a caring and empathetic adult (Landreth, 2012). Play therapy is proven to impact internalizing and externalizing behaviors, self-esteem, anxiety, suicide risk, attention problems, and aggression, and research confirms positive effect sizes across genders, ages, and presenting issues (Ray, 2011).

History of Play Therapy

Play therapy originated from Sigmund Freud's psychoanalytic framework in the 1900s, which he developed to explore children's self-expression (Klein, 1932). Freud first used play therapy to decrease anxiety with Little Hans when he recommended that the child should play (Klein, 1932). Anna Freud, Sigmund's daughter, recognized that children respond better to play therapy than to traditional talk therapy because the play opens the doors to a child's inner world (Sweeney et al., 2014). Anna Freud and Melanie Klein introduced toys and play into their practice (Sweeney et al., 2014). Virginia Axline's development of nondirective play therapy popularized play therapy as the natural communication of children and emphasized the need for therapeutic interventions to be appropriate for children's developmental levels (Lambert et al., 2007). Building on her work, Garry Landreth made significant contributions to the research and recognition of play therapy as a developmentally appropriate approach to counseling children (Lambert et al., 2007). While Landreth focused on Child Centered Clay Therapy (CCPT), the most practiced approach to play therapy in the United States, other fields of play therapy continue to grow (Bratton, 2010). Play therapy has evolved to use various theoretical approaches, including psychoanalytic perspectives, nondirective approaches, cognitive-behavioral approaches, and Adlerian approaches (Kottman, 2011). The

pioneers of play therapy established methods and practices that are necessary to meet the needs of children. While theorists differ in their approaches to play therapy, they all confirm that play therapy is the best modality for children to communicate and heal.

Play Therapy Research

Over the past few decades, play therapy research has increased to establish scientific recognition that play therapy is a research-based, developmentally appropriate therapeutic approach (Urquiza, 2010). Even though play therapy is considered the oldest and most well-known intervention for counseling children, criticism remains about the lack of scientific support for the efficacy of play as therapy (Kottman, 2011). While research studies involving play therapy in school settings are increasing, play therapy research targeting students with internalizing behaviors is scarce.

Play therapy data has expanded within the past thirty years, producing evidence that confirms different play therapy modalities and approaches (Ray et al., 2015). The dispute over play therapy approaches receives significant attention, as schools rely heavily on evidence-based reasoning to include in the curriculum. Despite play therapy's use since the early 1900s, many researchers in the field question its effectiveness due to the lack of empirical data (Dickinson, 2021; Frick-Helms& Drewes, 2010). Currently, gaps remain in the literature regarding the effectiveness of play therapy using different theoretical orientations (Bratton, 2010). Critics blame a lack of researched, evidence-based data for the research gap in play therapy (Bratton, 2010).

Even though more than 2,200 play therapy articles and books have been published in the past 30 years, empirical studies confirming play therapy's effectiveness are rare (Landreth, 2012). According to the Association for Play Therapy (APT), only

four peer-reviewed meta-analytic publications currently exist on the outcome effects of play therapy (Ray & McCullough, 2016). All the meta-analyses produced statistically significant findings for using play therapy as a treatment intervention. An analysis of the literature shows that a majority of the studies include nondirective Child-Centered Play Therapy (Lin & Bratton, 2015; Ray et al., 2015), and only two of the analyses allowed for the inclusion of other play therapy orientations (Bratton et al., 2005; LeBlanc & Ritchie, 2001). Two analyses explored randomized control treatment (RCT) methods to gauge effectiveness (LeBlanc & Ritchie, 2001; Ray et al., 2015). Two meta-analytic studies reviewed the impact of play therapy on internalizing and externalizing behaviors, while the other two studies explored overall effects. The largest meta-analysis of play therapy to date examined 93 research studies that showed a significant effect compared to no-treatment groups when utilizing play therapy for behaviors, aggression, emotional maladjustment, anxiety, low self-esteem, and mental disabilities (Bratton & Ray, 2000).

LeBlanc and Ritchie's (2001) meta-analysis included 42 play therapy outcome studies that revealed moderate treatment effects compared to no treatment. The study discovered two factors that played a significant role in play therapy's efficacy. Parental involvement and duration of treatment both led to increased positive results. The studies confirm a strong relationship between positive effect sizes, parental involvement, and duration in the play therapy process regardless of the presenting issue (LeBlanc & Ritchie, 2001).

Ray et al. (2011) and Bratton et al. (2005) also conducted meta-analyses, finding that positive results were greatest with parent collaboration. The study included pre- and post-measures, control groups, data to compute effect sizes, and identified play therapy

interventions. The strengths of this randomized control trial (RCT) research design include random assignment, control groups, exact intervention protocol, and appropriate data-analysis procedures (Ray & McCullough, 2016). The average number of sessions in school settings was 8.4, compared to 22.4 in clinical settings. However, play therapy yielded moderate treatment effects, demonstrating that play therapy is the preferred modality for treating students in elementary schools. Play therapy research reveals that children show statistically significant positive changes in disruptive behaviors, internalizing problems, academic progress, relationships, self-concepts, trauma, anxiety, and impairment when play therapy is the intervention (Ray & McCullough, 2016).

Researchers have summarized that steady research progress builds a strong foundation for the efficacy of play therapy as a valid intervention for children (Baggerly & Bratton, 2010). Since most of the research includes nondirective play therapy approaches, there is a need to expand the literature to include studies exploring directive play therapy approaches.

General Effectiveness of Group Play Therapy in Schools

While play is the natural language of children, group play involving two or more children is the natural process of building relationships for children (Sweeney et al., 2014). Groups are a microcosm of society (Yalom, 1995), and play is the language of children. Theoretically, combining play therapy's underpinnings with group therapy elements provides unique therapeutic circumstances for children to interact as they would typically. Landreth (2012) teaches that group play allows for children's innate constructive self-healing toward growth. The emphasis of group play therapy is to provide group experiences with communication and interaction through play with peers

in a natural setting. Relationships can cause distorted self-perceptions, while positive relationships within a group give insight into distorted misunderstandings and change mistaken beliefs and behaviors (Sweeney et al., 2014). Group play therapy combines unique experiences and therapeutic advantages not offered during individual counseling. Group play therapy is a process, social and psychological, that empowers students to learn how to learn from themselves and their peers through developing relationships with others and the counselor in the playroom (Sweeney et al., 2014). The goal of group play therapy during school is to allow students to learn, accept responsibility, control emotions, show respect, learn acceptance for self and peers, improve social skills, and remove barriers that impede academic progress (Baggerly & Parker, 2005). Group play therapy addresses presenting problems, mistaken beliefs, goals of misbehavior, and personalities. Sweeney (2011) defines group play therapy as

> [a] dynamic, interpersonal, and reciprocal relationship between two or more clients and a therapist trained in both play therapy and group therapy procedures. Group play therapy involves the selection of specific expressive and projective play media and the facilitation and development of safe relationships for clients to express and explore themselves and others (including feelings, thoughts, experiences, and behaviors). This occurs through expressive play, a natural medium of communication for children and a nonverbal means of expression for persons of all ages (Sweeney, 2011)

The advantages of group play therapy remain in the catharsis effect that students have with one another; the friendly atmosphere created with other children increases

meaningful relationships and addresses the loneliness that children often struggle with (Homeyer & Sweeney, 2005).

Group Play Therapy in Schools Research

A literature review on group therapy in elementary school reveals limited quantitative and even fewer qualitative studies. The literature does reflect that group play therapy is as effective as individual therapy for students in the school setting. In the past couple of decades, there have been significantly more studies exploring individual therapy than group therapy. One meta-analysis observed that the number of studies of individual therapy, including individual counseling, was 21, triple that of studies including group therapy, which was only seven (Ray, 2011). When comparing group play therapy outcomes, two meta-analyses revealed similar results for individual play therapy and group play therapy (Bratton et al., 2005; Tsai & Ray, 2011). Individual and group play therapy demonstrates positive results, confirming that individual therapy and group play therapy are equally effective (Ray, 2011).

The literature also supports group play therapy as a reliable intervention for various presenting concerns. One study demonstrated positive results in improving social interactions, self-awareness, and self-regulation (Chinekesh et al., 2014; Stone & Stark, 2013). A recent study investigated group play therapy's use for preschool children with problematic behaviors and symptoms of anxiety using Child-Centered Group Play Therapy (CCGPT) (Chinekesh et al., 2014). Using Single Case Design (SCD), researchers conducted CCGPT on four students referred for anxiety and problematic behaviors. Researchers utilized three methods to collect data: parent/teacher reports, direct observations, and pre/post teacher and parent rating scales examining anxiety

symptoms. The intervention showed decreased anxiety and problematic behaviors (Swan et al., 2019). Another study investigating group play therapy found that social skills improved during a group therapy study, and disruptive behavior decreased during a single-case design (Meany-Walen & Teeling, 2016). A different study explored group therapy's impact on presenting concerns of trauma, social adjustment, internalizing behaviors, and externalizing behaviors was also significant (Meany-Walen et al., 2015;). Of the empirical studies, most utilized students in short-term, non-experimental designs.

In addition, the literature also highlights group cohesion as a contributing factor for positive outcomes in group play therapy. In 2002, group play therapy revealed successful results during a study of children who survived an earthquake and developed notable group cohesion, highlighting decreases in anxiety and suicide risks (Shen, 2002). Literature reviewing group play therapy involves many theoretical approaches that have adapted to group settings, including Theraplay (Siu, 2014), Adlerian play therapy (Meany-Walen & Kottman, 2019), and child-centered group play therapy (Landreth, 2012). When reviewing group play therapy's theoretical orientations, a substantial number of the studies are nondirective child-centered play therapy approaches. Most studies investigate nondirective CCPT play therapy approaches compared to directive Adlerian Play Therapy (AdPT), and research investigating group play therapy demonstrates the same trend (Ray, 2011). Research for elementary school students supports that group play therapy has established a solid foundation for its utilization. However, even though there was a call for researchers to explore play therapy's process and outcome factors 20 years ago, there is still insufficient research utilizing group play

therapy (Shannonhouse et al., 2017). Despite the scarcity, research confirms that group play therapy is an effective intervention for children with various presenting concerns.

Theoretical Tenants of Adlerian Theory

The founder of Adlerian therapy, Alfred Adler, believed that it is essential to become familiar with the person's social context by exploring birth order, lifestyle, and parental education (Adler, 1976). Adlerian theory is also referred to as individual psychology due to the focus on individual uniqueness, personality, and creativity (Kottman, 2011). Along with Freud and Jung, Adler significantly contributed to the initial development of the psychodynamic approach to therapy (Corey, 1999). Adler was a member of the Vienna Psychoanalytic Society alongside colleague Sigmund Freud (Adler, 1976). As time passed, Adler found that his beliefs diverged from Freud's, and he created his theory of Individual Psychology (Adler, 1976). Adler then resigned as president of the Vienna Psychoanalytic Society and founded the Society for Individual Psychology in 1912 (Corey, 1999).

Individual Psychology focuses on social interests and the purposefulness of behavior in developing a healthy style of life (Corey, 1999). Unlike Freud, Adler believed that individuals live in a world of meanings, and it is not reality that is so important but rather the meaning given to it (Pietrofesa, 1968). Adler believed that people give meaning to experiences that shape their behaviors. Adler focused on his belief that systems individuals belong to reflect a holistic view of self within a community (Pietrofesa, 1968). Adler focused on encouraging feelings of belonging and believed that an individual's understanding of the context of their experiences determines a person's sense of self and purpose of behaviors (Pietrofesa, 1968).

Adlerian theory teaches the importance of the therapeutic relationship, phenomenology, determinism, personal choice, and responsibility (Adler, 1976). Adlerian theorists understand the impact of culture and social environments on individual thoughts, feelings, and beliefs. Kottman (2003) acknowledges Adler as one of the first theorists to recognize the importance of children's perceptions of their experiences and how personality impacts behavior. According to Alfred Adler (2014), "Play should be seen as educational aids and stimuli for the child's psyche, imagination, and life skills. Every game is a preparation for the future. In observing children during play, we can see their whole attitude towards life; Play is of the utmost importance to every child" (p. 42). Even though Adler did not work with children, he believed in the powers of play as critical when working with children.

Adlerian theorists move through four phases of Adlerian theory: building an egalitarian relationship, investigating lifestyles, gaining insight, and reorientating or re-educating to new ways of feeling, thinking, or behaving (Kottman & Meany-Walen, 2018). In Adlerian theory, developing an egalitarian therapeutic relationship is critical to developing trust to explore lifestyles and gain insight safely. When a trusting relationship begins, the counselor begins to collect information to understand better and interpret the individual's lifestyle. This information is relayed back to the individual to bring into awareness the subconscious view of self and behavior goals. Reeducation allows individuals to reshape behaviors, create new goals, and find a sense of belonging within their systems.

Adlerian theory assumes people are creative and unique, feel the need to belong, and create lifestyles to help them manage life, and that childhood experiences are

essential to developing these lifestyles and that human behavior is goal-oriented (Kottman, 2019). The core tenants of Adlerian theory encompass basic assumptions and theoretical underpinnings to guide counselors through the phases of Adlerian theory (Kottman, 2019). Following Adler's theoretical underpinnings, Adlerian theorists navigate through the four phases to develop goals, build relationships, explore lifestyles, gain insight, and facilitate reeducation. These philosophical underpinnings serve as a guide to understanding mistaken beliefs and identifying appropriate interventions.

Social Interest

Adlerian therapy theorizes that individuals are born with a desire and capacity to connect with others, and this developmental construct of social interest serves as the basic understanding of development (Kottman & Meany-Walen, 2018). The sense of belonging is a basic human need that expands from family to school and the community (Kottman, 2019). One of Alfred Adler's core theories of individual psychology revolves around the term Gemeinschaftgefühl, which loosely translates to the English concept of social interest. Social interests, as understood by Adlerian theorists, are a need everyone is born with to feel a sense of belonging to others (Adler University, 1976). Since people are born into social environments, the original family, social interest is understood as an innate perception of self within a larger society (Adler, 1976). An individual's perception of self within the larger society is a gauge of healthy functioning. Adlerian theorists believe an individual's social interest measures mental health (Sweeney, 2011). Adler taught that social interest gives insight into an individual's mental health and presenting concerns so appropriate interventions can be developed (Adler, 1976). One of Adlerian play therapy's central tenets is that children are socially embedded and desire connection

(Kottman, 2011). Even though individuals are born with the desire for connection and belonging, social interest increase in play therapy to develop positive relationships.

Crucial Cs

Using Adlerian principles, the Crucial Cs, developed by Amy Lew and Betty Lou Bettner, make Adlerian principles easier to conceptualize clients in counseling (Dreikurs, 1989). The Crucial Cs align with Adler's and Dreikurs's goals in individual psychology that allow understanding of the sense of self within systems (Dreikurs, 1989). The Crucial Cs are Connect, Capable, Count, and Courage. Successful individuals have four underlying unconscious beliefs that guide their behavior: feeling connected, feeling capable, feeling that they count, and developing courage (Sweeney et al., 2014). Focusing on Crucial Cs allows counselors to gauge success and identify interventions to implement (Kottman, 2019). The Crucial Cs are goals that guide counselors to develop interventions that allow individuals to develop into healthy functioning adults (Kottman, 2001). For example, for a child who needs to enhance the Crucial C of courage, the counselor must use interventions and techniques to encourage the child to try new experiences. The counselor might break down the task into chunks, allowing the child to take the reduced risk of the new experience in smaller steps. The counselor can model how to make mistakes or teach the child self-talk strategies necessary for trying new experiences. The counselor would encourage, provide support, and point out the child has taken a risk. An appropriate phrase for teaching courage might include, "You were worried about the task, but you figured it out." Crucial C's guide provides therapists with a concrete model for conceptualizing presenting concerns and finding effective student interventions.

Furthermore, children need to feel connected and that they belong to cooperate effectively. When children feel isolated, they develop attention-seeking behaviors to feel like they belong to a group (Kottman, 2001). Children who struggle to connect to others in their environments often seek attention in a negative manner (Kottman, 1999). In addition to connection, children must believe they can develop behaviors that align with self-control, competence, and willingness to accept responsibility (Kottman, 1999). Children also need to believe that they count or are significant to others. If children do not believe they count, they might react to this hurt by attempting to hurt others (Kottman, 1999). Finally, courage is the last Crucial C; when children are willing to face life's challenges even if they are unsure, they will be successful (Kottman, 2019). Kottman notes that children with courage are "willing to take chances and believe they can handle challenging situations" (p. 291). When children lack courage, they feel inadequate compared to others and lack the motivation to try new behaviors or take appropriate risks (Kottman, 2019). The Crucial Cs serve as a tool for counselors to evaluate children's needs and develop appropriate interventions.

Holism

Phenomenology and holism are guiding factors in the Adlerian approach (Sweeney et al., 2014). The belief that individuals develop connections, are goal-directed, and are creative is understood holistically (Meany-Walen & Kottman, 2019). The individual's perception of reality and their environment is critical to understanding the self. Adlerian theorists believe that holism develops with the intersecting factors of hereditary, environments, freedom to make choices, perceptions of experiences, and goals of behaviors (Meany-Walen, 2020). The different systems individuals belong to and how

they interact within each system are critical components to holistically understanding themselves. Individuals are creative, unique, and self-motivated and make choices based on their understanding of themselves, their environments, and their experiences (Adler, 1976). Since children are still developing their cognitive skills, they sometimes mistakenly interpret their experiences, create mistaken beliefs, and behave accordingly. Consolidating experiences, systems, and perceptions of the world creates a holistic lens through which to view individuals.

Lifestyle

According to Kottman and Meany-Walen (2016), lifestyles serve as the lens through which individuals operate. Adlerian perspectives highlight the importance of unconscious communication and how understanding these dynamics using the lens of lifestyles can predict the therapeutic relationship (Kottman, 2019). Psychodynamic constructs are particularly relevant to trust and relationship building when developing a therapeutic relationship. As children learn to interact and develop relationships, they develop strategies for feeling significant (Taylor & Bratton, 2014). Adlerian theorists understand personality priority as a behavior pattern resulting from an individual's belief system developed by lifestyles about their belonging, significance, and mastery that guides how individuals navigate their relationships and situations within their environments (Meany-Walen & Kottman, 2019).

Beginning in early childhood, children develop personality, make meaning of their lives, and develop a sense of belonging from their first social sphere, their families. Personality priorities are pleasing, comfort, control, and superiority. The personality priorities serve as a guide to understanding the holistic individual. Culture and birth order

also play prominent roles in the development of significance and patterns of behavior named lifestyles. These patterns infiltrate how individuals socialize in other systems, such as school, friendships, and community (Kottman & Meany-Walen, 2019). To develop into healthy adults, children need to believe that they are loved unconditionally, that they belong to a group that is essential in making good choices, and that they are responsible for their choices (Meany-Walen & Kottman, 2019). Children are born into different systems that play a role in shaping their beliefs and behaviors. The family is the first system in which children develop behavior patterns to meet their needs. Crying and smiling are infants' first attempts to interact in the social world. Children who believe their significant adults will meet their needs with nurturing and positive affection are more likely to develop into healthy adults with secure relationships (Dinkmeyer, 1965; Meany-Walen, 2011). Both home and school environments contribute to children's development and lifestyle (Kottman, 2019). Family atmosphere, parenting style, and family constellation influence how children develop and establish their beliefs. Children's experiences also influence how they view themselves as a significant part of a community (Meany-Walen, 2011). School environments teach children academic skills and emotional behaviors that provide opportunities for children to develop meaningful relationships and accomplishment opportunities (Meany-Walen & Kottman, 2019).

Purposeful Behavior

People are goal-driven, making behavior purposeful. Individuals use behavior to achieve their goals of gaining attention, gaining power, gaining revenge, or proving their inadequacy (Dreikurs & Soltz, 1964). Identifying this focus on subjective future orientation as a guiding principle was a significant breakthrough in conceptualizing

human thinking, feeling, and action (Ferguson, 2003). Each interaction with others creates new experiences and perceptions that cause the individual to develop a worldview. Behavior is a manifestation of lifestyles and perceived experiences. Behavior is purposeful and serves individuals in reaching their goals (Sweeney et al., 2014). To understand a client's behaviors, counselors must understand the goal of the client's misbehavior and how they perceive themselves in their environments (Sweeney et al., 2014). The goal of misbehavior is a concept developed by Rudolf Dreikurs (Adler University, 2019), who taught that all behaviors are purposeful, whether conscious or unconscious. Behaviors result from how individuals react to their systems (Dickinson, 2021).

Children commonly have four goals of misbehavior: power, attention, revenge, or proving inadequacy. The goals of misbehavior guide counselors toward understanding children's behavior, allowing the child to develop healthier and more appropriate goals (Ansbacher, 1988). Children develop goals of misbehavior when they feel like they do not belong or count. In the words of Dreikurs and Soltz (1964), "Children want desperately to belong. If all goes well and the child maintains courage, he has few problems. He does what the situation requires and gets a sense of belonging through usefulness and participation. However, his sense of belonging is restricted (p. 58). When counselors identify the child's goals of misbehavior, they can better develop interventions to meet the child's needs (Dickinson, 2021). Since children are still developing cognitively, they often misinterpret as they work to make meaning from their experiences, resulting in mistaken beliefs (Dreikurs, 1989). Children internalize their mistaken beliefs, which become a part of their worldview and drive their misbehavior.

An essential construct of Adlerian theory is that people are born to create and use their creativity to achieve desired goals (Sweeney et al., 2014). Dr. Terry Kottman (2001) drew upon Adlerian theories to create developmentally appropriate interventions and counseling techniques by developing Adlerian play therapy (AdPT). AdPT allows children to heal in a developmentally appropriate manner while utilizing the Adlerian perspectives of case conceptualizations, presenting concerns, and flexible interventions.

Adlerian Play Therapy as an Evidence Based Intervention

In 1987, Kottman created AdPT so that the fundamentals outlined in Adler's psychology would be developmentally applicable to children in counseling (Kottman, 2011). Kottman combined the concepts of Adlerian psychology with nondirective and directive play therapy processes to gain a deeper understanding of how children view themselves, others, and the world (Kottman, 2009). The use of AdPT is growing rapidly, and researchers recognize it as the third most utilized play therapy approach. In alignment with Adlerian theories, school counselors observe children holistically as socially embedded, goal-directed, subjective, and creative beings (Kottman, 2011). The theoretical underpinnings of AdPT include (a) children are socially embedded and need to feel like they belong, (b) children strive to overcome feelings of inferiority throughout their lives, (c) children are creative, (d) children's behavior is purposeful, and (e) how children perceive events is their reality (Kottman & Ashby, 2015).

