EFFECTS OF CHILD-CENTERED PLAY THERAPY ON SOCIAL SKILLS, ACADEMIC ACHIEVEMENT, AND SELF-CONCEPT OF CHILDREN WITH LEARNING DISABILITIES: A SINGLE-CASE DESIGN

by

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ABSTRACT

JENNIFER GEDDES HALL. Effects of child-centered play therapy on social skills, academic achievement, and self-concept of children with learning disabilities: A single-case design (Under the direction of DR. PHYLLIS POST)

A multiple baseline design across participants was used to examine the effects of child-centered play therapy (CCPT) on the social skills, academic achievement, and self-concept of third grade students who were identified with a specific learning disability (LD). Two male, African American students and one female, Caucasian student were included in this study. Students participated in sixteen 30-minute play therapy sessions. The primary dependent variable was student self-report of total social skills using an adapted version of the Social Skills Rating Scale (SSRS). Academic achievement was measured through weekly curriculum-based measures which were a part of the students' regular education curriculum. The Piers-Harris 2 was used as a pre/post measure of self-concept.

Results of this study did not show a functional relation between CCPT