AdPT strives to understand the child's lifestyle and sense of belonging, which illuminates mistaken beliefs. Behavioral, cognitive, and attitudinal changes occur when school counselors seek to understand children's lifestyles within their different systems (Meany-Walen & Kottman, 2019). Even though there are many similarities between

AdPT and other play therapy approaches, Adlerian play therapists are unique in facilitation (Kottman, 2019). Adlerian play therapists recognize the importance of directive and nondirective play therapy techniques as they view children holistically. AdPT counselors select toys to explore lifestyles, discover mistaken beliefs, and practice metacommunication to give insight and encourage, reorient, and re-educate. During the facilitation, AdPT therapists also collaborate with caregivers to gain invaluable information. Adlerian play therapy allows children to practice social behaviors, gain insight, and practice new behaviors in a therapeutic relationship.

A unique aspect of AdPT is the active involvement of parents in the play therapy process. Caregivers and teachers play a critical role in supporting changes in thinking, feeling, and behaving that the child develops during play therapy (Kottman, 2011). Counselors work with the significant adults in the child's life, both at home and school, to gather information, conceptualize, give insight, and teach new behaviors. In addition to caretakers, teachers also influence children and provide critical information about how the children learn and interact in the school setting. A benefit to conducting play therapy in the school setting includes accessing teachers and caregivers to gain insight into children's lifestyles.

In Adlerian play therapy, counseling is directive and active, empowering students to feel like equal partners. Communication between the counselor and the child encourages growth, insight, communication, and building relationships through play techniques. Like Adlerian therapy, Adlerian play therapy unfolds through four phases where counselors combine directive and nondirective play therapy skills to meet children's specific needs (Kottman & Meany-Walen, 2016). The AdPT four phases of the

counseling process include (a) building an egalitarian relationship, (b) exploring the child's lifestyle, (c) helping the child gain insight into their lifestyle, and (d) reorienting and re-educating the child (Kottman, 1999, pp. 288–289). The four phases allow the counselor, caregivers, and teachers to gain insight into the child's lifestyle that can identify mistaken beliefs and the child's goals of misbehavior. The counselor communicates and collaborates with the parents and teachers throughout each of the four phases of play therapy.

Phase 1: Building an Egalitarian Relationship

The first phase of AdPT includes (a) establishing an egalitarian relationship, (b) utilizing nondirective play therapy skills such as tracking, (c) reflecting feelings, and (d) restating content based on mutual trust and respect (Kottman, 2019). Adlerian play therapists understand the importance of an egalitarian relationship in which shared power and responsibility deepen the connection with the child. Primary goals of this phase are to help students to feel loved, secure, and develop a sense of belonging to function healthily in relationships (Dinkmeyer, 1965). The most crucial phase in AdPT is developing a healthy give-and-take relationship with the child that allows for trust, mutual respect, consistency, and dependability (Dreikurs, 1989). Adlerian play therapists understand that all children deserve respect and are significant, creative, unique, and capable of contributing to the world in meaningful ways (Kottman, 2011). Counselors should never force children to participate in play activities or to interact with the counselor. Instead, children should feel empowered and respected in the relationship (Kottman, 2003).

The counselor should begin the relationship with the caretakers and teachers before meeting the child to gain insight into the child's lifestyle (Kottman & Meany-

Walen, 2016). Counselors can develop egalitarian relationships through basic play therapy skills such as tracking, reflecting feelings, restating content, encouraging, and cleaning the playroom together. Before moving to the next phase, counselors establish an egalitarian relationship and maintain it throughout the play therapy process (Kottman, 2003).

Phase 2: Exploring the Child's Lifestyle

In the second phase of AdPT, the counselor explores the child's lifestyle through questioning caretakers and teachers, observation, and planned play therapy activities (Kottman, 2019). Adlerian play therapists believe children have the ability from infancy to create their unique lifestyles based on their perceptions of the world (Adler, 1976; Meany-Walen, Bullis, et al. hat 2015). The counselor conceptualizes the child through the lenses of different systems, such as culture, home, school, and community (Kottman, 2003). Children develop lifestyles based on how they perceive themselves, others, and their experiences of the world around them (Kottman, 2003). When contemplating lifestyles, the counselor uses these concepts to conceptualize and interpret the intersectionality of the child's life tasks, family constellation, goals of misbehavior (e.g., attention, power, revenge, inadequacy), the Crucial Cs (i.e., courage, capable, connect, and count), and personality priorities (i.e., pleasing, comfort, superiority, and control).

Based on lifestyle information gathered during the first and second phases of therapy, the Adlerian play therapist develops a conceptualization and treatment plan that guides the rest of the process. The counselor uses information from interactions with the child, caretakers, teachers, and play sessions (Kottman & Meany-Walen, 2016). Lifestyle information can be collected formally or informally through conversation or observation.

Counselors might ask caretakers questions regarding the family atmosphere, early recollections, child strengths, and misbehaviors (Kottman, 2019). Lifestyle information often emerges through observation, drawings, dramatic play, and games (Kottman, 2019). Lifestyle information serves as a guide for future play therapy sessions (Kottman, 2019).

Phase 3: Helping the Child Gain Insight

The third phase of AdPT helps children gain insight into their lifestyles, mistaken beliefs, and goals of misbehavior. The vital goal of this phase is to raise the child's awareness of their mistaken beliefs by encouraging the child to understand their assets, goals of behavior, beliefs about self in their environments, personality priorities, and Crucial Cs (Kottman, 1999). The third phase utilizes more directive play therapy techniques designed to meet individual student needs through stories and metacommunication. Drawing on the Adlerian principle that people often lack insight into their behavior patterns, counseling interventions allow individuals to become aware of their beliefs and behaviors to make the desired changes.

The third phase draws on the first two phases to develop appropriate interventions specific to the child's needs (Kottman, 2019). The egalitarian relationship is critical in this phase since the counselor challenges the child's self-beliefs to gain insight into the thoughts, feelings, and behaviors needed so the child can change and function more productively (Meany-Walen, 2011). The counselor encourages the child to decide how their behavior impacts their life and their desire to change it. Metacommunication, such as spitting in the soup, is often used in the third phase to encourage insight into perceptions, feelings, and behaviors. The counselor might identify how the child's behaviors impact them and interfere with behavior goals (Kottman, 2001). Confrontation,

humor, metacommunication, metaphors, storytelling, and roleplay allow children to gain insight into how they see themselves in the world and empower them to make the desired changes (Kottman, 2003).

Phase 4: Reorientation and Reeducation

The final phase includes play therapy activities designed to teach and reinforce constructive thinking patterns actively. In addition to re-educating the child, parent and teacher consultation remains critical to support the changes in the different environments. Parents and teachers learn how to encourage the child's new behaviors and beliefs of self. The counselor actively plays with the child and adults to practice the new behaviors across settings while encouraging new appropriate behaviors (Kottman & Meany-Walen, 2016). Adlerian play therapists believe actions speak louder than words (Kottman & Meany-Walen, 2016).

During this phase, counselors must remain active participants to continue supporting and encouraging the child in learning to solve problems and continue to use new behaviors. During this phase, generalizing the new behaviors includes playing with toys, art, puppets, games, music, dance, and other interventions designed to encourage new behaviors and thinking patterns. Children are encouraged to be active participants and create new solutions to problems rather than rely on adults to solve their problems (Meany-Walen & Kottman, 2019). Generalizing new behaviors outside the playroom requires ongoing encouragement, support, and practice from the counselor and the other significant adults in the child's life (Kottman, 2003). When children practice new behaviors successfully in their natural environments, such as the classroom, playground, or home, termination of the therapy is determined appropriate.

Adlerian Play Therapy Research

Adlerian play therapy is the third most used approach to play therapy when working with students (Meany-Walen & Teeling, 2016). However, even though AdPT has become one of the most recognized play therapies with children, there remains a notable need for more evidence-based research. To address the research needs, Dr. Terry Kottman developed and wrote the AdPT treatment manual to distribute to counselors to gain evidence-based research and empirical support (Meany-Walen, 2020). Currently, more than ten evidence-based published research articles report on treatment utilizing AdPT (Meany-Walen, 2020). Of the studies published, one was a randomized control trial (RCT), and nine were single-case designs (SCD) (Meany-Walen, 2020). The studies collected data using observations, the Teacher Report Form (TRF), the Child Behavior Checklist (CBCL), the Direct Observation Form (DOF), the Index of Teacher Stress (ITS), the Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2), the Child Adolescent Perfectionism Scale (CAPS), and the Conners Rating Scales-Revised (CRS-R). The data was collected by teachers using the TRF and ITS assessments, unbiased, trained observers for the DOF, and students using the CAPS instrument. Parents also assisted teachers in collecting behavioral data using the CRS-S,

Kristen Meany-Walen, a mental health coordinator for a school district in Iowa, conducted the first published research study on AdPT. The study used RCT, which solidified AdPT, an evidence-based intervention. The Substance Abuse and Mental Health Services Administration recognized AdPT as an effective intervention to improve on-task behaviors within the classroom. Meany-Walen studied the impact of AdPT on 58 students between the ages of 5 and 9, randomly placed in control and treatment groups

for 16 sessions within eight weeks (Meany-Walen, 2020). The study showed that students who received AdPT showed AdPT had a statistically significant impact on increasing on-task behaviors.

Nine research studies utilized Single Case Design (SCD) to study the impact on disruptive classroom behaviors. Meany-Walen, Bullis, et al. conducted an SCD in 2015 that investigated the impact of GAdPT on reducing disruptive classroom behavior. The study involved two six-year-old male participants for a duration of six sessions. Both participants showed a decrease in disruptive behaviors, and their on-task behaviors increased to the normal range of functioning (Meany-Walen, Bullis, et al., 2015).

Another SCD using only individual AdPT involved five boys referred by their teachers for disruptive classroom behaviors (Meany-Walen, Bratton, et al., 2015). Two students received individual AdPT, while the others were in the control group and did not receive AdPT. This study also showed improvements in disruptive behaviors and increased on-task behaviors with the students who received the intervention but showed no change in behaviors for the control group.

Dillman Taylor et al. conducted an SCD in 2019 that also investigated externalizing behaviors with three students referred to a counselor due to their behaviors. Of the three students, two students showed improved behavior, and one student showed a decrease in desirable behaviors. Another study conducted by researchers Akay and Bratton (2017) showed no effect when exploring the impact of AdPT on students with anxiety and maladjusted perfectionism. Even though parent and teacher reports suggested improvements in anxiety and perfectionism, the students' self-reports revealed no improvements.

Meany-Walen (2020) combined interventions when blending individual AdPT and GAdPT. The study examined two second-grade students referred to counseling for behavioral symptoms of ADHD and poor social skills and the impact of both AdPT and GAdPT. The study revealed beneficial results during the intervention phase and questionable results during the follow-up phase. An additional research study combined treatment interventions when investigating African American preschoolers who displayed disruptive behavior (Stutey et al., 2017). Participants showed moderate effects after the individual AdPT intervention phase and moderate to significant effects following the GAdPT intervention.

Meany-Walen and Teeling (2016) also studied the effects of AdPT on disruptive behaviors and social skills using SCD. Three students received individual AdPT for 12 sessions and showed improvements in social and classroom on-task behaviors. Recently, a publication that included a study investigating disruptive behaviors and GAdPT revealed beneficial results during the follow-up stage (Meany-Walen, 2020).

Group Adlerian Play Therapy Application

According to Kottman (2019), Group Adlerian Play Therapy (GAdPT) incorporates the same philosophical underpinnings and phases as Adlerian play therapy with individual children: building an egalitarian relationship with members of the group, investigating the children's lifestyles, helping the children to gain insight, and reorienting/re-educating the children (Dickinson, 2021). GAdPT merges theoretical concepts of play therapy skills, leadership roles, responsibilities, and goals of each phase of Adlerian play therapy with group counseling skills, goals, and benefits (Dickinson, 2021). Two or more children are joined together in a group and move through the four

phases of Adlerian play therapy using group skills and processes (Kottman, 2019). Group interventions align well with Adlerian play therapy and Adlerian theory since social embeddedness is the cornerstone of the theory (Meany-Walen & Kottman, 2019). Group counseling naturally integrates with AdPT, providing opportunities to express creativity, develop a social connection, observe students holistically, and reinforce personal responsibility (Ziomek-Daigle et al., 2008). The emphasis of GAdPT is redirecting mistaken goals, resulting in positive changes for group members (Kottman & Meany-Walen, 2018).

To address each student's needs, the counselor forms a small group of referred participants who struggle with similar presenting concerns. Group therapy sessions align with processes like group therapy regarding screening, establishing goals, and moving through group stages (Meany-Walen & Kottman, 2019). The group also reflects the parallel pattern of typical group play therapy, including forming, storming, norming, performing, and adjourning (Sweeney et al., 2014). Following the theoretical tenets and guidelines of GAdPT, the school counselor forms and develops group content to meet the group and individuals' goals. Group content development aligns with the goals and phases of GAdPT. While maintaining individualized conceptualization plans and interventions within the group, the counselor actively engages with each child. The GAdPT evolves into its social world, where the children learn to function. Each session of GAdPT provides opportunities for connection and growth. Additionally, group play therapy provides additional opportunities for children to practice new social skills, build meaningful relationships, gain insight, and receive prompt feedback from peers and counselors (Sweeney et al., 2014).

Dr. Rebecca Dickinson was the first researcher to analyze the impact of Group Adlerian Play Therapy using a randomized control trial (RCT) (Dickinson, 2021). The study looked at the impact of GAdPT on children with emotional and behavioral difficulties during their participation in GAdPT. As a part of the study, Kottman and Dickinson published a treatment manual specifically for research for group Adlerian play therapy (Dickinson, 2021). The Group Adlerian Play Therapy Treatment Manual outlines specific recommendations for working with groups during each phase, appropriate play materials, spacing, group size, and recommendations for inclusion into the group (Dickinson, 2021).

According to Kottman (2011), the past 30 years have brought a revival of play therapy as an important therapeutic modality for people of all ages. AdPT is one of the top play therapy approaches used to treat students with mental health problems and has evidence-based research to support its effectiveness (Meany-Walen & Kottman, 2016). Adapting play therapy to a group setting is not a new concept. It has documented success in many play therapies, such as child-centered play therapy (Landreth, 2012), theraplay (Siu, 2014), and Adlerian play therapy (Dickinson, 2019; Meany-Walen et al., 2015).

Group Adlerian Play Therapy and Parent Collaboration

School counselors must work with parents, students, teachers, and administrators to remove systemic barriers and assess schools for social-emotional needs that impede learning. Since school counselors are on the front lines of mental health needs with students, it remains critical to know how to advocate for students struggling with mental health needs. Landreth (2012) notes, "The goal of play therapy in schools is to help children prepare to profit from the learning experiences offered". Successful facilitation

of group therapy in schools is dependent on the support of parents, teachers, and administrators. School counselors are responsible for educating and collaborating with stakeholders to teach group play therapy's rationale, benefits, and procedures. School is a unique setting that presents obstacles to the facilitation of group play therapy. To gain support from parents, the administration, and stakeholders, school counselors must relate the goals of play therapy to the school and academic success (Sweeney et al., 2014).

One of the integral parts of Adlerian play therapy (AdPT) is parent and teacher consultation. Many parents need more information about the purpose and impact of play therapy. School counselors advocate for students when they develop collaborative relationships with parents, teachers, and administrators to develop a school climate that celebrates diversity and creates a sense of belonging (Ziomek-Daigle et al., 2008). In alignment with AdPT, consulting with the parents to explain the practice of play therapy, the process, the interventions, the research, and the misconceptions helps parents understand how play therapy can impact their children.

Group Adlerian play therapy is a developmentally appropriate intervention that relies on the family constellation and student lifestyles as a part of the treatment process and lends itself to diverse cultures. Consultation with parents follows the four phases and goals of AdPT. During the first phase, the counselor aims to build a positive working relationship with the significant adult in the child's life. The counselor understands the caregiver's perception of the presenting problem and inquiries about the child's developmental history. The counselor seeks to understand the parents' lifestyle, parenting practices, values, and relationships during the second phase. The third phase focuses on the parents or teachers to gain insight into the student's behavior from a different

perspective and begin shifting students' thinking and feelings towards understanding their beliefs. Finally, the fourth phase consists of teaching parenting skills if needed and working with the parents on Adlerian parenting strategies to help them change behavior. Counselors also work with teachers to instruct them in Adlerian techniques for classroom management or teach them about issues that might interfere with student success.

To address parents who worry about their child missing instructional time, the school counselor works with the parents to educate them about the benefits of play therapy and how it improves behaviors that impede learning. Sharing play therapy research with parents and stakeholders promotes the support of staff and parents. Additionally, the counselor should collaborate with the teacher to find a non-instructional time to deliver the intervention. Group play therapy in the school setting is a short-term intervention to increase academic success. During the school day, group play therapy sessions should be short to reduce the time the student is out of the classroom (Sweeney et al., 2014).

Most importantly, school counselors must seek to understand how culture impacts counseling services. Counselors sit in a unique position to address social justice issues based on the profession's emphasis on prevention, multiculturalism, and strength-based approaches and have an ethical obligation to develop multicultural awareness and awareness of personal bias (Bemak et al., 2011). Developing awareness is only the beginning of becoming a multiculturally competent counselor. School counselors must advocate for systemic change for the students and families whose voices are unheard. To ensure the ethical and professional well-being of students, counselors must incorporate the principles of multicultural and social justice counseling theories into their practice.

This approach is essential for effectively addressing the diverse needs of individuals, communities, and society.

School counselors lead by example from a social justice perspective to encourage community members to develop a sense of belonging for all students, teachers, and administrators (Ziomek-Daigle et al., 2008). Many cultures stigmatize counseling services, including African American communities. Many African American families encourage seeking help from other family members or church members (Brumfield & Christensen, 2011). In a phenomenological study investigating African American parents' perceptions of play therapy, factors that impeded parents from pursuing counseling included previous negative experiences with counseling, feeling judged as a parent, lack of confidentiality, negative media portrayals of counseling, and cultural perceptions of counseling (Brumfield & Christensen, 2011). One participant in the study said they were aware of the stigma associated with counseling and said people would either think their child was crazy or make derogatory statements and negative assumptions about the parents' character and parenting skills (Brumfield & Christensen, 2011). Understanding each client's cultural worldview is critical to meeting the unique needs of each student. Collaborating with parents allows counselors to educate parents on play therapy misconceptions, explain how play therapy can help their child remove barriers that impede learning, review confidentiality to address their concerns about being judged by community members, and, most importantly, develop a trusting relationship with the parents.

Kottman (2003) emphasizes that therapeutic change has more significant impacts and lasts longer when parents are involved in the therapeutic process of their children,

which is an essential component of Adlerian play therapy. Involving parents and teachers during the play therapy process allows a greater understanding of how they can encourage their children to continue to develop positive behaviors in settings outside the playroom.

Group Adlerian Play Therapy and Social Justice

The discussion on play therapy would lack imperative information if discussions of race and culture were absent. Recently, the social justice movement has surfaced in the counseling field to advocate for counselors to remove barriers for students and provide support that leads to success. Social justice encompasses a broad perspective that incorporates social issues that involve families, communities, and societies (Chung & Bemak, 2011). The social justice framework will shrink the achievement gap, increase academic achievement, and provide a safe space for learning for all students (Singh et al., 2010). School counselors are ethically obligated to respect and affirm individuals' cultural identities and advocate for human development (American Counseling Association, 2018). Counselors who practice with a social justice mindset and utilize a multicultural lens uniquely position themselves to address social justice issues based on the profession's emphasis on prevention, multiculturalism, and strength-based approaches (Bemak et al., 2011). School counselors must work as leaders to integrate and promote multicultural awareness and social justice competencies into their practice.

The Multicultural and Social Justice Counseling Competencies (MSJCC) address the expectation that counselors continuously reflect on their and clients' worldviews to provide support where needed (Ratts et al., 2015). The competency aligns beautifully with the Adlerian theory of assessing students' lifestyles. Historically, Adlerian

psychologists practiced viewing their clients with a systemic lens while considering the student's needs. Also, the American Counseling Association's (2018) competencies reiterate, "When counselors identify systemic factors that act as barriers to their students' or clients' development, they often wish that they could change the environment and prevent some of the problems that they see every day."

The keystone of GAdPT is understanding students and how they interact in their school, community, and family systems and how these dynamics impact students' beliefs and behaviors. GAdPT guides school counselors to view through a social justice lens that connects to the different systems in which they participate, such as families, schools, and communication (Ansbacher, 1992). By focusing on specific constructs of social interest, Crucial Cs, and the family atmosphere, GAdPT empowers diverse students to gain insight into their own beliefs and how they belong in the world.

As a result, positive relationships between parents, teachers, and administrators form while instilling awareness and creating positive relationships to increase cultural acceptance and diversity. The cultural networks to which students belong, such as school, family, and community, play a vital role in accessing education and mental health services (American Counseling Association, 2018). When school counselors work with families and communities as allies, this relationship can become a source of strength for disadvantaged students and their families. Suppose parents and communities partner in the counseling and advocacy process outlined in the Group Adlerian Play Therapy Manual. In that case, mental health attitudes may penetrate more systemically into the individual cultures from which the economically disadvantaged or otherwise

marginalized student participating in the program originates (American Counseling Association, 2018).

Students in underserved populations are more likely to succeed when the school climate supports the belief that all students can be successful when given access to evidence-based interventions and multiculturally competent counselors who utilize advocacy competencies (Bemak et al., 2011). While parents of economically disadvantaged students may have limited mental health options, outreach to educate families and communities on counseling services, processes, and impacts may encourage them to serve as assets and advocates for their children (American Counseling Association, 2018). School counselors advocate for students within schools by collaborating with key stakeholders, including parents, community members, and other teachers and staff, to provide access to success for all students (Chang et al., 2012). Through community collaboration, a counselor can work with students to voice their concerns to the school administration regarding access and equity.

School counselors also must understand minority groups' experiences with counseling and their perceptions about the process. African American communities often stigmatize counseling due to the history of racism that continues to suppress African American families; many seek answers themselves or utilize other sources for support, such as extended family or church. A recent study on African American parents' perceptions of play therapy confirmed that they would be open to play therapy if they understood the intervention, had a qualified counselor they could trust, and could attain perceived support from the family and community (Brumfield & Christensen, 2011). Counselors must seek to understand how family relationships influence the development

of racial identity and family values (Agarwal & Meany-Walen, 2019). Adlerian play therapists seek to encourage student assets by reinforcing students' strengths.

School counselors are fundamental players in the success of students and the success of schools. The different roles that school counselors play depend on the students and the needs of the school. The American School Counselor Association (ASCA) laid the foundation for school counselors to holistically address students' needs related to career development, academic development, and social development (2019). School counselors provide a comprehensive school counseling program, including classroom lessons, small-group counseling, and individual student meetings. Advocacy is vital for the multicultural counselor because the only way the school's staff and faculty may have access to the student's culture is through the parents and students. As Singh et al. asserted in 2010, "School counselor advocates are encouraged to address educational inequities and differences in academic achievement grounded in race/ethnicity, gender, class, disability status, and sexual orientation, which may prevent many students from maximizing their academic, social, and personal potential" (p. 135). Multiculturally competent counselors use social justice advocacies to guide their small groups and interventions, speak out, and operate under standards that empower students, families, and communities.

Group Adlerian Play Therapy in Schools

In Landreth's (2012) words, "Children learn through play; therefore, play therapy is adjunct to the learning environment, an experience that helps children maximize opportunities to learn in the classroom" (p. 86). Play therapy in the school setting can help students with undiagnosed mental health needs due to its acceptance as a

developmentally suitable intervention (Landreth, 2012). Grounded on Adlerian theory and Adlerian play therapy principles, Kottman adapted AdPT and GAdPT to meet more students' developmental needs in the school setting. GAdPT has proven effective for students experiencing academic, emotional, and behavioral issues. GAdPT transitions smoothly to the school setting and group play modality due to Adlerian theory's emphasis on social embeddedness and directive interventions (Kottman & Meany-Walen, 2018).

Since children attend school an average of seven hours per day, early educational experiences significantly impact students' academic and emotional development. GAdPT in the schools allows students to receive services while adapting to the time constraints in the school setting and allowing access to services. School counselors who practice GAdPT gain access to more students with mental health needs while removing emotional barriers that impede learning in developmentally appropriate ways. Group play therapy empowers school counselors to access more students in less time. Since 80% of students who need mental health services do not receive them (Merikangas et al., 2010), GAdPT is the gateway to meeting the needs of students. Sweeney et al. (2014) declare, "Group play therapy is not only a powerful therapeutic intervention, but it often provides a more compelling and expedient milieu than individual therapy." (pg.3).

School counselors have unique roles in advocating for students while working with the school system. Group Adlerian play therapy empowers students to discover who they are and their mistaken beliefs and allows them to practice their new skills in a safe space. Students' experiences and perceptions are invaluable sources of information that can reveal the factors that produce anxiety and off-task behaviors and the factors that decrease them so the student can succeed academically and emotionally. In the school

setting, GAdPT provides opportunities to overcome emotional struggles that interfere with the academic achievement of numerous students, yielding a more significant impact on student success.

Group play therapy is ideal in school settings because it allows school counselors to access more children, see positive changes quicker, and reach students who would not typically be able to access counseling (Sweeney et al., 2014). Specifically, GAdPT is prescriptive to student and systemic change by emphasizing students' lifestyles through observation and parent collaboration (Kottman & Meany-Walen, 2018).

Advantages offered to students by GAdPT in the school setting include a sense of belonging, connection, interpersonal learning, socializing opportunities, and generalizing new behaviors while allowing school counselors to access more students (Kottman & Meany-Walen, 2019). Interacting with peers and the school counselor in the school setting allows students to experience how they view themselves within their social systems, interact with adults and peers, and express themselves (Kottman, 1999). Group relationships formed with peers in the school setting provide the underpinnings for students to develop solid relationships with their peers and the other systems in which they participate (Meany-Walen & Kottman, 2019). GAdPT provides additional opportunities for children to practice new social skills, build meaningful relationships, gain insight, and receive prompt feedback from peers and counselors (Sweeney et al., 2014). Group cohesion is also a noted benefit of GAdPT, which has proven to increase positive outcomes in group play therapy by developing egalitarian relationships and meaningful interactions with peers and the counselor (Sweeney et al., 2014). Students

learn to take responsibility for their behaviors and beliefs as they apply their new beliefs and behaviors outside of the group (Meany-Walen & Kottman, 2019).

GAdPT follows the basic process of small-group counseling while combining the underpinnings of Adlerian Play Therapy (Kottman, 1999). The Group Adlerian Play Therapy Treatment Manual advises meeting with the child and their families independently prior to group therapy to foster a positive therapeutic relationship and develop an egalitarian relationship (Dickinson, 2019). School counselors determine the appropriateness of each student in the play therapy group through lifestyle assessments, collaboration with teachers and caregivers, and interactions with potential group members (American Counseling Association, 2019). Groups have individual and group goals that are similar across group members (Meany-Walen & Kottman, 2019). Teachers, caregivers, and group members discuss the purpose of the group and its goals during group formation.

Using the four phases of Adlerian play therapy, group AdPT is conducted on two students in the school setting (Meany-Walen & Kottman, 2019). During phase one, the therapist focuses on building the relationship individually with clients and within the group setting. During this phase, group facilitators guide group members in building relationships with each other. Play therapy techniques are utilized to foster connections, and basic counseling skills help to guide group goals, help children share in decision-making, and handle conflict within the group.

During the second phase, investigating lifestyles is the goal. Using play activities, the counselor observes the children within the group play therapy sessions and how they interact with one another (Dickinson, 2021). Meany-Walen and Kottman (2019) explain

that analyzing lifestyle during a group setting occurs quicker than in individual sessions because children can show their emotions, interactions, and behaviors. During GAdPT, children unmask how they resolve and create conflict, self-soothe, and feel important. Using play therapy activities such as drawing, sand trays, and games, the counselor observes the interactions between the children. Following lifestyle observations and analysis, the counselor typically consults with the parents individually.

During the third phase, the therapist guides the children to gain insight using metacommunication and feedback and through interactions. Furthermore, play techniques such as puppet shows, and sand trays guide the children to gain insight into mistaken beliefs and goals of misbehavior. The therapist teaches and encourages insight and change with the children in the group, as well as helping the adults to foster change at home.

During the final phase of GAdPT, the counselor leads the children to develop goals to restructure mistaken beliefs, feelings, and behaviors. During group play, group members have opportunities to generalize and practice new behaviors. As the new behaviors and thoughts form into habits, the counselor moves towards termination. The Group Adlerian Play Therapy Treatment Manual thoroughly describes the process of GAdPT to guide counselors in uniformly conducting sessions.

Group Adlerian Play Therapy Research Related to Internalizing Behaviors and Academic Achievement

School counselors have the responsibility to discover how to serve their students best. As the use of AdPT and GAdPT continues to grow, so does the research to demonstrate the positive impacts it has on students. The Adlerian Play Therapy Manual

includes a section on specific adaptations for using Adlerian play therapy in the group setting during each phase of play therapy (Meany-Walen & Kottman, 2019). Meany-Walen and Kottman also published a conceptual research piece providing a case study of GAdPT for school counselors to use as a guide when providing GAdPT (Meany-Walen & Kottman, 2019). Furthermore, Dickinson and Kottman developed a treatment manual for counselors providing GAdPT.

Alongside AdPT, GAdPT is beginning to gain momentum in research publications. More than ten AdPT research studies have been published since 2010 in peer-reviewed journals, with four publications using GAdPT as the treatment intervention (Meany-Walen, 2020). A review of the literature shows success for GAdPT in four single-case designs where GAdPT was the independent variable for students in elementary school (Dillman Taylor et al., 2019; Meany-Walen, Bullis, et al., 2015; Meany-Walen, Kottman, et al., 2016; Meany-Walen & Teeling, 2016). All four studies also investigated using GAdPT to present concerns about externalizing behaviors, off-task behaviors, or disruptive behaviors. All studies showed beneficial treatment outcomes. The studies identified students based on referrals from parents and teachers who exhibited externalizing or off-task behaviors. Most previous research on Adlerian play therapy and Group Adlerian play therapy has conducted single-case design studies to examine externalizing behaviors.

The first group Adlerian play therapy study was conducted in 2015 by Meany-Walen, Bullis, Kottman, and Dillman Taylor, which supported the delivery of Adlerian play therapy in a group setting in an elementary school. Two of the studies investigated only GAdPT (Dillman Taylor et al., 2019; Meany-Walen, Bullis, et al., 2015;), and the

other two studies combined AdPT with GAdPT (Meany-Walen, Kottman, et al., 2017; Meany-Walen & Teeling, 2016). All studies revealed a decrease in off-task or disruptive behaviors. Several studies where GAdPT was the intervention showed growth in fewer sessions compared to students who received individual play therapy (Meany-Walen, 2020). The duration of sessions ranged from six sessions to twelve sessions, either weekly or biweekly. The studies using GAdPT often followed the 30-minute, twice-weekly approach in the school setting.

Researchers credit the expedited change to the social interactions that yield immediate feedback from peers and counselors, natural opportunities to practice new skills, and an increased sense of belonging experienced only in Group Adlerian Play Therapy (Meany-Walen, 2020). Meany-Walen and Kottman combined interventions in a 2017 study by blending individual AdPT and GAdPT with two second-grade students referred to counseling for behavioral symptoms of ADHD. The study revealed beneficial results during the intervention phase and questionable results during the follow-up phase (Meany-Walen, 2020). Another research study combined treatment interventions when investigating African American preschoolers who displayed disruptive behavior (Stutey et al., 2017). Participants showed moderate effects after the individual AdPT intervention phase and moderate to significant effects following the GAdPT intervention. More recently, an RCT design compared filial therapy and Adlerian play therapy treatment effects on students with ADHD. While both groups significantly improved sustained attention, the students who participated in filial therapy had much more extensive results than those who participated in AdPT (Hooshang et al., 2019). The results of this study verified the Adlerian belief in the importance of parent consultation. While AdPT is an

effective treatment for students with attention problems, the impact is enormous when the parents are involved in the therapy.

Even though each study resulted in various degrees of effectiveness, overall, they all noted that research supports the impact of GAdPT (Meany-Walen & Kottman, 2019). GAdPT is a young play therapy approach that has already shown much promise in efficacy, and that has many advantages for counselors working with children. In general, GAdPT appears to be a promising intervention for students in the school setting. GAdPT can easily be implemented in the school setting, addressing the need to provide all children with developmentally appropriate and effective interventions.

While research involving internalizing behaviors and academic achievement is limited, the literature reveals that play therapy increases self-esteem and personal relationships, decreases behaviors, and increases academic abilities (Baggerly, 2004). Research shows that play therapy is an effective intervention for decreasing symptoms of internalizing behaviors and increasing academic achievement for students (Blanco & Ray, 2011; Blanco et al., 2012; Cheng & Tsai, 2014). Bratton et al. (2005) conducted the most prominent play therapy meta-analysis with 93 controlled outcome studies demonstrating that play therapy proved beneficial for children with internalizing behaviors. The post hoc analysis identified that 36 of the 93 studies conducted with elementary school students involved various presenting issues (Meany-Walen & Kottman, 2019). While examining school-based interventions, the study revealed a moderate effect size of .69, with an average of 8.4 sessions (Bratton et al., 2005). Ray (2011) added that play therapy is a practical intervention for students in elementary school. The mean effect size for play therapy with parent and teacher consultation also

showed significantly more positive results than the play therapy studies, where the only intervention involved counselors (Ray, 2011).

In the past, most play therapy studies explored Child Centered Play Therapy (CCPT)/nondirective play therapy methodologies. The studies span 60 years of research involving more than 63 evidence-based studies that support the use of play therapy as an effective treatment for internalizing and externalizing behaviors (Bratton et al., 2005), anxiety (Ray, 2011; Schottelkorb et al., 2015; Stulmaker & Ray, 2015), self-esteem (Cheng & Tsai, 2014), and attention problems (Muro et al., 2006; Ray et al., 2015; Schottelkorb & Ray, 2009). While most studies examining play therapy in the school setting involve child-centered play therapy or nondirective play therapy interventions, Bratton encourages researchers to expand the literature to include well-designed studies that explore other theoretical play therapy approaches (Baggerly, 2004). Currently, only one evidence-based study conducted in the school setting examined Adlerian play therapy (Meany-Walen & Kottman, 2019). The study showed that AdPT is an effective intervention for decreasing children's disruptive behaviors and teacher stress. The researchers urged future studies to examine the effects of AdPT and GAdPT on children with other mental health disorders. Recent studies have focused on the impact of play therapy on externalizing behaviors and disruptive behaviors, leaving a gap in the research investigating internalizing behaviors (Meany-Walen & Kottman, 2019).

Limitations of the Literature

To meet the demands of students, school counselors need to use effective interventions in group therapy. Unfortunately, no research has rigorously investigated Group Adlerian Play Therapy in a school setting. Evidence-based interventions prove

their effectiveness through scientifically proven data. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA, 2017) requires modalities based on scientific evaluation to claim evidence-based status. The Association for Play Therapy urges researchers to conduct and use evidence-based research as a treatment modality for children (Association for Play Therapy, 2018).

Play therapy is a growing field for school counselors and is proven to have a significant impact on students for various presenting concerns. Despite its infancy, AdPT is already the third most utilized play therapy modality, and research supports the impact on students with disruptive behaviors. However, no known research investigates the efficacy of GAdPT resulting in a dire need for evidence-based research to effectively guide school leaders, counselors, and educators to meet the needs of students. Most of the AdPT studies explored disruptive behaviors or externalizing behaviors, used single-case design, and lacked sufficient parent consultation, which is considered one of the primary constructs of Adlerian play therapy. Future research should consider varying research methodologies and explore various presenting concerns. Furthermore, despite the research demonstrating the effectiveness of play therapy, more research is needed that includes treatment manuals, randomized assignments, large sample sizes, parent collaboration, and control groups to solidify play therapy as evidence-based.

Chapter Summary

The recent escalation of students with mental health needs has intensified the need for school counselors to find and implement evidence-based interventions. Schools can bridge the gap of students with unmet mental health needs. Educators and parents can

refer children with internalizing and externalizing behaviors to school counselors who can use effective interventions. School counselors have the means and access to work with many students in the limited time of the school day by reaching many students who would otherwise not have access to counseling. However, due to the immense mental health demands of students since the pandemic, school counselors are struggling to meet the avalanche of social and emotional needs of students too many students. Group Adlerian play therapy is a dynamic process that reaches more students in the school setting than individual play therapy in developmentally appropriate ways. School counselors have the unique role of advocating for students while working with the school system. The experiences and perceptions of school counselors are invaluable sources of information that identify students with internalizing behaviors and show how GAdPT can serve as an effective intervention for students returning to school after the global pandemic.

CHAPTER 3

METHODOLOGY

For this study, GAdPT was used for treating students with internalizing behaviors while also investigating the possible effects on academic achievement. Participants were fourth and fifth-grade students between nine and eleven years old and referred for exhibiting internalizing behaviors. GAdPT sessions were offered at selected elementary schools twice a week for twelve sessions. Treatment providers followed the GAdPT treatment manual and participate in fidelity checks throughout the interventions (Kottman, 2019). The following research questions guided the study:

RQ1: Does participation in GAdPT decrease internalizing behaviors among referred elementary students?

RQ2: Does participation in GAdPT increase academic achievement among elementary students referred for internalizing behaviors?

Research Hypotheses

For this study, the following research hypotheses were formulated to understand the effects of the experimental treatment, GAdPT, on fourth and fifth graders referred for internalizing behaviors compared to a waitlist control group (WC).

1. Students in the treatment group will demonstrate a significant decrease in pretest and posttest mean scores on the Child Behavior Check List Internalizing Behaviors scales compared to students in the waitlist control group as reported by parents.

2. Students in the treatment group will demonstrate a significant decrease in pretest and posttest mean scores on the Teacher Rating Scales Internalizing Behaviors scales compared to students in the waitlist control group as reported by teachers.
3. Students in the treatment group will show a greater increase on the Reading Inventory Scores than students in the waitlist control group as reported by Lexile scores on computer-adaptive assessment measures.
4. Students in the treatment group will show a greater increase on the Math Inventory Scores than students in the waitlist control group as reported by quantiles on computer-adaptive assessment measures.

Participants

The local school district's Internal Review Board (IRB) and the University of Georgia's IRB approved the human subjects' research before participant recruitment began. The researcher maintained the confidentiality of data by coding students and instruments and distorting voices and videos to protect subjects' identity and privacy. The researcher followed the ethical research responsibilities of the American School Counselor Association Code of Ethics (2022) by including consent, confidentiality, and reporting results. The administration of the participating elementary schools in a school district in the southeast region of the United States approved the study in their schools.

School 1 shows 79% of the students score proficient or above in math, and 73% of the students score at or above in reading. The percentage of economically disadvantaged is 3.7%, and minority enrollment is 26%. The ethnicity breakdown for

School 1 is as follows: African American (10.8%), Hispanic (6.4%), Asian/Pacific (4.8%), two or more races (4.2%), and White (73.6%).

School 2 shows 77% of the students scored at or above proficient in math, and 71% scored at or above in reading. The school's minority population is 47%, and 16% are economically disadvantaged. The ethnicity breakdown for School 2 is as follows: African American (26.5%), Hispanic (9.4%), Asian/Pacific (3.1%), two or more races (7.6%), and White (53.3%).

School 3 qualifies as a Title 1 school. The state identifies Title 1 schools for assistance due to a high percentage of the students identified as economically disadvantaged. School 3 shows 38% of the students scored at or above in math, and 35% scored at or above in reading. The school's minority population is 93.7%, and 69% of the school's population is economically disadvantaged. The ethnicity breakdown for School 3 is as follows: African American (66.4%), Hispanic (19.3%), Asian/Pacific (0.6%), two or more races (7.0%), and White (6.3%).

Each participant received an ID number to conceal their identity. Delivered in sealed envelopes, the CBCL and the TRF assessments sent to parents and teachers had student names and ID numbers on the envelope. Treatment providers identified students' families who would need the Spanish version of the CBCL and consent forms. No names were on assessments, only student ID numbers. The researcher received the scored assessments with only student ID numbers, not student names. The study did not exclude students based on race, ethnicity, gender, religion, or social class. Eligibility for the study was determined based on the following criteria:

(a) Student is enrolled in fourth, and fifth grades at one of the identified elementary schools

(b) Student is referred to the study by the classroom teacher or the parent for symptoms of internalizing behaviors and screened by treatment provider for appropriateness of group play therapy.

(c) Student scores in the at-risk or clinical range on the Child Behavior Checklist OR the Teacher Rating Scale in the Internalizing Behaviors Subscale.

(d) Student, parent, and teachers assent to participate in the study.

(f) Student is not engaged in outside counseling.

(g) Student is not labeled with a significant cognitive delay as determined by education placement.

One hundred and thirty-one students received referrals for the study. To qualify, students had to score in the clinical or at-risk range on the internalizing behaviors scale on the CBCL or TRF. Ninety-four students met the qualification criteria for the study. Ninety-four students qualified for the study. Following the qualifying of students for the study, the researcher obtained Reading Inventory scores (RI) and Math Inventory scores (MI) from treatment providers using student ID numbers. The CBCL, TRF, RI, and MI scores were pretest data.

The researcher stratified students first by school and then by grade. Next, they randomly assigned students to either the treatment group (GAdPT) or the waitlist group (WG) by inputting student ID numbers into a Randomization Calculator. The researcher

assigned forty-eight students to the treatment group, GAdPT, and forty-six to the waitlist group (WG). After treatment providers were notified of group assignments using student ID's, a professional blinded to the study, stored students' group assignments in a locked cabinet for the duration of the study. All 94 students completed the study. This study utilized five treatment providers and included nine treatment groups and nine waitlist groups. Following GAdPT recommendations, the number of students in each group ranged from five to seven.

The students represented the following ethnicities: 59% White, 17% African American, 12% biracial, 9% Hispanic, 2% Asian, and 1% Native American. Participants were 57% fourth grade and 42% fifth-grade students. Male students represented 44% of the students, and female students represented 56% of the participants who completed the study. Age distribution among students at the beginning of the study was as follows: 36% 9-year-olds, 43% 10-year-olds, 19% 11-year-olds, and .02% 12-year-olds.

Table 3.1

Demographic Information for Participants in Treatment (n=48) and Waitlist Control (n=46) Groups

		Treatment Group	Waitlist Group
School	School 1	21	21
	School 2	21	19
	School 3	6	6

Grade	4th Grade	28	26
	5th Grade	20	20
Age	9	19	15
	10	16	24
	11	12	6
	12	1	1
Gender	Male	21	20
	Female	27	26
Ethnicity	Black	7	9
	Biracial	8	3
	White	29	27
	Hispanic	3	5
	Asian	1	1
	Native American	0	1

Treatment Providers

Each treatment provider participating in the study conducted two treatment groups except for the treatment provider at School 3, who conducted one treatment group. School 3 needed more referrals to conduct two treatment groups, therefore only conducted one treatment group and one waitlist group. The treatment providers in the study were certified master's, specialist, and doctoral-level school mental health

providers who work as elementary school counselors or social workers. All treatment providers were female and identified as White. The age distribution was as follows: 40–45-year-olds, n = 1; 45–50-year-olds, n = 2; 51–55-year-olds, n = 2. The years of experience for treatment providers were as follows: 15–20 years of counseling experience, n = 2; 20–25 years of counseling experience, n = 2; and 25–30 years of counseling experience, n = 1. School 1 had two treatment providers. School 2 had two treatment providers, and School 3 had one treatment provider. Each treatment provider completed a master's degree in a mental health field. All treatment providers received training in GAdPT protocol before working with students in the study. Treatment providers followed the guidelines, principles, and procedures outlined by Dr. Terry Kottman in the Instructor's Manual for Group Adlerian Play Therapy (2019) and recorded all sessions with filters to protect student identity. To ensure treatment fidelity and protocol consistency, Dr. Terry Kottman performed fidelity checks using the GAdPT Skills Checklist (APPENDIX A).

Procedures

After obtaining permission from school administrators at local elementary schools, a flyer went home to the parents of students in fourth and fifth grader at participating elementary schools seeking referrals for students who exhibited internalizing behaviors (APPENDIX B). Teachers in the fourth and fifth grades also received flyers. The flyers explained symptoms of internalizing behaviors, eligibility requirements, and contact information for interested parents or teachers. Teachers and parents referred interested students who exhibited internalizing behaviors such as

excessive worry, anxiety, depression, withdrawal, inability to regulate emotions, and somatic symptoms.

Consent

Once student referrals were received, the researcher contacted the parents of referred students by sending home a sealed envelope with the student's name and ID number, a detailed letter about the study, informed consent, and the Child Behavior Checklist (CBCL). Teachers received a similar sealed envelope with the student's name and ID, study information, informed consent, and the Teacher Rating Form (TRF). The informed consent letter described the purpose of the study, the procedures, eligibility criteria, and foreseeable risks. Parents and teachers also received assessment information, the timeline of the treatment and waitlist groups, group requirements, and the possibility of their child being in the waitlist group. Parents and teachers who agreed for their students to participate signed the consent forms, acknowledging that they understood the qualifications for the study and completed the CBCL. Parents and teachers returned forms and assessments in sealed envelopes. Treatment providers then checked for informed parent and teacher consent and gave the researcher the completed assessments containing only student ID numbers. Treatment providers then met with each student who qualified for the study to explain the purpose of the study and allowed students to sign consents before beginning treatment. Students acknowledged that they understood participation was voluntary and could stop treatment at any time. Students were screened for groups using the scores from the CBCL and TRF assessments. Students who scored in borderline or clinical range on the Internalizing Behavior scales or the CBCL or TRF qualified for the study.

Group Random Assignment

Once consents and completed assessments were received and the CBCL and TRF assessments scored, the researcher notified treatment providers, using student codes, who qualified for the study and if they were in the treatment or waitlist group. Treatment providers then recorded students' RI and MI scores, with only student codes to complete the pretest assessments. Students scoring in the at-risk or clinical range on the CBCL or the TRF were eligible to participate in the study. Following randomized and control trial procedures, students were stratified first by school, then by grade level, and then randomly assigned to one of two groups: (a) GAdPT treatment group and (b) waitlist control group. Due to variations in discipline, climate, and classroom counseling instruction, stratified random assignment allows for controlling specific variables.

Treatment providers then notified parents of students who did not qualify and offered school counseling services or referrals if needed. In addition, parents of students who qualified for the study were notified of their child's group assignment to either treatment group or waitlist group. Each treatment provider conducted two control groups and two waitlist groups, except for the treatment provider from School 3, who conducted one treatment group and one waitlist group due to limited referrals. GAdPT groups require at least two students, with at most eight students (Kottman, 2019).

Once students were found eligible, treatment providers used professional judgment to screen students for group membership. Screening evaluations of group members included information from parents and teachers, treatment providers' interactions with the child, and the group's chronological and developmental ages (Meany-Walen & Kottman, 2019). When selecting group members for GAdPT, children

with different therapeutic goals can be in the same group. Research has confirmed that group play therapy benefits various presenting concerns so students can have differing goals (Meany-Walen & Kottman, 2019). Personality and behavioral characteristics could hinder or benefit a child or an entire group. Therefore, screening for students participating in a group is critical (Ray & Cheng, 2018). Treatment providers consider the differences in student behaviors and how behaviors would impact other group members' ways of thinking, feeling, and behaving (Meany-Walen & Kottman, 2019).

Provider Training

Dr. Terry Kottman published a comprehensive treatment manual for Adlerian Play Therapy specifically designed for research purposes and subsequently revised to include Group Adlerian Play Therapy in 2019 (Dickinson, 2021). Within the GAdPT section of the treatment manual, specific recommendations detail how to work with groups throughout each phase including guidance on appropriate play materials, spacing, group size, and recommendations for inclusion into the group (Dickinson, 2021)

During five 8-hour training days, treatment providers participated in a virtual synchronous training with Dr. Kottman and Dr. Dickinson through lectures, discussions, experiential activities, videos, and practice play therapy. Additionally, treatment providers had the unique opportunity to engage in supervised GAdPT sessions with their own biological children and their children’s friends, with parent consent, who were not part of the study.

Dr. Kottman and Dr. Dickinson taught essential skills, conceptualization, and techniques of GAdPT by approaching the children with a holistic perspective rooted in Adlerian principles. The training covered the fundamentals of AdPT and GAdPT and was

endorsed by the Association of Play Therapy. Following the training, treatment providers completed an examination covering the content of the training to receive a certificate of completed licensure hours to count towards their play therapy licensure.

Due to a yearlong gap between the original training and the start of the study, treatment providers also attended an additional training before beginning groups for the study. The additional training focused on how to implement GAdPT in the school setting, specifically tailored for the study's objectives. Treatment providers discussed appropriate activities to offer during the study to address the needs of students within the school day and created a menu of Group Adlerian Play Therapy activities to use during the appropriate phases of the study. The GAdPT curriculum outlines purposeful activities to serve both group treatment objectives and individual student needs. Embedded within GAdPT are the foundational principles of AdPT, encompassing social embeddedness, goal-directedness, subjectivity, and creativity.

Group Adlerian Play Therapy encompasses a combination of directive and nondirective play activities to empower students to gain insight, take appropriate risks and engage with their peers. Play activities include expressive arts, movement, games, and interactive play, each with a purpose tailored to specific phases of GAdPT. Furthermore, the study includes the comprehensive GAdPT school curriculum, developed by Dr. Kottman, Dr. Dickinson, and Ms. Kelly Owen for the purpose of this study (Appendix C). The study includes the detailed Group Adlerian Play Therapy Curriculum developed by Ms. Kelly Owen under the guidance of Dr. Kottman and Dr. Rebecca Dickinson, attached in Appendix C.

Treatment Group

Students in the treatment group (n = 48) received 30-minute, biweekly Group Adlerian Play Therapy sessions for 6 weeks, totaling 12 sessions. The number of sessions each student received varied based on student absences. Students left their classrooms to participate in GAdPT in specially equipped playrooms at identified schools during the day. Teacher input guided the scheduled times of the GAdPT sessions during the school day while also following group recommendations to keep sessions short to reduce the time the student was out of the classroom (Sweeney et al., 2014).

` A meta-analysis of play therapy research shows medium to large effects with as few as 14 sessions (Bratton et al., 2005). GAdPT should last at least 10 weeks for students to receive full therapeutic benefits (Kottman, 2019). Kottman and Meany-Walen (2019) note that GAdPT produced faster treatment results in fewer sessions when compared to AdPT. Even though results might occur quicker, Dr. Terry Kottman recommends conducting at least twelve sessions to allow students to fully experience and maximize the benefits of GAdPT (Meany-Walen & Kottman, 2019). Group AdPT shows positive results when conducted biweekly for 30-minute sessions in the school setting (Meany-Walen & Kottman, 2019).

The Group Adlerian Play Therapy curriculum adheres to the four phases of Adlerian Play, which are (a) building egalitarian relationships, (b) exploring the child's lifestyle, (c) helping the child to gain insight, and (d) reeducation/reorientation. Within each phase of GAdPT, treatment providers practice Adlerian Play Therapy skills such as tracking behavior, restating content, reflecting feelings, encouraging, asking questions, metacommunication, and giving insight. Furthermore, treatment providers may return the

responsibility, actively play with the child, clean the playroom with the child, and set limits (Kottman, 2019).

During phase one, the therapist focuses on building relationships individually with students and within the group setting. During this phase, treatment providers guide group members in building relationships with each other. They use play therapy techniques to foster connections and employ basic counseling skills to guide group goals, assist children in decision-making, and address conflicts within the group. Play therapy techniques foster connections, and basic counseling skills help guide group goals, help children share in decision-making, and handle conflict within the group.

During the second phase of Group AdPT, investigating lifestyles is the goal. Using play activities, the counselor observes the children within the group play therapy sessions and how they interact. Meany-Walen and Kottman (2019) explain that analyzing lifestyle during a group setting occurs quicker than in individual sessions because children can show their emotions, interactions, and behaviors. During Group AdPT, children unmask how they resolve and create conflict, self-soothe, and feel important. Using play therapy activities such as drawing, sand trays, and games, the counselor observes the interactions between the children. Following lifestyle observations and analysis, the counselor typically consults with the parents individually.

During the third phase of Group Adlerian Play Therapy, the school counselor guides the students to gain insight using metacommunication, feedback, and interactions. Furthermore, play techniques such as puppet shows, and sand trays guide the children to gain insight into mistaken beliefs and misbehavior goals. The school counselor teaches and encourages insight, behavior change, attitude change, and change at home.

During the final phase of Group AdPT, the counselor leads the students to develop goals to restructure mistaken beliefs, feelings, and behaviors. Unlike individual play therapy, during group play, group members have the opportunity to generalize and practice new behaviors. As the new behaviors and thoughts form into habits, the counselor moves towards termination.

The curriculum in this study thoroughly described the process of each group session to guide treatment providers to conduct sessions uniformly. Treatment providers also uniformly practiced parent consultation by adhering to GAdPT recommendations for consistent parent collaboration and communication (Appendix F). During parent consultation, the focus aligned with the four phases of AdPT for collaboration.

Waitlist Control Group

After all students completed the posttest assessments, the students in the waitlist group started GAdPT. Students randomly assigned to the waitlist control group (n = 46) received the same intervention as the experimental group for the same time as students in the treatment group. Students in the waitlist group received 30-minute, biweekly sessions of GAdPT for 6 weeks, totaling 12 sessions. The number of sessions each student received varied based on student absences. The treatment providers notified students and parents on the waitlist of their child's group assignment.

Parents in the waitlist group completed the posttest simultaneously with the experimental group. Unlike the experimental group, the waitlist group did not participate in the intervention until after the posttest instruments, the CBCL, TRF, and MI/RI. Once posttest data was collected, each child in the waitlist control group was placed in a GAdPT group and began play therapy sessions. The treatment providers provided

GAdPT to the WG students, following the study protocol to ensure the ethical delivery of services. The same treatment providers who conducted the experimental groups also conducted the waitlist groups.

Data Collection

Alongside consents and a detailed letter explaining the study, parents received the Child Behavior Checklist (CBCL) in sealed envelopes with the students' names and assigned ID numbers. Teachers also received consent forms, a detailed letter explaining the study and the Teacher Rating Forms (TRF). Teachers were given coverage in their classrooms to complete assessments in a quiet environment if requested. The CBCL/TRF assessments are paper documents with approximately 113 questions. The assessments took approximately 10 minutes to complete. Parents and teachers signed consents and completed pretest information within a week in the provided sealed envelope. Treatment providers collected envelopes and recorded the receipt of consent and assessments using the assigned student ID number. The researcher received the completed assessments with only student ID numbers. The researcher hand scored each assessment following administration and scoring guidelines qualifying students for the study (Achenbach & Rescorla, 2001). The researcher notified treatment providers of the students who qualified for the study using coded student ID’s.

After collecting parent and teacher consents qualified students met with treatment providers individually to discuss participation in GAdPT and sign student consents. Treatment providers recorded the Math (MI) and Reading (RI) Inventory scores of consenting students using their coded student ID. The MI and RI are computer-adaptive assessments that fluctuate in difficulty depending on student responses. The school

district requires students to take the MI and RI at least three times a year to gauge academic growth and needs. Students may take the computer assessments more than three times as needed within the district's testing window. The students in the study adhered to the district's testing calendar when taking the MI and RI assessments. The CBCL, TRF, MI, and RI served as baseline data before participation in GAdPT. A minimum of three data points is required to establish a solid baseline (Purswell & Ray, 2014).

Once the CBCL/TRF and MI/RI pretests were received, and students were qualified for the study, the researcher stratified students by school and grade before random treatment group (GAdPT) or waitlist group (WG). The researcher put student ID numbers into a randomization calculator resulting in forty-eight students to GAdPT and and forty-six to WG. After treatment providers were notified of students' group assignments using student ID's, a professional blinded to the study, stored students' group assignments in a locked cabinet for the duration of the study.

Students receiving GAdPT participated in two 30-minute sessions per week for 6 weeks. All play therapy sessions facilitated by treatment providers trained in GAdPT followed the Group Adlerian Play Therapy (GAdPT) protocol provided by Dr. Terry Kottman (Kottman, 2019). The sessions occurred in the treatment provider's office or designated playroom at the elementary school, complete with toys and materials needed to conduct GAdPT, according to the treatment manual for GAdPT (2009). Students in the waitlist group did not receive treatment during this time.

At the end of 6 weeks, parents, teachers, and students completed posttests, to include either the CBCL, TRF, RI or MI. The treatment providers gave parents the

CBCL and the teachers with the TRF in sealed envelopes, with the students' name and student ID. Teachers were given support in their classroom as needed to complete the TRF in a quiet environment. Students took the MI and RI, aligning with the school district's testing window, which served as the posttest instruments for the study. Treatment providers received the CBCL/TRF assessments with student names and ID numbers to record receipt. The researcher received the CBCL and TRF with only student IDs to score as posttest data. Treatment providers recorded student MI and RI scores and submitted scores with only student IDs. After collecting posttest data, students in the waitlist group began treatment. All student information was kept confidential. The researcher excluded all student and teacher names from any documentation by coding assigned student ID numbers for all assessment data collected for the pretest and posttest. The data is only accessible to the researcher, who will destroy it upon completion of the study.

Intervention

After stratification and randomization of students, the experimental group began biweekly 30-minute GAdPT sessions. Students in the experimental group completed 12 sessions based on the principles and procedures of GAdPT (Meany-Walen & Kottman, 2019). The treatment providers notified students, parents, and teachers of the referred student's group assignment to either the treatment or waitlist group. Once treatment providers notified students of their group assignment, they worked with teachers to schedule times to conduct GAdPT that minimized missed instruction.

Adlerian Play Therapy is a manualized treatment model. Dr. Rebecca Dickinson developed a curriculum to help manualize Group Adlerian Play Therapy in 2019 for her

dissertation. The curriculum for GAdPT provides purposeful play activities for each session that are easily adaptable to meet the unique needs of each group member. Also, the curriculum creates a sense of belonging and cohesion for group members and moves to more risk-taking activities designed to provide insight and reeducation for students. Furthermore, it follows the four phases of AdPT using purposeful activities, moment activities, expressive arts, play activities, and games. The directive and nondirective activities allow students to develop meaningful relationships, gain insight, take risks, and practice social interaction within the four phases of GAdPT, such as (a) building egalitarian relationships, (b) exploring lifestyles, (c) helping children gain insights, and (d) reeducation/reorientation. Each play activity has a purpose that fits within the goals of the phases of GAdPT. Within each phase, Dr. Terry Kottman recommends using specific skills, such as tracking behavior, restating content, reflecting feelings and meaning, encouraging, asking questions, and metacommunication (Kottman, 2019).

Parent Consultation

Furthermore, treatment providers mirrored the AdPT process during parent consultation, communicating group activities, purpose, developing relationships, mistaken beliefs, and reorientation/reeducation. Treatment providers met individually with parents at the beginning of the treatment to develop egalitarian relationships and understand the student's lifestyle. Adlerian play therapists help parents to understand the magnitude of their involvement in the process. During the meeting, treatment providers provided interview questions adapted from the GAdPT treatment manual (Kottman, 2019) to understand better the students and their families' lifestyles (APPENDIX F). Consultations with parents in the second and third stages involved individual and group

emails about the student's and group's weekly progress and goals. The final stage of parent consultation included individually meeting with parents to discuss insights into attitudes and behaviors, better understand the student's lifestyle, and reeducate and encourage parents and teachers to refine parenting or teaching skills if needed.

Fidelity

The researcher implemented several procedures to ensure treatment fidelity. First, treatment providers attended intensive training in Group Adlerian Play Therapy protocol from the developer Dr. Terry Kottman and researcher Dr. Rebecca Dickinson. Treatment providers attended additional training before the start of the treatment due to the yearlong gap between the original training and the start of the intervention. Throughout the study, treatment providers recorded and submitted videos weekly to the researcher. Each submitted video used a coding system to protect the identity of treatment providers and their students. Treatment providers submitted a video of every session conducted each week, totaling 18 videos submitted to the researcher weekly. The researcher distorted the images and disguised voices to conceal the student's identity. Throughout the study, the researcher received 108 videos and organized the videos by session number and phase. Randomization software randomly selected videos to submit to Dr. Kottman each week, who then scored 10% of each video. The GAdPT Skills Checklist (APPENDIX A) confirmed treatment providers' consistency with the treatment protocol (Dickinson, 2021). Fidelity checks support the internal validity of an intervention (Solomon et al., 2009). For the current study, protocol adherence was calculated by averaging the scores of each reviewed video, yielding an average of 92% for fidelity to the treatment model, indicating that 92% of all treatment providers fell within treatment protocol.

Instrumentation

Internalizing behaviors, if left untreated, may lead to chronic emotional or substance abuse problems that worsen over time, emphasizing the importance of early intervention (Achenbach & Rescorla, 2001). The first step in helping students with these behaviors is reliable and valid assessments. Parent and teacher reports of anxiety and other internalizing behaviors complement one another to provide a holistic view of the student. Parent and teacher reports can also be helpful for younger students who might lack the ability to express their emotional distress or may lack the understanding that their somatic symptoms might be related to their internalizing behaviors (ASEBA; Achenbach & Rescorla, 2001). Both parent and teacher reports are critical to assessment since the parents have the perspective of the child at home, and the teachers have the perspective of the child in the classroom and social settings. For example, many youths with internalizing behaviors try to mask their anxiety in the classroom due to embarrassment or fear of getting in trouble, yet the symptoms of anxiety surface in the comfort of their homes.

For this study, students referred by parents or teachers qualified for the study if they scored in the at-risk or clinical range on the Child Behavior Checklist (CBCL)/Teacher Rating Form (TRF). Using standard administration, the CBCL and TRF measure symptoms of behaviors that parents and teachers rate as barriers to learning. Parents completed the CBCL to assess internalizing and externalizing behaviors at home, and teachers completed the TRF to assess these behaviors in the classroom and social settings at school. The CBCL/TRF scores served as pretest and posttest data for internalizing behaviors. The Math Inventory (MI) and Reading Inventory (RI) assessed

academic achievement. Students took the MI and RI on computers for pretest and posttest data.

Child Behavior Checklist (CBCL)

The CBCL is a norm-referenced instrument of the Achenbach System of Empirically Based Assessment (ASEBA) normed on the same general population sample as age and gender based on national probability samples (ASEBA; Achenbach et al., 2003). The CBCL is a commonly used checklist in counseling research designed to assess emotional and behavioral problems and adaptive functioning as rated by parents (Achenbach et al., 2003). Parents completed the Child Behavior Check List (CBCL) for students aged 6–18 before the treatment intervention. The assessment entails 118 items asking parents to rate their child on a 3-point scale regarding problem behaviors in Internalizing Behaviors, Externalizing Behaviors, and Total Problems, consisting of eight subscales. The subscales include Anxious/Depressed, Withdrawn, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior. Specifically, the internalizing domains are (1) Anxious, (2) Withdrawn-Depressed, and (3) Somatic Complaints (Achenbach & Rescorla, 2001). The subscales use a response format ranging from not true (0) to very accurate (2). Parents and teachers rate students between the ages of six and 18 years old on 118 items. The empirically based problem behaviors students might display are acting fearful or anxious, acting too young for their age, or having frequent stomachaches or nightmares.

Each assessment generates raw scores for internalizing and externalizing behaviors, converted into T scores and percentiles to show how students compare to other school-age children. T scores between 60 and 63 fall within the borderline range, while

scores above 63 falls within the clinical range (Achenbach & Rescorla, 2001). The CBCL is a copyrighted assessment and, therefore, not provided as an appendix for this study. Assessment may be purchased from the Achenbach System of Empirically Based Assessment (https://aseba.org/). The test-retest reliability score for the CBCL empirically based problem scales shows the test-retest correlation of .90, and test-retest reliability coefficients show .91 for internalizing behavior problem scores. Internal consistency of the empirically based problem scales demonstrates alpha coefficients of .78 to .97.

Teacher Report Form (TRF)

The Teacher Report Form is identical to the CBCL but completed by teachers. The teacher report instrument assesses students' academic performance and behavioral and emotional functioning (Achenbach & Rescorla, 2001). Like the CBCL, the TRF is for students ages 6–18 years old and requires teachers to score students' classroom performance on a 118-item form. Teachers record responses on a Likert scale: 0 indicates "not true," 1 represents "somewhat true," and 2 signifies "very or often accurate" (Achenbach & Rescorla, 2001). The scores computed and produced on the TRF are comparable to the CBCL scores, except the norms' foundation is from teacher reports of nonrefereed students. Achenbach and Rescorla (2001) reported adequate internal consistency for the TRF, with an alpha of .90 on the TRF Total Adaptive Scale; for the problem scores, alphas of .72 to .95; and for the DSM-oriented scores, alphas ranging from .73 to .94.

Reading and Math Inventories

Many school districts use the Math and Reading Inventories to make educational decisions about learning and instruction. The Math Inventory (MI) and Reading

Inventory (RI) provide metrics to assess students' academic performance to grade-level expectations (Scholastic, 2014). The MI and RI are computer-adaptive, research-based assessments that provide immediate data measuring student growth in math and reading (Scholastic, 2011; Scholastic, 2014). The MI and RI received "convincing evidence" ratings for the reliability and validity of their scoring methods, the number of alternate forms, sensitivity to student improvement, end-of-year benchmarking, and specification of improvement rates (Hanover, 2013). These assessments measure student achievement and growth and compare student, class, and grade-level performance with other students' performance from around the district and state. The RI assesses students' answers to questions about text passages. The MI assesses students' responses to math problems. The MI and RI Inventories are given to students three times a year and cover reading and math standards within 20–30 questions. Most students finish the assessments within 20–30 minutes. Reading scores use Lexiles, and Math scores use quantiles.

Reading Inventory

The Reading Inventory RI is a 20–25-minute computer-adaptive test that measures reading fluency and comprehension skills. Two subtests, Foundational Reading Assessment, and Reading Comprehension Assessment, merge to track student growth of foundational reading and comprehension skills. The Foundational Reading Assessment measures phonological awareness, letter-word identification, fluency, and decoding word skills with students in grades K–2 using an 82-test item bank. Students who score 49 or above move from the Foundational Reading Assessment to the Reading Comprehension Assessment. The Reading Comprehension Assessment measures student fluency with reading skills to determine readiness for the comprehension assessment. The Reading

Comprehension Assessment produces Lexile measures for teachers to match students to books, articles, and short readings at the right level for independent reading, inform instruction, and informally monitor students' reading progress. Students' scores reflect Lexile reading levels, a scientifically based system for measuring comprehension to guide students to challenging books without discouraging them. Educators often use Lexiles to indicate the difficulty of text for students, separate from grade level. At the beginning of the year, students take the Reading Inventory as a baseline assessment. Student progress is measured using the Reading Inventory throughout the year.

The Reading Inventory assesses students' reading comprehension in grades K–12. The purpose of the Reading Inventory is to assess the reading level that a student can comprehend with 75% accuracy (Scholastic, 2014). Drawing from a question bank of 6,000 testing items from all reading levels, students' progress through roughly 33 short reading passages and then complete four answer choices to assess student comprehension. The Reading Measure increases in difficulty as participants answer questions correctly.

When students answer questions incorrectly, the software adjusts the difficulty of questions to maintain students' probability of selecting the correct answer. The Reading Inventory reliability scores indicate high reliability for all items, ranging from .74 to .94 for internal consistency, meaning that items within the subscales consistently measure the construct. Educational research and research conducted by Scholastic demonstrate that the SRI meets the highest standard of reliability (Scholastic, 2014).

Math Inventory

Math Inventory (MI) is a computer-based, adaptive assessment that measures students' readiness for math instruction while monitoring growth (Scholastic, 2014). The MI measures progress for students K–Algebra II using the Quantile Framework, a scientifically proven measure for math achievement and concepts. Aligning to the Common Core State Standards, the MI measures what students do not know to identify what students are ready to learn. This Framework presents a synonymous context across mathematics by organizing skills and concepts into practical, ordered relationships (Scholastic, 2014). The MI assesses mathematical understanding for students with 25–45 questions on skills in five different strands, including algebra, geometry measurement, numbers and operations, and probability and statistics.

The Quantile Framework includes more than 500 math skills and concepts that measure students' mathematical readiness and growth. Students take these assessments a minimum of three times per year. The MI rates the highest marks for reliability and validity by the National Center for Response to Instruction. For adaptive computer tests, there are no fixed forms or test items. Therefore, traditional measures of reliability are not appropriate. Marginal reliability is computed by determining the section of the test performance that is not due to an error. Marginal reliability exceeding .80 demonstrates that scores accurately discriminate student ability. Reliability scores indicate a high marginal reliability of .97, showing consistent measurement of student mathematical ability. The test-retest reliability between two Math Inventory Quantile measures is 0.78, considered significant (Scholastic, 2014).

Data Analysis

The researcher applied a two-factor repeated measures split-plot analysis of variance to investigate the pretest and posttest data in order to address the research questions. For each dependent variable, a two (group) by two (repeated measures) split-plot ANOVA was performed in SPSS to analyze group differences and changes across time. A split-plot ANOVA model framework is adequate to evaluate impact, allowing for random effects to account for the variation of results to random group assignment. In the analysis, the treatment group serves as the between-subject variable, and time (pretest/posttest) serves as the within-subject variable and possible interaction effect of group membership with change across time, which is a particular interest in this study. Split-plot ANOVAs are extensions of the general linear model.

Assumptions for performing repeated measures within/between interaction ANOVA were met, except for the assumption homogeneity of intercorrelation. Before conducting the analysis, dependent variables (CBCL/TRF, MI/RI) were inspected to screen data for independence, normality, outliers, homoscedasticity (homogeneity of variance), homogeneity of intercorrelation and sphericity. The assumptions considered in this study include continuous dependent variables (scores on CBCL/TRF/MI/RI), categorical within-subject factors (treatment group/waitlist group), typically distributed dependent variables, and uniform differences between levels.

The assumption of independence was met in this study because of having more than one independent variable, all of which were categorical. The completion of assessments by teachers and parents occurred independently of one another, further affirming the fulfillment of this assumption (Pallant, 2013). Because ANOVA relies on

the f-statistic, each group must have a normally distributed dependent variable. A histogram and a Kolmogorov-Smirnov test of normality were conducted as part of the visual assessment to evaluate the normality of the data. Scatterplots of residuals against the values of each dependent variable in the model assessed homoscedasticity. Though some outliers were detected, they did not appear to influence the data and were retained. The assumption of homogeneity of variances was tested using Levene's Test of Equality of Variances. A Levene's test result with a significance exceeding the predetermined criterion of 0.05 indicates that the assumption of homogeneity of variance has been satisfied. In addition, a one way ANOVA was run on pretest scores on all dependent variables for treatment and waitlist groups to ensure there were no statistical differences between groups on pretest measures. Levene's Test for Equality of Variances revealed there was homogeneity of variances for pretest scores for each dependent variable or treatment and waitlist groups. Though the assumption of intercorrelation was noted, the robustness of the ANOVA against minor violations and the large sample size that enhances the stability of statistical tests, ensures validity of the results. The assumption of sphericity does not need to be assessed since this study only has two categories of pretest and posttest.

Upon the study's conclusion, the pretest and posttest data resulting from the CBCL/TRF were manually scored following their respective manuals. Independent analyses were conducted for the CBCL internalizing behaviors and TRF internalizing behaviors as dependent variables. In addition, the MI and RI assessments, which are self-administered computer-based tests, were administered again to students after the study, aligning with the school district's designated testing window. Independent analyses were

also performed for the Math Inventory and Reading Inventories. The data analysis examined the increase in quantiles and Lexile scores, serving as indicators of improved academic achievement.

A two-factor split-plot analysis of variance was performed for each dependent variable, internalizing behaviors, and academic achievement, to determine if the treatment group yielded significant results over time. The independent variables consisted of the treatment groups, namely, the GAdPT group and the WC group, with two distinct time points, the pretest and posttest, for each dependent variable. Once assumptions were examined and met, a two-factor (time X treatment) repeated measures split-plot analysis of variance was conducted. This analysis sought to investigate the effects of the GAdPT (the experimental and waitlist control groups) and time (the pretest and posttest measurements) on each dependent variable, encompassing internalizing behaviors and academic achievement.

Power Analysis

The study explored the differences between groups and within groups over time using repeated measures with two different data points. Using G*Power, priori power calculations were run for repeated measures ANOVA for two groups of measurements, showing a sample size of 24 students was needed, determined by an effect size of 0.25, $\alpha = 0.05$ and a required power level of 0.80. This was a sufficient sample size to compare treatment and waitlist groups in the RCT study analysis. The sample size of 24 allowed for detection of medium effects, and the alpha level of .05 allowed for interpretation of the statistical significance of findings (Thompson, 2002). The significant differences between the means across time were tested using the .05 alpha level, and the effect size

was tested for each analysis using the omega-squared statistic (ω^2) to assess the practical significance of the finding. Cohen's guidelines were used to interpret ω^2 effect size: .01 = small, .06 = medium, and .14 = large. A decrease in scores on the CBCL and TRF implies improvement in targeted behaviors. An increase in the MI quantiles and RI Lexiles indicates improvement in academic achievement.

Minimizing Threats to Internal and External Validity

The real-world applicability of this study in the school setting provides valuable information. Many elements of this study guard against internal and external threats to validity, such as using adequate sample size, random group assignment, a manualized treatment protocol, fidelity checks, a clearly defined population with specific inclusion criteria, and multiple sources of measurement and blinded assessors. Stratified random assignment by school and age allowed greater control over confounding variables such as individual school environments and developmental limitations.

The assessments utilized in the study show strong validity and reliability. All assessments were completed independently and coded to protect student identity. Self-administration and the use of coding prevent parents and teachers from reporting socially desirable responses on the questionnaires. This method circumvents the presence of an interviewer during data collection, which, according to Nederhof (1984) and Wiseman (1972), seems to provide a greater sense of anonymity. The use of self-report measures protects against researcher bias influencing assessment results since assessments are taken privately without the researcher present and coded to protect student identity.

Utilizing a pretest to select students who score in the borderline or clinical range also prevent selection bias. Students did not require a diagnosis to participate in the study,

allowing students who might lack access to counseling to participate in the study. However, to protect the internal validity of the treatment, students were restricted from participating if they received outside counseling or special education services. Furthermore, the CBCL/TRF MI/RI assessments do not recommend that students retake the assessment within one month. To protect internal validity with the testing effect, students took all posttests 10 weeks after the pretest. Maturation might impact the external validity of the study. While it is expected that students naturally improve academically and behaviorally with maturity, all students in the study underwent the maturation process. The researcher hypothesized that students in the treatment group would show more significant change over time than those not in the treatment group.

The treatment providers are experienced professionals in the fields of school counseling and child mental health services. To protect against treatment infidelity, all treatment providers recorded and then coded their sessions before submitting these video recordings to the researcher. The researcher, in turn, edited the videos to conceal identities. Using a randomization calculator, the researcher randomly submitted edited videos to Dr. Kottman, who subsequently conducted random inspections of the videos using the Group Adlerian Play Therapy Checklist to ensure a minimum fidelity rate of 85% to the prescribed treatment model. Furthermore, the researcher refrained from conducting any small groups to mitigate the potential influence of researcher bias.

Moreover, the utilization of stratified random assignment by school site permitted additional control over potential confounding variables such as school climate. Despite earnest efforts to mitigate the influence of extraneous factors, it is essential to acknowledge the presence of limitations, wherein factors beyond the scope of the

intervention may contribute to the study's outcomes. A final threat to the external validity of randomized controlled trials (RCTs) is attrition. A split-plot ANOVA is an effective method to address attrition in the context of repeated measures (Grace-Martin, 2019). Conventionally, participants with missing data are excluded from the comprehensive analysis.

Chapter Summary

Despite the exaggerated symptoms of internalizing behaviors since the coronavirus pandemic, the expectation persists for students to meet academic standards. Students dealing with internalizing behaviors struggle to meet these standards due to emotional obstacles that hinder their academic achievement. Furthermore, schools are responsible for educating all students. Students whose mental health needs remain unaddressed face increased risks of dropout, substance abuse, addictions, and the burden of enduring lifelong mental health needs. A substantial proportion of students, one-third, deal with mental health problems that will never receive mental health care. Of the students who do receive help, approximately 80% receive therapeutic interventions within the school setting. This data accentuates the added responsibility placed upon school counselors to identify evidence-based strategies for ameliorating the mental health challenges that impede academic achievement. The research reiterates the dire need for a randomized control trial to deepen our comprehension of the impact and efficacy of Group Adlerian Play Therapy, particularly concerning its potential to empower students toward enhanced academic achievement.

CHAPTER 4

RESULTS

This chapter presents the results of the study. Results of the data analysis are presented in the order in which the hypotheses were tested. This dissertation hypothesizes that the students who participated in GAdPT would decrease scores on internalizing behaviors on both parent and teacher scales. In addition, this dissertation hypothesized that students who participated in GAdPT would increase their academic achievement scores on standardized reading and math inventories. Results are presented for this Randomized Control Trial for treatment X time analysis using a Split Plot ANOVA analysis. All analysis utilized an alpha criterion of p= 0.05 for statistical significance.

Data Screening

Methodological assumptions that accompany split-plot ANOVA were considered and evaluated (Armstrong & Henson, 2005). Mixed Model or Split Plot ANOVAs are extensions of the General Linear Model that share model assumptions such as independence, normality, and homogeneity of variance (Field, 2013).

An effective analysis for dealing with missing data is the mixed model ANOVA (Grace-Martin, 2019). Most statistical analysis drop cases from the entire analysis if they have missing data on any of the data points. In contrast, the mixed model ANOVA permits that only the missing data point is dropped and the remaining data in the case is retained (Grace-Martin, 2019). Of the 94 students participating in the study, all 94

students completed the study and returned all assessments. There were no missing data points in the analysis.

Assumption of Independence

The assumption of independence means that student's score does not impact other student scores. Participants that were referred were stratified by school and grade then randomly placed in either the waitlist or treatment group. Teachers and parents completed assessments independently of each other and cases were not influenced by other cases meeting the assumption of independence (Pallant, 2013).

Assumption of Normality

First preliminary analyses were conducted on all study variables to assess for normality through skewness and kurtosis scores. All variables fell within acceptable levels of skewness and kurtosis (Table 4.1) Normality was visually assessed by plotting histograms of the data. The histograms did not reveal any concerns regarding normality. Furthermore, inspection of the Kolmogorov-Smirnov (KS) values further demonstrated the assumptions of normality were met.

Table 4.1

Descriptive Statistics of Major Variables (n=94)

Variable		Pre-test				Post-test			
		M[a]	SD[a]	S[a]	K[a]	M	SD	S	K
Treatment Group	**Internalizing Behaviors**								
	Parent Score	67.79	7.67	-.354	.878	58.83	8.146	.293	0.47
	Teacher Score	63.71	9.92	-.499	.941	48.25	8.05	.335	-.328
	Academic Achievement								
	Reading Scores	822.83	281.93	-.570	.173	992.79	235.20	-.280	-.616
	Math Scores	523.19	189.82	.071	.346	709.94	168.27	-.362	-.052
Waitlist Control Group	**Internalizing Behaviors**								
	Parent Score	64.24	10.16	-.696	.935	63.74	10.65	-.314	.925
	Teacher Score	59.50	11.58	-.323	-.428	63.52	11.72	-.359	.090
	Academic Achievement								
	Reading Scores	802.87	239.07	-.206	-.065	866.24	230.12	-.471	.602
	Math Scores	551.65	148.42	-.307	-.762	622.74	158.17	-.606	.082

Abbreviations: M, Mean; SD, Standard deviation; S, Skewness; K, Kurtosis

Outliers

Data was screened for outliers using box plots. Ten students were statistical outliers. In addition, by inspection of each variable's boxplots, outliers did not have values greater than 1.5 box-lengths from the edge of the box. The trimmed mean values showed the univariate outliers did not appear to influence the data, so they were retained.

ANOVA is robust to this violation of normality when sample sizes are sufficiently large (above 30). The sample in the current study is sufficiently large at 94. The Mean and Trimmed Mean of scores are similar as to indicate outliers are not causing a problem (Pallant, 2013).

Assumption of Homogeneity of Variance

Homogeneity of variance, also known as homoscedasticity, is the assumption that the variances of dependent variables, internalizing behaviors, and academic achievement, are equal across groups. Split plot ANOVAs with only two levels generally do not consider homogeneity of variance a concern due to the robustness to unequal variances in the mixed ANOVA model with only two groups. Levene's tests for each dependent variable (CBCL, TRF, RI or MI) were not significant indicating this assumption was met. Additionally, randomization and a priori power analysis controlled for problems with homogeneity of variance (Pallant, 2013).

In addition, results from a one-way between group ANOVA to compare pretest means revealed no statistically significant differences between the treatment and waitlist groups for each dependent variable. There was homogeneity of variances for pretest scores for each dependent variable *(CBCL, p= .091; TRF, p= .138; RI, p= .426, MI,*

p=.306) for treatment and waitlist groups, as assessed by Levene's test for equality of variances

Homogeneity of Intercorrelations

Researchers must choose specific statistical tests based on the nature of their data and research questions. The primary purpose of the Box's Test of Equality of Covariance, also known as the Box's M test, is to assess the equality of covariance matrices among different groups with multiple dependent variables. In this study, Box's M was significant for dependent variables CBCL (<.001), TRF (.047), and RI (.003), indicating a violation of the assumption that there are similar covariances (Winer, 1971). The Box M statistic for MI (.150) met the assumption of equality of covariance matrices.

The assumption of Equality of Covariance Matrices can be a sensitive test and is violated a little in studies with equal and large sample sizes, such as this study (n=94) (Maxwell & Delaney, 2004). Pillai's trace is the most robust statistic for general protection against departures from the multivariate normality and Homogeneity of Variance–Covariance Matrices (Tabachnick et al., 2007). Therefore, the researcher utilized Pillai's trace to report data.

The Box M serves different purposes in different statistical analyses. A Mixed Analysis of Variance, also known as a Split Plot ANOVA, involves between subjects and within subjects with repeated measures (pre-post assessments) that focuses on the impact of the main effects and their interactions rather than specifically assessing the equality of covariance matrices (Beyene, M. 2016). For this study, the Box M test results were interpreted to fit the needs of the study, a Split Plot ANOVA.

Sphericity

Sphericity is always met for two levels of a repeated measure factor and is, therefore, unnecessary to evaluate. The assumption of sphericity only needs to be tested if your within-subjects factor has three or more categories. In this study, the within-subjects factor, time, only has two categories: pre-intervention and post-intervention.

Hypothesis 1

To address the first research question, a split-plot ANOVA was performed on the Child Behavior Checklist-Internalizing Behavior scores using SPSS Version 27 (IBM Corp. (2020). Time was entered as the within subject's variable and the treatment group was entered as the between-subject variable. Table 4.2 presents the pretest and posttest means and standard deviations for the treatment group (n=48) and waitlist group (n=46) on the Internalizing Behaviors scale of the CBCL.

Results of an two factor repeated measures analysis of variance indicated that the dependent variable, CBCL-Internalizing Behaviors, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (treatment, waitlist) [$F(1,92)= 83.656$, $p<0.001$, $\eta_{p2=}.476$.], statistically main effect for time [$F(1,92) = 128.80$, $p<.001$, $\eta_{p2=}.583$], and no statistical significant main effect for group [$F(1,92) = 2.270$, $p=.135$, $\eta_{p2=}.024$].

Table 4.2

Mean Scores of the Child Behavior Checklist for Internalizing Behaviors

	Treatment Group *n*=48	Waitlist Group *n=46*

	Pretest	Posttest	Pretest	Posttest
CBCL				
Mean	67.79	53.83	64.24	63.73
SD	7.67	8.14	10.16	10.65

Note: a decrease in mean scores indicates an improvement in internalizing behaviors.

To conduct a split plot ANOVA to identify interaction effect between groups over time on the CBCL, data assumptions were analyzed and met. Table 4.3 presents the results of the split plot ANOVA for the Child Behavior Checklist.

Table 4.3

Summary of Split Plot Analysis of Variance for the Internalizing Behaviors Subscale of the CBCL according to group assignment.

Source	df	SS	MS	F	*p*	Partial η^2
Between Subjects						
Intercept	1	725863.338	725863.338	4896.170	<.001	.982
Play Group	1	336.572	336.572	2.270	.135	.024
Error 1	92	13639.114	148.251			
Within Subjects						
Time	1	2806.510	2806.510	128.796	*<.001	.583
Time X Group	1	1822.893	1822.893	83.656	*<.001	.476

Error 2	92	2004.708	21.790
Total	94	6634.111	

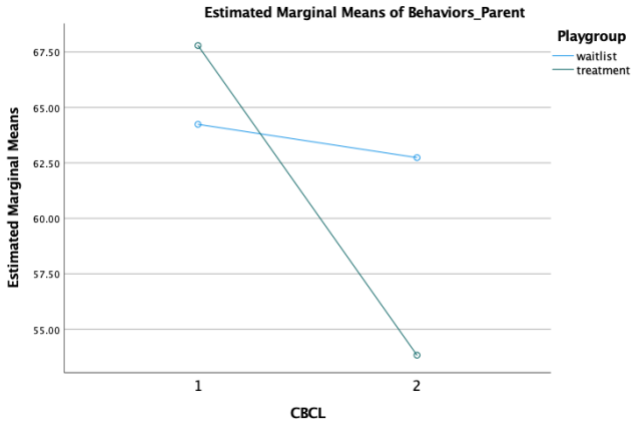

Figure 4.1 Mean scores for the CBCL Internalizing Behavior Problems from pretest to posttest.

These results indicated that according to parent reports, students who participated in the GAdPT treatment group, showed a statistical decrease in students' internalizing behaviors from pretest to posttest, when compared to students who were on the waitlist control group. Findings reveal that GAdPT demonstrated a large treatment effect of (η_p^2 = .476) on parent scores of internalizing behaviors when compared to the waitlist group, indicating the practical significance of the GAdPT intervention. Furthermore, results from the ANOVA interaction effect indicated that the students who attended GAdPT obtained significantly lower scores on the Child Behavior Checklist -Internalizing Behaviors Subscales when compared to the waitlist control group from pretest to posttest. Based on these results, Hypothesis 1 was retained.

Hypothesis 2

A split-plot ANOVA was performed again to address the second research question on the Teacher Rating Form- Internalizing Behaviors subscale using SPSS Version 27 (IBM Corp. 2020). Time was entered as the within subject's variable and the treatment group was entered as the between-subject variable. Table 4.4 presents the pretest and posttest means and standard deviations for the treatment group (n=48) and waitlist group (n=46) on the Internalizing Behaviors scale of the TRF.

Results of an two factor repeated measures analysis of variance indicated that the dependent variable, TRF-Internalizing Behaviors, revealed a statistical significant interaction effect of time (pretest, posttest) x group membership (treatment, waitlist) [F(1,92*)*=139.112, *p<0.001,* ηp2=.602], statistically main effect for time [F (1,92) = 47.949, *p<.001,* ηp2=.343], and a statistically significant main effect for group [F (1,92) = 7.808, *p=.006,* ηp2=.078].

Table 4.4

Mean Scores of the Teacher Rating Form for Internalizing Behaviors

	Treatment Group *n*=48		Waitlist Group *n=46*	
	Pretest	Posttest	Pretest	Posttest
TRF				
Mean	63.70	48.25	59.50	63.52
SD	9.92	8.06	11.58	11.71

Note: a decrease in mean scores indicates an improvement in internalizing behaviors.

In order to conduct a split plot ANOVA to identify interaction effect between groups over time on the TRF, data assumptions were analyzed and met. Table 4.5 presents the results of the split plot ANOVA for Teacher Rating Form for Internalizing Behavior Problems.

Table 4.5

Summary of Split Plot Analysis of Variance for the Internalizing Behaviors Subscale of the TRF according to group assignment.

Source	df	SS	MS	F	*p*	Partial η^2
			Between Subjects			
Intercept	1	648490.005	648490.005	3522.228	<.001	.975
Play Group	1	1437.537	1437.537	7.808	*.006	.078
Error 1	92	16938.447	184.114			
			Within Subjects			
Time	1	1536.154	1536.154	47.949	*<.001	.343
Time X Group	1	4456.792	4456.792	139.112	*<.001	.602
Error 2	92	2947.447	32.037			
Total	94	8940.393				

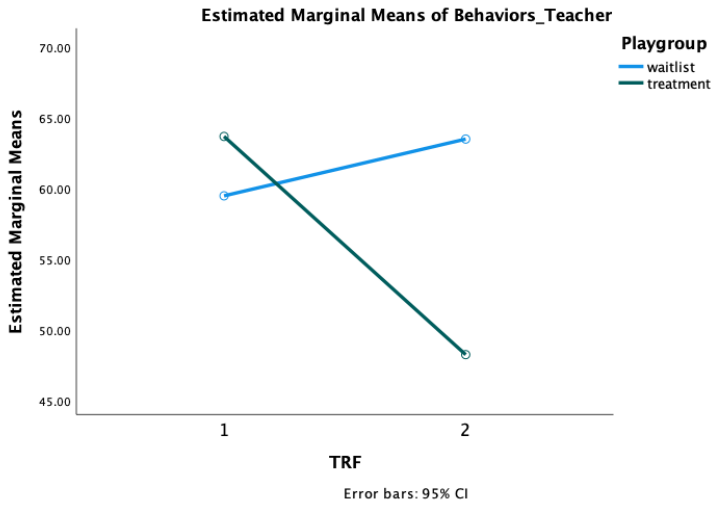

Figure 4.2 Mean scores for the TRF Internalizing Behavior Problems from pretest to posttest.

These results indicate that according to teacher reports, students who participated in the GAdPT treatment group showed a significant statistical decrease in students' internalizing behaviors from pretest to posttest, when compared to students who were in the waitlist control group. Results show a large treatment effect of ($\eta_p^2 = .602$) for change over time the intervention GAdPT on teacher scores of internalizing behaviors when compared to the waitlist control group, revealing a statistical significance of the intervention. Furthermore, results from the ANOVA interaction effect that the students who attended GAdPT obtained significantly lower scores on the Teacher Rating Form-Internalizing Behaviors Subscales, when compared to the waitlist control group from pretest to posttest. Based on these results, Hypothesis 2 was retained.

Hypothesis 3

The third research question also performed a split-plot ANOVA. This mixed ANOVA analyzed students' academic achievement, specifically their scores on the

computerized standardized assessment, Reading Inventory using SPSS Version 27 (IBM, 2020). Time was also the within subject variable and the treatment group was entered as the between-subject variable. Table 4.6 presents the pretest and posttest means and standard deviations for the treatment group (*n*=48) and waitlist group (*n=46)* of the Reading Scores on the Reading Inventory (RI).

Results of a two factor repeated measures analysis of variance indicated that the dependent variable, RI- Reading Inventory, revealed a significant interaction effect of time (pretest, posttest) x group membership (treatment, waitlist) [F (1,92) =2 3.315, *p<0.001,* ηp2=.202] statistically significant main effect for time [F (1,92) = 111.725, *p<.001,* ηp2=.548] and no statistically significant main effect for group [F (1,92) = 2.115, *p=.146,* ηp2=.023].

Table 4.6

Mean Scores of the Reading Inventory

	Treatment Group *n*=48		Waitlist Group *n=46*	
	Pretest	Posttest	Pretest	Posttest
Reading Inventory (RI)				
Mean	822.83	992.79	802.86	866.23
SD	281.93	235.20	239.10	230.11

Note: an increase in mean scores indicates an improvement in reading scores.

In order to conduct a split plot ANOVA to identify interaction effect between groups over time on the Reading Inventory, data assumptions were analyzed and met. Table 4.7 presents the results of the split plot ANOVA for Reading Inventories.

Table 4.7

Summary of Split Plot Analysis of Variance for the Reading Inventory according to group assignment.

Source	df	SS	MS	F	*p*	Partial η^2
			Between Subjects			
Intercept	1	142619993	142619993	1218.953	<.001	.930
Play Group	1	252123.386	252123.386	2.115	.146	.023
Error 1	92	10764183.9	117001.998			
			Within Subjects			
Time	1	639402.837	639402.837	111.725	*<.001	.548
Time X Group	1	133433.263	133433.263	23.315	*<.001	.202
Error 2	92	525616.317	5723.003			
Total	94	1298452.42				

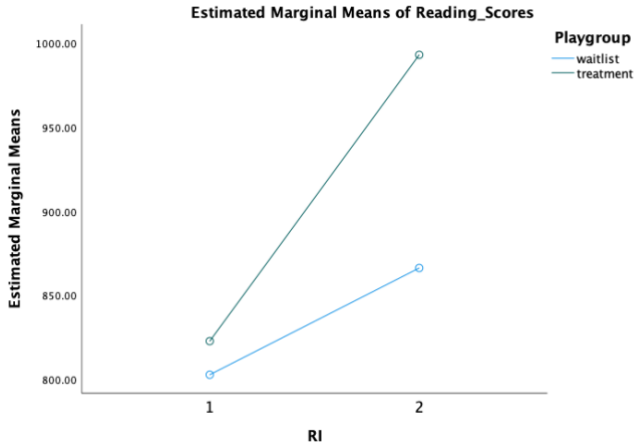

Figure 4.3 Mean scores for the RI-Reading Inventory, Academic Achievement from pretest to posttest

These results indicate that according to Reading Inventory Scores, students who participated in the GAdPT treatment group showed a statistical increase in students' reading scores from pretest to posttest, when compared to students who were in the waitlist control group. The effect size of (η_{p^2} = .202) for change over time indicated a large effect size using the intervention GAdPT and its impact on student reading scores when compared to the waitlist control group. Furthermore, results from the ANOVA interaction effect indicate that the students who attended GAdPT obtained significantly higher scores on the Reading Inventory when compared to the waitlist control group from pretest to posttest. On the basis of these results, Hypothesis 3 was retained. The statistically significant results indicate practical significance of GAdPT.

Hypothesis 4

Finally, the fourth research question performed a split-plot ANOVA. This mixed ANOVA analyzed students' academic achievement, specifically their scores on the

computerized standardized assessment, Math Inventory using SPSS Version 27 (IBM Corp. (2020). Time was also the within subject variable and the treatment group was entered as the between-subject variable.

Students in the treatment group showed a greater increase on the Math inventory Scores than students in the waitlist control group as reported by quantiles on computer-adaptive assessment measures. Table 4.8 presents the pretest and posttest means and standard deviations for the treatment group (n=48) and waitlist group (n=46) of the Math Scores on the Math Inventory (MI). Results of an two factor repeated measures analysis of variance indicated that the dependent variable, MI- Math Inventory, revealed a significant interaction effect of time (pretest, posttest) x group membership (treatment, waitlist) [F(1,92)=27.167, $p<0.001$, ηp2=.228], statistically main effect for time [F (1,92) = 780785.163, $p<.001$, ηp2=.595] and no statistical significant main effect for group [F (1,92) = .809, $p=.371$, ηp2=.009].

Table 4.8

Mean Scores of the Math Inventory

	Treatment Group *n*=48		Waitlist Group *n=46*	
	Pretest	Posttest	Pretest	Posttest
Math Inventory (MI)				
Mean	523.18	709.93	551.65	622.73
SD	189.817	168.26	148.41	158.17

Note: an increase in mean scores indicates an improvement in math scores.

In order to conduct a split plot ANOVA to identify interaction effect between groups over time on the Math Inventory, data assumptions were analyzed and met. Table 4.9 presents the results of the split plot ANOVA for Reading Inventories.

Table 4.9

Summary of Split Plot Analysis of Variance for the Math Inventory according to group assignment.

Source	df	SS	MS	F	*p*	Partial η^2
Between Subjects						
Intercept	1	68073752.9	68073752.9	1358.763	<.001	.937
Play Group	1	40515.003	40515.003	.809	.371	.009
Error 1	92	4609182.10	50099.805			
Within Subjects						
Time	1	780785.163	780785.163	135.000	*<.001	.595
Time X Group	1	157119.631	157119.631	27.167	*<.001	.228
Error 2	92	532089.326	5783.580			
Total	94	1469994.12				

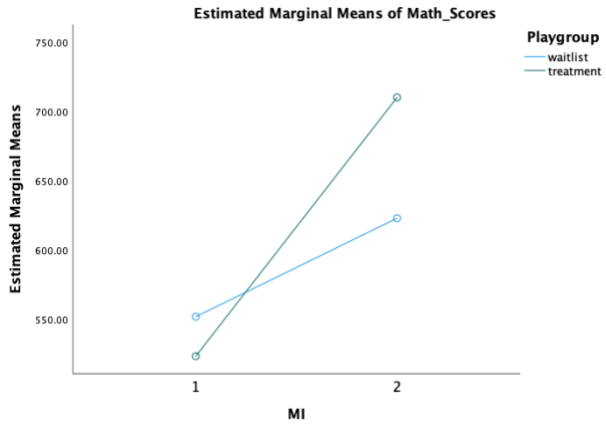

Figure 4.4 Mean scores for the MI Math Inventory-Academic Achievement from pretest to posttest.

These results indicate that according to Math Inventory Scores, students who participated in the treatment group GAdPT showed a statistically increase in students' math scores from pretest to posttest, when compared to students who were in the waitlist control group. The large effect size of (η_p^2 = .228) for change over time indicated a large effect for the impact of GAdPT on students' math scores when compared to the waitlist control group. The results show the practical significance of GAdPT. Furthermore, results from the ANOVA interaction effect indicate that the students who attended GAdPT obtained significantly higher scores on the Math Inventory when compared to the waitlist control group from pretest to posttest. Based on these results, Hypothesis 4 was retained.

Clinical Significance

Internalizing Problem Behavior Outcomes

According to Kazdin (2003), clinical significance refers to the benefit the treatment offers to students in real life. To better understand if the GAdPT intervention positively impacted students' internalizing behaviors and academic achievement,

individual students' pre-and post-test scores for dependent variables were examined. Clinical significance focuses on evaluation of treatment effects on a client's functioning (Kazdin, 2003). The number and percentage of participants who moved from clinical or borderline levels of behavioral problems to normal functioning on the CBCL and TRF were used as an indicator of the clinical significance of the GAdPT intervention on the lives of participants (Kazdin, 2003). Specifically, clinical significance was determined by detecting the number of students in the treatment group (n=48) who moved from being considered Clinical ($T \geq 64$) or Borderline ($T \geq 60$-63) to Normal range ($T<60$; Achenbach and Rescorla, 2001). Using clinical/borderline cut off scores identified by the CBCL/TRF, individual participants who scored at clinical level at pretest on the Internalizing Behaviors Scale were tracked for progress to establish movement toward nonclinical scores at posttest.

Child Behavior Checklist Parent Scores- Internalizing Behaviors

Student's T-Scores on the Internalizing Behaviors Problem scales on the CBCL and TRF were examined to establish clinical significance of GAdPT on students' behavior. According to the parent ratings for Internalizing Problems on the CBCL pretest, 78 students (GAdPT =42; Waitlist=35) were identified at borderline or clinical range on the pretest. Of the 42 students (clinical =37, borderline = 5) in the treatment group who presented as clinical or borderline, 31 moved to normal functioning, 6 moved from clinical to borderline, and 5 students stayed at the clinical level. The students who remained clinical each showed a decrease in behaviors on internalizing behaviors subscale with an average 9-point decrease in score on posttest. Therefore, of the 42 students in GAdPT who demonstrated clinical functioning levels of internalizing

behaviors as reported by parents prior to treatment, 31 (73%) were identified as achieving normal functioning at the posttest (Table 4.10).

Teacher Rating Form - Internalizing Behaviors

A total of 63 students were identified by teachers on the Internalizing Behaviors Scale on the TRF at pretest as exhibiting clinical or borderline levels of concern. At posttest, of the 35 students (clinical=26, borderline=9) who received GAdPT treatment, 32 moved to normal functioning, 1 moved from clinical to borderline and 2 remained in clinical with an average 10-point decrease in score. Hence the 35 students in the GAdPT group who demonstrated clinical levels of functioning of internalizing behaviors as reported by teachers prior to treatment, 32 of the 35 (91%) were identified as exhibiting normative functioning levels at posttest (Table 4.10).

Academic Achievement Outcomes

Reading Inventory

To determine clinical significance for academic achievement, Reading Inventory Scores and Math Inventory scores were examined to evaluate improvement in students' academic achievement from pretest to posttest. The Reading Inventory measures student scores by Lexile's, which is a measure of a student's reading ability and development (Scholastic, 2011). Reading Inventory Scores below 539 (4th Grade) and 619 (5th Grade) are considered below basic grade level (Scholastic, 2011). Scores from 540 to 739 (4th Grade) and 620 to 829 (5th Grade) are considered basic. Scores between 740 and 940 (4th grade) and between 830 and 1010 (5th grade) are proficient. Scores above 941(4th grade) and 1011 (5th grade) are considered advanced on the Reading Inventory.

A total of 20 students (4th grade = 14, 5th grade =6) of the 48 treatment group students were identified as below grade level on the Reading Inventory (4th < 739, 5th <829). Of the 20 students who scored below grade level, 11 students moved to grade level (4th >740, 5th >832) and 2 moved to advanced (4th> 941; 5th >1011). Hence of the 20 students in the GAdPT group who read below grade level as reported by the Reading Inventory prior to treatment, 13 (65%) were identified as reading on grade level or above at posttest. Of the students who scored below grade level, 4 of these students moved to basic 540-739 (4th grade) and 620-829 (5th grade). Two students remained below grade level but showed an increase in reading achievement with an average increase of 223 Lexile's on Reading Inventory posttest.

Math Inventory

The Math Inventory measures student growth by Quantiles. Quantiles show students' readiness for standards-based math instruction (Scholastic, 2014). Math Inventory Scores below 389 (4th Grade) and 539 (5th Grade) are considered below grade level (Scholastic, 2014). Scores between 390 and 533 (4th grade) and between 540 and 644 (5th grade) are considered basic. Scores between 534 and 629 (4th grade) and between 645 and 771 (5th grade) are proficient. Scores above 630 (4th grade) and 772 (5th grade) are considered advanced on the Math Inventory.

A total of 31 students (4th grade = 21, 5th grade = 10) of the 48 treatment group students were identified as below grade level on the Math Inventory (4th < 533, 5th <644). Of the 31 students who scored below grade level, 8 students moved to on grade level (4th >534; 5th >645) and 14 moved to advanced (4th> 630; 5th >772). Hence of the 31 students in the GAdPT group who performed below grade level as reported by the

Math Inventory prior to treatment, 21 (67%) were identified as performing on grade level or above at posttest. Of the students who scored below grade level at posttest, 4 of these students moved to from below basic to basic (4th grade, 390–533, 5th grade, 540–644). The students who remained below grade level each showed an increase in math achievement with an average 113 increase in quantiles on the posttest.

Table 4.10

Summary of Clinical Significance for the Treatment Group

	Pretest					Posttest				
Source	N	B	C		Total B/C	N	B	C		Total B/C
					Internalizing Behaviors					
CBCL	6	*5*	37		42	37	6	5		11
TRF	11	*9*	26		35	43	1	2		3
Source	BB	B	P	A	Total Below	BB	B	P	A	Total Below
					Academic Achievement					
RI	8	12	13	15	20	2	7	14	25	9
MI	17	14	9	8	31	4	3	12	29	7

**Abbreviations N, Normal; B, Borderline; C, Clinical*

**Abbreviations BB, Below Basic; B, Basic; P, Proficient; A, Advanced*

Chapter Summary

This chapter outlines the results of the data analysis performed. Specifically, a Split Plot ANOVA was performed to examine the impact of GAdPT in the school setting for referred students with internalizing behaviors and how their involvement with GAdPT affected their academic achievement. Dependent variables were inspected and screened for assumptions of a Mixed ANOVA such as independence, normality, outliers, variance

homogeneity, and intercorrelations homogeneity. Assumptions for performing repeated measures ANOVA were met. Results were presented in order of the tested hypothesis and demonstrated statistically significant interaction effects for each hypothesis. These findings demonstrate the clinical significance of GAdPT intervention in the school setting for students referred for internalizing behaviors. Furthermore, the results found the clinical significance of GAdPT intervention for increasing academic achievement for students referred for internalizing behaviors.

In summary, the evidence presented in this study indicates that GAdPT is an effective intervention to positively impact internalizing behaviors and their academic achievement. This study is the first randomized control trial to utilize GAdPT in the school setting, to examine the impact of GAdPT on internalizing behaviors, to examine the impact of GAdPT on academic achievement and to utilize parent consultation in the school setting. After an exhaustive review of the literature, this study is the second largest play therapy randomized control trial to date (Ray & McCullough, 2016). This study is critical for school counselors to promote GAdPT as an evidence-based intervention to meet the dire needs of students struggling with mental health needs.

CHAPTER 5

DISCUSSION, IMPLICATIONS, AND RECOMMENTATIONS

This randomized controlled trial examined the effectiveness of GAdPT on students with internalizing behaviors and their academic achievements. Specifically, this school-based study examined the effects of GAdPT treatment on students' internalizing behaviors as measured by parents and teachers and how the treatment impacted their academic achievement as measured by Reading Inventory (RI) and Math Inventory (MI) scores compared to the waitlist control group over time. Treatment effects for internalizing behaviors were measured by pre-to posttest scores on the Internalizing Problems scales on the Child Behavior Checklist (CBCL) and pre-to post scores on the Internalizing Problems scales on the Teacher Rating Form (TRF). Treatment effects for academic achievement were measured by pre-to post scores on both the RI and MI, a computerized standardized assessment. A total of 94 students completed the study.

Of the four hypotheses, all four were retained at the .05 level of significance, indicating an improvement in both internalizing behaviors and academic achievement with the treatment group when compared to the waitlist control group. Partial eta squared effect sizes were calculated to assess and measure the magnitude of these results of difference between the groups over time and practical significance (Kazdin, 1999). The results of this study reveal the benefit of GAdPT in the school setting for students who exhibit internalizing behaviors and for students who struggle academically.

Group Adlerian Play Therapy's Effects on Internalizing Behaviors

The Internalizing Behaviors Subscale was used on the CBCL and the TRF to measure students' internal behaviors that often go unnoticed in the classroom. Achenbach and Rescorla (2001) explained that the Internalizing Problem Scale sums the anxious/depressed, withdrawn-depressed, and somatic complaints to score behaviors that affect students but often go unnoticed in the classroom. Characteristics of internalizing behaviors include behaviors directed at the self, such as excessive worrying, withdrawal, depression, inattention, and somatic complaints (Achenbach & Rescorla, 2001). These behaviors have adverse social-emotional and academic achievement impacts (Blanco et al., 2012, 2019). Students' internalizing behaviors predict their academic success (Denham et al., 2012).

Internalizing Problems, a two group by two repeated measures time split plot ANOVA was performed in SPSS to analyze group differences, changes across time and the possible interaction effect of group membership with change across time, which was the primary focus of this study. The repeated measures approach was used to measure change between groups over time. The two levels of time were pretest and posttest for each dependent variable.

Results of Hypothesis 1 revealed a statistically main effect for time ($p < .001$) with a large effect size ($\eta p2=.583$). Parents reported decreased internalizing behaviors on the Internalizing Problem Subscale of the CBCL from the pretest to the posttest. Specifically, there was a substantial difference in mean scores, declining from 67.79 at the pretest to 53.83 at the posttest, signifying a significant main effect associated with time on parent reports. A reduction in CBCL scores indicates that parents reported a

remarkable improvement in their child's internalizing problems over the course of the study.

The interaction term between time and group was examined to determine if the changes from pretest to posttest were statistically different in the treatment group compared to the waitlist group. The mixed-method ANOVA results for internalizing behaviors revealed a statistically significant ($p < .001$) Time x Group Assignment interaction, indicating that the change in scores from pretest to posttest was more significant for the treatment group than the waitlist group. A visual inspection of group means in Table 4.1 reveals that while the waitlist group demonstrated a 0.51 decrease in t-scores on internalizing problems, students in the treatment group demonstrated a 13.96 decrease in t-scores on internalizing problems. Additionally, results show a significant effect ($\eta p2 = .476$) on internalizing behaviors compared to the control group, suggesting the practical significance of the GAdPT intervention. Parents reported their children in the treatment group were found to have significantly fewer internalizing problems after participation in GAdPT as compared to the waitlist group.

Results of Hypothesis 2 indicate a statistically main effect for time ($p < .001$) with a large effect size ($\eta p2=.343$). Teachers reported decreased internalizing behaviors on the Internalizing Problem Subscale of the TRF from the pretest to the posttest. Notably, a substantial difference in mean scores declined from 63.70 at the pretest to 48.25 at the posttest, signifying a significant main effect associated with time on teacher reports. Specifically, the reduction in TRF scores indicates that teachers reported a remarkable improvement in their students' internalizing problems over the course of the study.

Furthermore, results from the TRF also revealed a statistically significant main effect for group ($p < .006$) with a medium effect size ($\eta p2=.078$). Results of the TRF show a statistical difference in group means between the treatment group (48.25) and waitlist group (63.52) at posttest, signifying that students in the treatment group have significantly fewer internalizing problems at school than students in the waitlist group at posttest.

According to the TRF, the interaction term between time and group was examined to determine if the changes from pretest to posttest were statistically different in the treatment group compared to the waitlist group. The mixed-method ANOVA results for internalizing behaviors on the TRF revealed a statistically significant ($p < .001$) Time x Group Assignment interaction with a large effect size. ($\eta p2 = .602$). The results indicate that the change in scores from pretest to posttest was more significant for the treatment group than the waitlist group. A visual inspection of group means in 4.4 reveals that while the teachers noted the waitlist group demonstrated an increase of 4.02 in t-scores on internalizing problems in the classroom, teacher scores of students in the treatment group demonstrated a 15.45 decrease in t-scores on internalizing problems. Teachers reported that their students in the treatment group exhibited fewer internalizing problems after participation in GAdPT. In comparison, teachers reported that students in the waitlist group exhibited more internalizing problems without treatment.

Furthermore, the finding that, according to parents, 73% of students ($n = 31$) moved from clinical or borderline levels of concern to normal functioning, and according to teachers, 91% of students moved from clinical or borderline levels of concern to

normal functioning following treatment presents evidence for the clinical significance of GAdPT intervention for students in the school setting.

Previous studies have noted that emotional symptoms such as internalizing behaviors are common among young students and often surface before or at the beginning of elementary school (Bitsko et al., 2022). Anxiety and mood disorders are the more prevalent psychological disorders in young students, with 12% of students between the ages of 3 and 17 diagnosed before middle childhood (American Psychiatric Association, 2013; U.S. Department of Health and Human Services, 2021). Internalizing behaviors lead to numerous barriers to academic, social, and emotional success within the school setting, such as difficulty making and keeping friends, isolation, low self-esteem, academic failure, dropping out, poor school involvement, and suicide (Pedersen et al., 2019). School counselors have the unique ability to implement a comprehensive mental health program to identify and intervene for students with internalizing problems (National Association of School Psychologists, 2015). Based on the results of GAdPT, it is evident that this intervention has the ability and the potential to decrease internalizing behaviors that can negatively impact student success.

Group Adlerian Play Therapy's Effects on Academic Achievement

Results of Hypothesis 3 demonstrate a statistical main effect for time ($p < .001$) with a large effect size ($\eta p2=.548$). Standardized assessments revealed that reading scores increased on the RI from the pretest to the posttest. There was a notable difference in mean scores, increasing from 822.83 on the pretest to 992.79 on the posttest, evidencing a significant main effect of time in reading scores. An increase in reading scores on the RI shows students improved reading ability throughout the study.

The interaction term between Time and group was examined to determine if the changes in reading ability from the pretest to the posttest were statistically different in the treatment group compared to the waitlist group. The mixed-method ANOVA results for reading scores revealed a statistically significant ($p < .001$) Time x Group Assignment interaction with a large effect size ($\eta p2 = .202$), indicating that the change in reading scores from pretest to posttest was more significant for the treatment group than the waitlist group. A visual inspection of group means in Table 4.6 reveals that while the waitlist group demonstrated a 63.37 increase in Lexiles on the Reading Inventory, students in the treatment group demonstrated a 169.96 increase in Lexiles. Lexile scores on the Reading Inventory indicate that students in the treatment group increased significantly more in reading academic achievement after participating in GAdPT compared to the waitlist group.

Results of Hypothesis 4 demonstrate the main effect for time ($p < .001$) with a large effect size ($\eta p2=.595$) from pretest to posttest on the Math Inventory. The Math Inventory revealed that math scores increased on the MI over time, with a notable difference in mean scores from 523.18 on the pretest to 709.93 on the posttest. The drastic increase in math scores for students receiving treatment indicates a significant main effect of time.

Furthermore, the interaction term between time and group was examined to determine if the changes in math ability from the pretest to the posttest were statistically different in the treatment group compared to the waitlist group. The mixed-method ANOVA results for scores on the Math Inventory revealed a statistically significant ($p < .001$) time x group assignment interaction, with a large effect size ($\eta p2 = .228$),

indicating that the change in scores from the pretest to the posttest was more significant for the treatment group than the waitlist group. A visual inspection of group means in Table 4.8 reveals that while the waitlist group demonstrated a 71.08 increase in math quantiles on the Math Inventory, students in the treatment group demonstrated a 186.75 increase in math quantiles. Scores on the Math Inventory signify that students in the treatment group increased math academic achievement after participating in GAdPT than students in the waitlist group.

Additionally, according to the Reading and Math Inventories, 50% of students (n = 12) moved from below grade level in math to grade level or advanced, and 77% of students (n = 24) moved from below grade level in math to grade level or advanced following the GAdPT intervention. The analysis results provide evidence-based data for school counselors supporting using GAdPT to increase academic achievement. Although both the waitlist and treatment groups improved over time, students in the treatment group reported a statistically significant improvement over those in the waitlist group. Based on the findings of this research, GAdPT impacts students' academic achievement effectively.

Results from this study are consistent with school-based studies utilizing standardized achievement tests with reported statistical analysis for academic achievement. Several previous studies about the application of play therapy to academic achievement indicate strong relationships between academic achievement and social-emotional factors such as behavior regulation, academic motivation, emotional regulation, and self-concept (McKown et al., 2016). Early researchers discovered evidence of increased IQ scores and reading ability after participation in play therapy

(Axline, 1947). In 2011, Blanco and Ray conducted a study using Child Centered Play Therapy (CCPT) in the school setting, which showed improved academic achievement compared to the control group. In 2017, Blanco conducted another study using CCPT as a manualized intervention when working with students with behavioral or learning difficulties. The students demonstrated statistically significant improvement on standardized academic assessments. Aside from the play therapy research conducted using CCPT in the schools, no other research utilizing Adlerian Play Therapy to investigate academic achievement has been conducted. The findings of this study support the previous literature that found play therapy impacts academic achievement.

Previous research using CCPT documented that reaching optimal benefits takes between 30 and 40 sessions (Bratton et al., 2005; LeBlanc & Ritchie, 2001). In 2012, Blanco found statistical significance using CCPT twice weekly for 26 sessions. Contrary to previous studies, this study found that GAdPT has a statistically significant impact on students' academic achievement in as little as 12 sessions. The statistical and practical significance of this study supports GAdPT as an effective treatment for struggling students. This research is of utmost importance given that students with internalizing behaviors are often overlooked, do not receive treatment, and continue to struggle academically throughout their school years (Myers & Pianta, 2008).

Discussion of Research Findings

Historically, there has been minimal research utilizing play therapy in schools to address internalizing behaviors and academic achievement. This is problematic due to the long-term impact untreated mental health problems can have on students. Based on an exhaustive review of literature, the present study is the largest controlled trial utilizing

group play therapy in the school setting and the second largest controlled play therapy study to date. Likewise, this study is the first to utilize GAdPT in the school setting and utilize parent collaboration, a crucial characteristic of AdPT. Since school counselors are typically given caseloads bigger than they can handle, GadPT is ideal for the school setting. School counselors can meet the needs of more students at quicker rates with this directive play therapy. Several researchers attest to the appropriateness of school-based play therapy to work with students twice a week for 30 minutes, which results in a significant decrease in scores on disruptive behaviors, as reported by teachers (Bratton et al., 2005; Kottman, 2003; Landreth et al., 2009; Ray, 2010; Ray et al., 2007; Ray et al., 2008).

GAdPT uses egalitarian relationships between the school counselor and students to create a therapeutic environment where students experience unconditional acceptance, safety, consistency, encouragement, connection, and a sense of belonging (Kottman, 2003). The treatment providers apply the principles and interventions in GAdPT, which align with the humanistic philosophy that historically impacts students' behaviors (Baggerly & Bratton, 2010; Ray et al., 2007; Shen, 2002). GAdPT focuses on the relationship between the treatment provider and the student and the student's relationships by focusing on collaboration, mutual respect, trust, and shared partnership (Dickinson, 2021).

The two studies on GAdPT previously conducted by Meany-Walen, Bullis, Kottman, and Dillman Taylor (2015) and Dickinson (2019) established procedures for AdPT in the group setting. GAdPT and AdPT are manualized treatments that decrease student behaviors (Kottman et al., 2019). The manualized delivery is ideal in the school

setting to ensure equal access and delivery to all students across settings. The critical concepts of AdPT adapt quickly to the group setting for students with internalizing or externalizing behaviors. GAdPT remains highly individual within the group setting, as treatment providers build relationships and connections with and between group members. GAdPT focuses on the whole child to address presenting issues in a developmentally appropriate stage.

Based on the results of this study, it is evident that GAdPT decreases internalizing behaviors and increases academic achievement in the classroom. Decreasing internalizing behaviors has long-term impacts on student outcomes both socially-emotionally and academically. Results from this study are comparable to other randomized control trials in the school setting utilizing play therapy to decrease behaviors (Blanco et al., 2015; Meany-Walen & Kottman, 2016) and studies investigating how play therapy impacts academic achievement (Blanco et al., 2012.; Perryman, 2018). The results of this study are consistent with other school-based studies which reported statistical significance using the CBCL and TRF and are similar to other studies utilizing the same parent and teacher reports for behaviors (Meany-Walen & Kottman, 2016; Stutey et al., 2015 Swan et al., 2019). The statistical, practical, and clinical significance of this study's findings supports GAdPT as an effective treatment for students with internalizing behaviors. These results are critical given the long term impact of untreated mental health on students.

Limitations of the Study

Although this study followed criteria for rigorous research, such as large sample size, manualized treatment protocol, clearly defined target population, clearly defined

inclusion criteria, multiple sources of measurement for dependent variables, and blind assessors, there are limitations to this study to consider when interpreting the results. It is impossible to control for extraneous variables in the school setting, such as students who attended gifted classes and speech classes, absenteeism, or school climate. Stratified random assignment by a school, then grade, permitted for greater control over confounding variables unique to the different school environments that would manifest in the clinical setting.

While the real-world setting of the school setting in this study supports the GAdPT application, the school is responsible for some limitations. Parents and teachers knew the students' assignments, which could have impacted student scores. Student ID numbers protected student identity to allow parents and teachers to safely answer questions honestly rather than reporting socially desirable responses. Furthermore, self-report measures protected against researcher bias influencing results since assessments were taken privately without the researcher present and coded to protect student identity (Nederhof, 1984; Wiseman, 1972). Blinding parents to the study was not ethical in the school setting or with GAdPT since a significant component is parent consultation.

Participants were represented in a limited range in age and were selected from a small sample near Atlanta, Georgia. Of the three schools selected to participate in the study, School C qualifies as Title 1 due to the low socioeconomic status of the school's families. Unlike the other two schools, this school had a meager referral rate for the study from teachers and parents. School A had 54 students referred to the study, School B had 59 students referred to the study, and School C, the Title 1 school, only had 18 students referred to the study, 67% fewer referrals than the other schools. When considering the

reason for a lack of referrals, the large population of minority students might be significant. School C is 94% minority, 67% African American students, and 69% qualify for free and reduced lunch. African American communities often stigmatize counseling due to the history of racism that continues suppressing African American families. Also, when teachers referred students for the study, many parents did not want their students to participate in "therapy." Although the researcher wanted to include a diverse school with African American students in the study to investigate the impact of GAdPT on African American students, only some African American families were interested in participating. Only 17% of the students in the study identified as African American.

Finally, using a nontreatment control group limits the interpretation of the results. The changes found between the waitlist control and treatment groups could be due to intervention rather than explicitly due to GAdPT. An active control group would have enabled blind ratings (Bryman, 2008; Rubin & Bellamy, 2012). However, this was not a practical or ethical solution. It would have required additional volunteer treatment. The GAdPT emphasizes parent consultation, which would not have been feasible with a blinded active control group. GAdPT protocol expects parent consultation in which the treatment providers develop relationships and ongoing communication with the parents. Parent consultation would not have been possible with a blinded active control group.

Implications for School Counselors

A statistically significant randomized control establishing the effectiveness of GAdPT reveals profound implications for school counselors. The results yield an evidence-based, manualized, and attainable approach that school counselors can implement to meet their students' increasing mental health needs. A primary intention of

this study was to present school counselors with a replicable practical intervention to maximize their effectiveness. The research adds to mounting evidence proving play therapy is the most effective counseling modality when working with children (Axline, 1949; Bratton et al., 2005; Blanco & Ray, 2011; Meany-Walen & Kottman, 2016). This study adds to the literature, cementing the finding that play therapy not only impacts student behaviors but also increases academic achievement (Axline, 1949; Blanco & Ray, 2011; Blanco et al., 2015; Bratton et al., 2005; Cheng & Ray, 2016; LeBlanc & Ritchie, 2001; Meany-Walen & Kottman, 2016; Meany-Walen et al., 2015).

Despite the undisputed evidence solidifying play therapy as best practice, the American School Counseling Association (ASCA) reports that many school counselors do not routinely practice play therapy in the school setting (Ray et al., 2015). School counselors mention many barriers to practicing play therapy, such as a lack of time, training, and skills (Ray et al., 2005). School counselors face ethical dilemmas when mandated to practice evidence-based interventions, such as play therapy. They need more time, training, and resources to perform their jobs. Even though most students receive mental health services in the school setting, school counselors do not always have the time, training, or resources to counsel students ethically (Foster et al., 2005).

The findings of this study highlight the need for CACREP to update its standards to include play therapy standards for school counselors. This study and countless other studies analyzing the impact of play therapy call attention to the dire need for play therapy to be the expectation rather than an added credential. In addition to reframing play therapy as an expectation, the findings of this study also emphasize GAdPT as an ideal modality to empower school counselors to treat more students in a shorter amount

of time. GAdPT showed significant decreases in behaviors and significant increases in academics in only six weeks (12 sessions). In contrast, in two metanalyses analyzing the impact of Child-Centered Play Therapy (CCPT), researchers reported that 30-40 CCPT sessions were needed for the optimal treatment effect (Leblanc & Ritchie, 2001; Bratton et al., 2005). School counselors need interventions that are time and cost-efficient. GAdPT meets the needs of students in a timely and realistic manner for the school setting.

In addition, treatment providers learned how to implement GAdPT in the school setting in only six training sessions. Out of the five treatment providers, none of them were registered play therapists. This information is promising since most school counselors need to be registered play therapists and have limited time or resources for training. The data in this study reveals that school counselors can undergo training in GAdPT in five days to learn how to practice and implement GAdPT in the school setting.

The results of this study also contribute to the efficacy of GAdPT among diverse students. 40% of the students in this study identify as a minority. Moreover, school 3 is a Title 1 school where 93.7% of the students identify as a minority and 69% of the students are economically disadvantaged. Barriers to mental health treatment are well-documented among minority students. Implementing GAdPT in schools efficiently addresses the mental health needs that impede learning and academic achievement. This study involves students across identity groups who demonstrate improved behaviors and academics, suggesting that GAdPT effectively meets the needs of diverse students in a culturally responsive manner.

One explanation for the increased rate of improvement using GAdPT is the structured and goal-oriented approach. GAdPT sessions use clear objectives, specific goals, structured activities, and interventions to give insight into new coping skills and problem-solving techniques. Furthermore, play is the natural mode of communication of children (Adler, 1927; Kottman, 1999), and group play allows students to experience more opportunities to connect, gain insight into their mistaken beliefs, and practice new behaviors (Kottman, 1998; Sweeney et al., 2014). Sessions are saturated with immediate feedback and opportunities to generalize new targeted behaviors. GAdPT addresses time issues in the school setting by including more students and using directive techniques to expedite behavior change. Time is maximized during GAdPT to accelerate the impact of counseling sessions, allowing school counselors to impact more students effectively (Adler, 1927; Kottman, 1998).

Another explanation for students' significant growth in the treatment is the use of scheduled parent consultation. Collaborating with parents is considered an integral aspect of numerous play therapy approaches (Kottman & Meany-Walen, 2016; Landreth, 2012; VanFleet, 2014). In a meta-analysis of play therapy outcomes, Bratton et al. (2005) discovered parent collaboration yielded the greatest significant effect sizes across 26 studies. Parent consultation is an essential part of GAdPT that allows counselors to view students through a systemic lens (Ansbacher & Ansbacher, (1956).). Children have an intricate connection with their surroundings, including families, schools, and communities, that simultaneously shape their behaviors (Dreikurs, 1989). Consequently, students' responses to the systems in which they live mold their behaviors and mistaken beliefs. Parent consultation offers insight into the interactions that mold student behaviors

and the opportunity to help reinforce new targeted behaviors and beliefs to improve therapeutic outcomes. As practiced in this study, parent consultation is a powerful catalyst for shaping student behaviors.

This study offers concrete evidence of the efficacy of GAdPT as a therapeutic approach and sheds light on the interconnectedness of internalizing behaviors and academic achievement. The results are especially encouraging considering the recent mental health crisis in the United States (U.S. Department of Health and Human Services, 2020). Numerous studies document internalization as the most prevalent and overlooked mental health disorder in elementary students (U.S. Department of Health and Human Services, 2021; Allen et al., 2020). Early intervention removes academic barriers for students struggling with mental health disorders. GAdPT answers the call for evidence-based interventions for students with internalizing behaviors within the school setting that are developmentally appropriate and easily implemented by school counselors (Zakszeski et al., 2023). School counselors can use research like this dissertation to advocate for their programs while aligning with their school's academic goals.

This study demonstrates a causal relationship between GAdPT and decreasing internalizing behaviors while increasing academic achievement. Several factors account for the substantial growth observed in this study. Primarily, the directive nature of GAdPT engages students in purposeful play and guided activities, fostering the development of self-esteem and confidence. Simultaneously, this approach facilitates the reduction of internalizing behaviors by providing students with insight and a reorientation of their emotions.

Moreover, the specific treatment protocol allowed treatment providers to cultivate connections among peers and treatment providers, promoting social interest and cooperation. This fosters peer relationships and offers opportunities to practice new behaviors and emotional regulation. Finally, the inclusion of parent consultation proved advantageous to equip parents with the understanding and support to meet their child's emotional needs at home, while simultaneously providing understanding of the student's family atmosphere, values and culture that might impact their behaviors at school. This collaborative approach creates a holistic support system benefiting each student involved. The combined factors practiced in GAdPT contributed to students' success in this study.

Recommendations for Current and Future Research

Current Research

The implications for current research of GAdPT reveal powerful knowledge for school counselors, such as:

- RCTs are considered the gold standard for evaluating the effectiveness of interventions due to their ability to control biases and confounding variables.
- An RCT provides school counselors with an evidence-based intervention to support the integration of GAdPT into the school setting. School Systems rely on evidenced-based interventions to address behavioral, emotional, and academic challenges among students.
- GAdPT decreases internalizing behaviors that often go unnoticed, such as anxiety, depression, inattention, low self-esteem, depression, and social withdrawal. The results of this study empower school counselors with an effective intervention to

positively impact students struggling with internalizing behaviors that hinder academic achievement.

- The critical constructs of GAdPT emphasize building social skills and self-awareness to regulate emotions and solve problems. Students generalize new behaviors and social competence in GAdPT that influence their classroom behavior and interactions, leading to improved academic performance.
- Internalizing behaviors act as barriers to learning. This study provides an evidence-based intervention to reduce internalizing behaviors to allow students to engage in classroom instruction to succeed academically.
- Providing evidence of the efficacy of parent consultation in GAdPT empowers school counselors to engage in consistent, ongoing parent collaboration to meet students' needs effectively. This study reveals that parent consultation catalyzes change and demonstrates how school counselors can collaborate and engage parents in the school setting.
- GAdPT demonstrates the positive impact it can have on students within the school setting in a limited amount of time with limited training. GAdPT is a cost and time-effective intervention school counselors can utilize to meet all students' emotional and academic needs.
- This study provides evidence to support GAdPT as an effective intervention for diverse populations. Adlerian play therapy recognizes and celebrates the whole child within their familial, cultural, and social backgrounds. The holistic approach acknowledges the different systems' impact on a student's well-being and how these systems impact students' mistaken beliefs and goals of misbehavior. In the

current study, students across identity groups improved internalizing behaviors and academics after participating in GAdPT.

Future Research

Based on the limitations and findings of this study, several recommendations for future studies are suggested:

- The present study was limited to a six-week period. A follow-up study investigating the long-term impact on GAdPT on internalizing behaviors and academic achievement would be beneficial.
- The present study only involved 4th and 5th grade students. Future studies should use students in different age groups to investigate the possible impact of GAdPT on their behaviors and academic achievement.
- While this study utilized parent collaboration within the treatment protocol, a comparison group including a group with consultation and a group without consultation would yield beneficial results. In addition, including teacher collaboration would also reveal beneficial data.
- Even though this dissertation was quantitative, a qualitative element would add unparalleled data documenting the caregivers' observations regarding their students' behaviors as they participated in GAdPT.
- To date, research on play therapy for military-connected children lacks rigorous research methodology. Future studies should investigate the impact of GAdPT with military-connected children.

Chapter Summary

This randomized control trial assessed the impact of GAdPT on elementary students who exhibit internalizing behaviors that often go unnoticed. Internalizing behaviors and academic achievement were analyzed before and after students participated in GAdPT to measure the impact of the intervention. Both parents and teachers reported positive results on internalizing behaviors following the intervention. In addition, this study provides solid evidence highlighting the link between academic achievement and internalizing behaviors while simultaneously validating the impact that GAdPT has on academic achievement, which is of notable interest to school districts.

After an extensive review of play therapy research studies, this study emerged as the largest randomized control trial to analyze group play therapy and the first randomized control trial to examine GAdPT in the school setting. Moreover, it is the first to include parent consultation, a unique aspect not previously explored in Adlerian play therapy studies, even though it is a crucial component of AdPT. All four hypotheses were retained, affirming that GAdPT led to substantial improvements behaviorally and academically compared to the waitlist control group. Furthermore, the connection between decreasing internalizing behaviors and increased academic performance offers transformative insights for educational policy formulation and practical implementation for school counselors. The effect sizes indicated statistical and clinical significance, emphasizing the substantial advantages of GAdPT practical intervention in schools.

The strengths of the study are manifold. Specifically, the rigorous adherence to the randomized research protocol, large sample size, manualized treatment, fidelity checks, diverse populations, and utilization of parent collaboration contribute to the robustness of the study. Utilizing a treatment protocol with fidelity checks not only underscores the reliability of the intervention but also empowers school counselors and researchers with a replicable model. While all research has limitations, the rigorous research procedures utilized in this study, coupled with the statistical and clinical significance of the outcomes, reinforce the credibility of the findings to identify GAdPT as a realistic and impactful intervention imperative for school systems to integrate into daily practice.

Since Adlerian theory is the theory most well-known by play therapists (Lambert et al., 2005), the results of this study are of particular interest to practicing play therapists and school counselors. GAdPT offers a goal-oriented, structured approach that expedites behavioral changes, empowering students to learn new beliefs and behaviors. Using parent collaboration, a key component of GAdPT, proved to also be a powerful catalyst for student success in this study.

To summarize, this study embarks on a critical mission to empower school counselors with a realistic and evidence-based intervention that can mitigate the internalizing behaviors that disrupt the lives of an increasing number of students, sometimes with tragic consequences. The prevailing mental health crisis our students face, exacerbated by the repercussions of the pandemic, has placed unparalleled pressure on school counselors. Never before has the crucial service of school counselors been so imperative. Since school counselors are on the front lines of the children’s mental health

crisis, GAdPT allows school counselors to confidently confront the challenging demands and enormous caseloads placed on them. This study empowers school counselors to reach students who might otherwise not be able to access mental health services using developmentally appropriate interventions.

The results of this study provide school counselors and districts with vital and lifesaving interventions that ethically warrant consideration as a new standard in elementary school counseling. As school systems increasingly recognize the value of integrating play therapy into the educational framework, this study serves as a crucial steppingstone toward comprehensive counseling models to ensure success for all students. GAdPT stands as an effective therapeutic intervention and a powerful catalyst for redefining the landscape of school counseling within the educational system.

United in purpose, school counselors, teachers, school districts, and parents must stand together to use evidence-based interventions to alleviate our children's struggles. Maya Angelou's insightful quote, "Do the best you can until you know better. Then, when you know better, do better," is a guiding principle imperative for school counselors, counselor educators, and school districts. The alarming statistics revealing the increasing rates of children who suffer with mental health challenges, and the sobering reality that a substantial number of students with mental health needs will never access treatment stresses the need for systemic improvement and the need to follow Maya Angelou's counsel to, "do better." GAdPT gives relief to the countless students who suffer in silence with unrelenting internalizing behaviors. Educational institutions and counseling programs must rise above theoretical and political divides to collectively work towards an improved future for our children. Knowledge is the most powerful weapon used to

change the world and play is the window into a child's soul. Through the insight gained by watching an innocent child playing, school counselors can hear with their hearts what the child needs to say without a word ever being spoken. School counselors are charged to give voice to the unheard and give sight to systems that cannot see. Play is the language of children and GAdPT is the gold standard. Let's go play!

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APPENDIX A

GROUP ADLERIAN PLAY THERAPY SKILLS CHECKLIST

Skills Phase 1 Building Relationships in Group Adlerian Play Therapy (in addition to the above skills):	**No opportunity or not appropriate to do**	**Had opportunity, appropriate, but did not do**	**Had opportunity, appropriate and did adequately**
Linking child to the therapist			
Linking child to another child(ren)			
Linking children as a group			
Balancing attention between/among children			
Drawing out child who is not participating			
Blocking child who is dominating group			
Negotiating conflicts			
Communicating any necessary group rules/norms that need identified (sometimes not needed)			

Skills Phase 2 Investigating Child's Lifestyle in Group Adlerian Play Therapy (in addition to the above skills):	**No opportunity or not appropriate to do**	**Had opportunity, appropriate, but did not do**	**Had opportunity, appropriate and did adequately**
Linking child to the therapist			
Linking child to another child(ren)			
Linking children as a group			
Drawing out child who is not participating			
Blocking child who is dominating group			
Balancing attention between/among children			
Inviting group members to interact with one another			
Designing interventions that require group interaction			

Skills Phase 3 Helping the Child Gain Insight in Group Adlerian Play Therapy (in addition to the above skills):	**No opportunity or not appropriate to do**	**Had opportunity, appropriate, but did not do**	**Had opportunity, appropriate and did adequately**
Linking child to the therapist			
Linking child to another child(ren)			
Linking children as a group			
Drawing out child who is not participating			
Blocking child who is dominating group			
Balancing attention between/among children			
Metacommunicating **at least three times about one or more of the following**:			
▯ how each child contributes to the group (positively)			
▯ how each child contributes to the group (negatively)			
▯ each child's goals of behaviors in the group			
▯ how each child feels in regards to other group members			
▯ how each child thinks about self in relationship to other group members			
▯ what each member thinks about the other members			
▯ the overall group process			
Creating interventions that require group interactions			

Skills Phase 4 Reorienting and Reeducating in group Adlerian Play Therapy (in addition to the above skills):	**No opportunity or not appropriate to do**	**Had opportunity, appropriate, but did not do**	**Had opportunity, appropriate and did adequately**
Linking child to the therapist			
Linking child to other child(ren)			
Linking children as a group			
Drawing out child who is not participating			
Blocking child who is dominating group			
Balancing attention between/among children			
Creating opportunities for children to lead the session			
Creating opportunities for children to follow the lead of other children			
Facilitating effective conflict resolution			
Encouraging child-directed feedback to one another			
Designing interventions that require group interaction			

APPENDIX B

REFERRAL FLYER

APPENDIX C:

GROUP ADLERIAN PLAY THERAPY CURRICULUM

The following is a menu of activities for the GAdPT sessions. Treatment providers worked together to adjust the activities with Dr. Terry Kottman and Dr. Rebecca Dickinson during the training to fit the needs of the schools. Group Adlerian Play Therapy activities and interventions are adjusted to meet the unique needs of each student (Kottman, 2019). GAdPT baskets were provided to each treatment provider with activity bags labeled with the corresponding session and materials.

Phase One: Build Egalitarian Relationship

Purpose	**Metaphors**
• Play Therapy is a shared process between the counselor and the children. • The counselor offers trust and respect to each child but must gain each child's trust and respect individually. • Consistency in the therapist's behavior promotes trust. • Shared power is not an absence of limits. • Each child can participate, answer questions, or share information. • Encouragement is used rather than praise. • To begin helping group members get to know each other. • Sharing information at a level comfortable to the child is part of self-determination. • Each child can reveal as much or as little information about him/herself as he/she feels comfortable.	**Use Here and Now Metacommunication** *Metacommunication is literally saying aloud what you are thinking.* Build connections between students. Build connections between settings. Reflect feelings. Link students • "You seem happy." • "I notice you like to go first" • "You had a strong reaction when I said…." • "I notice that you ask a lot of questions when I give directions." To help hesitant kids: • "If you are willing…" • "When you are ready…." **"If you think it, say it"- Kottman** *(Dickinson, R, 2019)

Week One

Phase 1: Build Egalitarian Relationship; **Sessions 1 and 2**

Introductions, review confidentiality, expectations, purpose, and create group rules and norms. In expressive arts activity, the puzzle piece treatment provider seeks to understand the child's worldview and sense of belonging, movement activity to make connections, and attention game to gain insight. “Build a Tower” to promote social connection and to work together. Movement activities "Gotcha" and "Mirror Mirror" to encourage group interaction (Ashby et al., 2008).

Week Two

Phase 2: Exploring Lifestyles; **Sessions 3 and 4**

Welcome by reviewing puzzle pieces from the previous week to develop a relationship and sense of belonging between group members and the treatment provider. Students complete Sand Tray World, Kinetic Family Button Drawing, or Animal Kingdom Personality Priorities Four Corners to gain insight into students' personalities, to allow students to build connections, assess student worldviews, and understand relationships in their lives. Students Movement activity, Circles of Comfort, Echoes or What's Your Chicken, to identify stressors and utilize metaphors while interacting with peers. It aims to help students interact, build group cohesion, encourage playful interactions, and allow for gentle risk-taking.

Phase 2: Exploring Lifestyles

Purpose	Metaphors
• The counselor uses observation and interactions to gain information on the child’s worldview. • The counselor uses this information to form a conceptualization of the child’s lifestyle.	Use Here and Now Metacommunication & Add Feelings/meaning metacommunication. Notice Patterns (over time and settings)

• Lifestyle information is used to base individual-specific interventions and metacommunication to test the counselor's hypotheses about the individual child. • In the second phase, the counselor explores the child's lifestyle, gathering information from the child through watching the child's play and asking questions about what happens in the child's life. • What are: Personality priorities, crucial C's?, goals of misbehavior?, Life Tasks? • Watch WHAT the child does: to understand how they (a) perceives self, the world, and others; (b) solves problems; (c) forms relationships; (d) gains a sense of belonging and significance; and so forth. *(Dickinson, R, 2019)	Connections (Between students) • "Seems like you like the art activities more than the dancing activities." • "I notice that you ask to go first each session." • "You frowned. I am guessing you don't like this activity." • "You like to go first. I', guessing you like to be in charge." • "You smiled when talking about your mom in your family drawing. I am wondering if she is important to you."

Week Three

Phase 2: Exploring Lifestyles and Phase 3: Gaining Insight: Sessions 5 and 6

Check in. Students will create their own Superhero cape to represent themselves to help recognize and identify personal strengths and how others perceive their strengths. They will participate in co-story telling with puppets, which aims to help gauge how students take responsibility for their problems and what solutions they seem to generate. Attention Activities "Unfortunately Fortunately" aims to help gauge how students take responsibility for their problems and what solutions they seem to generate. "Feather Balance" promotes control of oneself and flexibility with unexpected obstacles.

Phase 3: Gaining Insight

Purpose	Metaphors
• In the third phase, the play therapist helps the child gain a better understanding of his or her lifestyle and guides the child to consider making changes in his or her patterns of thinking, feeling, and behaving. • The therapist begins offering information to the child regarding patterns the therapist sees in the child's behavior, thoughts, feelings, and perceptions of self and others. • The therapist's hypotheses are tentative, leaving room for the child to disagree. • There is no expectation for the child to openly agree with the therapist's hypotheses. • At the very least, the therapist hopes to "plant a seed" from which the child's insight can grow.	Lifestyle Metacommunication " I have noticed that you like to be the boss in here. I am wondering if you also like to be the box at home." " We notice that you don't finish your sentences because you don't want people to be mad at you" "You seem to make jokes when you are uncomfortable." "I notice that you ask a lot of questions when I give instructions. I wonder if it is important to you to do things right."

Week Four

Phase 3: Gaining Insight; Sessions 7 and 8

Welcome using puzzle pieces quick draw activity to encourage students to self-disclose and to establish a sense of connection between group members. Students also create a pet to explore their emotional needs and how those needs can be appropriately met. Movement Activity "Carry That Load" helps students recognize the necessity of helping others through difficult times and allowing others to help them. Breathing Buddies, a breathing activity, encourages students to utilize relaxation techniques such as breathing.

Phase 4: Reeducation/Re-orientation (3 sessions)

Purpose	Metaphors
• This phase is more intentional in helping the child practice specific skills and apply insight directly to his/her life experiences. • This phase generally occurs both in and out of the therapy room and can involve collaboration with parents/teachers. • During this phase, the therapist invites the child and the significant adults in his or her life to explore different, more constructive attitudes and perceptions, helping them put these changes into place in their relationships with others and make shifts in their outlooks on the world. The counselor uses play techniques, art activities, sand tray experiences, therapeutic metaphors, brain storming, and direct instruction to teach new skills needed for gaining significance, interacting with others, and solving problems (Kottman).	**Bridging Metacommunication** **"Sometimes in here you let other people do things for you. I'm guessing you do that at home too."**

Week Five

Phase 4: Reeducation/Re-orientation; Sessions 9 and 10

After the welcome activity, students will play "Pass the Problem Sand tray" to improve problem-solving skills and cultivate a willingness to follow through with possible solutions to problems. "Tablecloth Turn" encourages taking risks. The activity is a cooperative activity that allows students to work towards a goal as a group by encouraging expression, connection, teamwork, and communication. Attention activity, "Ring the Bell," allows students to learn how to focus on their attention and utilize relaxation techniques. The "Dance Party" movement activity will enable students to interact with peers and build connections.

Week 6

Phase 4: Reeducation/Re-orientation; Sessions 11 and 12.

After check-in, students will play “Helium Stick” or “The Maze,” where students must problem-solve and practice new behaviors to solve problems as a group and discuss how their behaviors might interfere with their goals or mistaken beliefs. Students will also create “Jars of Sunshine” and write notes to themselves and others in the positive group that encourage connection and positive thinking. Students will listen to the Story of the Pearl and open their oysters to discover their pearls. Movement Activity, “Energy Stick,” reminds students that we are connected and create positive energy. The “Crucial C’s Dance Party” movement activity allows students to play and interact with peers while making different dance movements associated with other Crucial C’s.

APPENDIX D:

PARENT AND TEACHER CONSENTS

GROUP ADLERIAN PLAY THERAPY ON INTERNALIZING BEHAVIORS AND ACADEMIC ACHIEVEMENT

Researcher's Statement
We are asking you and your child to participate in a research study involving your child participating in school-based group play therapy sessions. The information in this form will help you decide if you want to be in the study. Please ask the researcher(s) below if anything is unclear or if you need more information.

The purpose of the study is to help children who struggle with internalizing behaviors such as anxiety, inattention, low self-esteem, perfectionism, depression, etc. to reduce their internalizing behaviors.

Researchers in child development suggest that children with less internalizing behaviors do better academically. We want to learn more about how Group Adlerian Play Therapy decreases internalizing behaviors and increases academic achievement in students.

Adlerian Play Therapy is an evidence-based intervention that has proven to successfully decreased student behaviors in the school setting. Furthermore, Group Adlerian Play Therapy has many benefits over individual play therapy for school counselors because it allows them to access more children, see positive changes quicker, and reach students who would not typically be able to access counseling. Students participating in Group Adlerian Play Therapy will play group games and activities with specific therapeutic goals.

There are four phases of Group Adlerian Play Therapy such as:
Phase 1: **Establish relationships** play activities to establish relationships with students, teachers, and parents.
Phase 2: **Explore lifestyle** parent communication and play activities to understand the child holistically.
Phase 3: **Develop Insights** play activities to explore the goals of misbehavior and mistaken beliefs
Phase 4: **Re-education:** Play activities to help the student to practice new behaviors and ways of thinking to decrease internalizing behaviors.

In order to collect information, your child will participate in 12 group play therapy sessions that be twice a week for 6 weeks. All sessions will occur during regular school hours at a time determined by the teacher. Students referred for the study will be randomly placed in either the treatment or waitlist groups using a 1:1 ratio. The waitlist group will begin treatment as soon as the posttest is complete. The sessions will occur in a designated playroom at the elementary school, complete with toys and materials needed to conduct Group Adlerian Play Therapy.

In order to collect information, parents will complete the Child Behavior Checklist at the beginning, middle and end of the study. The assessment is a checklist that asks caregivers to rate the frequency of behaviors (such as worrying, stomachaches, daydreaming, etc.) that takes about 10 minutes to complete. Students' Math and Reading Inventory scores will also serve as data for the study. We will compare results from before the student participates in Group Adlerian Play Therapy and after they participate in Group Adlerian Play Therapy. Students in the waitlist group will complete the same assessments.

If you are interested in participating in the study, please read the additional information on the following pages, and feel free to ask questions at any point.

Study Procedures
If you agree for your child to participate, you will be asked to:

- Complete the Child Behavior Checklist at the beginning, middle, and end of the study.
- Allow your child to participate in the Treatment Group or the Waitlist Group. Group assignments determined by random assignment with a ratio of 1:1.
- Allow your child to participate in 12 group play therapy sessions with other students referred for internalizing behaviors that will be twice a week for 6 weeks. All sessions will take place during regular school hours at a time determined by the teacher and treatment provider.
- Allow your child to be videotaped using a lens and sound filter to ensure student confidentiality. Student voices will be distorted to protect identity as well. Videos will be turned in to the researchers to ensure the treatment of Group Adlerian Play Therapy is being conducted as planned.

Risks and discomforts The risks of participating in this study include the following:

- Collection of information that may cause embarrassment or may be associated with stigmatization.
- Video recording may get to the hands of someone other than the research team members. All videos will be recorded using video and audio filters to protect student confidentiality. Students will be unidentifiable. All videos will be stored on a password-protected computer in the researchers. All videos will be destroyed upon completion of the study.

Benefits

- A possible benefit of this study to students is to improve internalizing behaviors that impact them academically, socially, or emotionally. In addition, students might improve their relationships with teachers and students. The results of this study will provide school counselors across the nation with data that helps them to use evidence-based interventions to help students academically and emotionally in the school setting. Although positive changes are expected, they cannot be guaranteed.

Incentives for participation
There are no incentives for participation.

Audio Recording

Sessions will be videotaped with filters to conceal student identity. The primary researcher/therapist will have access to the video recordings. The unidentifiable video tapes will be turned in to Dr. Terry Kottman, who developed Adlerian Play Therapy. She will follow random sampling procedures and randomly view segments of videos to ensure the treatment (Group Adlerian Play Therapy) is being conducted as planned. Students will be assigned a random code to be used in place of their names. Names will be removed from all materials, including assessments and videos. Videos will be destroyed at the completion of this study.

You can decide if you give permission for these recordings to be used for educational purposes. Educational purposes include teaching others about communication and play in classroom, conference, and/or scientific presentation settings. Educational purposes audio recordings will be kept indefinitely for teaching and demonstration purposes.

Please provide initials below if you agree for audio recordings of you and your child playing to be used for educational purposes (i.e., teaching students, teachers, and professionals about language and play; scientific presentations). You may still participate in this study even if you are not willing for the audio recordings to be used for educational purposes.

_____I give permission for audio recordings of my child and me playing to be used for educational purposes.

_____I do not give permission for audio recordings of my child and me playing to be used for educational purposes.

Privacy/Confidentiality
The information collected from you and your child will include information that identifies your child directly and indirectly. A coding system will be used to assign a number to each student. All information will be identified by the number codes. Identifying information, the master list of codes and filtered video recordings will be stored separately. Once the initial data collection phase is completed, all identifying information will be destroyed. Until that time, the principal investigator will have access to identifiable data. Research assistants will only have access to the video recordings devoid of any identifying information and the codes associated with the files.

The project's research records may be reviewed by Office for Human Research Protections and by departments at the University of Georgia responsible for regulatory and research oversight. Researchers will not release identifiable study results to anyone other than individuals working on the project without your written consent unless required by law (e.g., subpoenaed audio files). An exception to the confidentiality assurance is if there is reasonable cause through study interactions to suspect child maltreatment, the researchers are mandatory reporters of suspected child abuse or neglect.
If you decide to withdraw from the study, identifiable information will remain as part of the study. It may continue to be analyzed unless you make a written request to remove, return, or destroy the data.

If you have questions
The leading researcher conducting this study is Kelly Owen. Please ask any questions you have now. If you have questions later, you may contact Dr.Jolie Daigle at jdaigle@uga.edu. If you have any questions or concerns regarding your child's rights as a research participant in this study, you may contact the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Consent/Permission to Participate in Research:
To document your agreement to participate and permission for your child to take part in this study, please sign below. Your signature indicates that you have read or had read to you this form and have had any initial questions answered.

Your Child's Name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Date _____

Signature of Researcher: _____ _____Date _____

Please sign both copies, keep one and return one to the researcher.

APPENDIX E:

STUDENT CONSENT

Assent Script/Form for Participation in Research

Group Adlerian Play Therapy on Internalizing Behaviors and Academic Achievement

We are doing a research study to find out how children like you benefit from Group Play Therapy. This study involves looking at if Group Adlerian Play Therapy is helpful to you. Group play therapy is a time when you will come to a playroom with other children and a counselor who will ask you to play with the toys in lots of the ways you like. Sometimes for children it is hard to share feelings with words and it helps to play with toys to express how you feel.

If you agree to be in the study, you will be asked to come to group play therapy once a week for 12 weeks which will take about 45 minutes per week. Some students will come to group play therapy in January and some students will start group play therapy in April. No one gets to choose who starts in January or who starts in April. It is decided by chance.

If you decide to be a part of this study, please remember you can stop participating any time you want to and nothing bad will happen. The information from this study will help school counselors to know if Group Adlerian Play Therapy helps students. We will not use your name or show your face on any papers written about this study.

You do not have to say "yes" if you don't want to. No one, including your parents, will be mad at you if you say "no" now or if you change your mind later. We have also asked your parent's permission to do this. Even if your parent says "yes," you can still say "no." Remember, you can ask us to stop at any time. Your grades in school will not be affected whether you say "yes" or "no." We will not use your name on any papers that we write about this project. We will only use a number so other people cannot tell who you are.

You can ask any questions that you have about this study. If you have a question later that you didn't think of now, you can talk to Mrs. Owen or email her at Kelly.owen@cobbk12.org

Name of Child: _____ Parental Permission on File: ♦ Yes **♦** No** ***(If "No," do not proceed with assent or research procedures.)*

***(For Written Assent)* Signing here means that you have read this paper or had it read to you and that you are willing to be in this study. If you don't want to be in the study, don't sign.**

Signature of Child: Date: _____ *(For Verbal Assent)* Indicate Child's Voluntary Response to Participation: ♦ Yes **♦** No

Signature of Researcher:

Date: _____

APPENDIX F:

PARENT COLLABORATION

Treatment providers practiced parent collaboration for the duration of the study. This study utilized parent collaboration practices that were realistic with the time demands of school counselors that school counselors can easily replicate.

Phase 1: Parent Phone Call

Initial Meeting (Parent): Call the parent to establish a relationship (use professional judgment to determine which questions will help you develop a positive relationship with the parents best and understand the child's lifestyle).

- Describe your child at home. Strengths? Weaknesses?
- Describe your child's relationship with the caregivers/siblings in the home.
- Describe the routine happenings in a typical day for your family.
- How does the child stand out in the family?
- What traumatic events or trials have occurred during your child's life? (death, divorce, etc.)
- What is your family's philosophy on discipline?
- Which behaviors does your child engage in that are bothersome to family members? What do family members do in response to this behavior?
- What are your child's responsibilities?
- Describe mealtime.
- What is your most significant concern for your child?
- What hopes/dreams do you have for your child?
- How is school for your child?

- How do they respond to correction or consequences at school?
- How does your child get along with adults?
- How does your child get along with other kids their age?
- What is your child's greatest fear? How do they express their fears? How do you respond?
- What makes your child sad? How do they express their sadness?
- How does your child sleep at night?
- When does your child seem the happiest?

Phase 2 and 3: Parent Emails

Email all parents separately to recap the purpose of the phase, new skills, and activities. Treatment providers can use a template for the email when discussing the purpose of activities and skills practiced. Treatment providers may add personalized information about each student in individual emails. Ask how students are doing at home. Encourage parents to ask their children about the activities practiced and what they learned about themselves in the group. Encourage parents to play the games in groups with their children at home to strengthen family relationships. Let the parent know which strengths or Crucial C's you notice in the student. Ask them to observe their child's behaviors at home and notice any patterns they observe. Briefly explain each Crucial C and which Crucial C their student should practice at home if needed. If the treatment provider notices any mistakes, beliefs, or goals of misbehavior, let parents know skills to practice at home to generalize new behaviors. Encourage parents to practice new behaviors with their child at home.

Phase 4: Parent Phone Call

Treatment providers will call each parent to check in on students and review progress on Crucial C's, mistaken beliefs, and behavior goals. Discuss how to generalize new behaviors and ways of thinking at home.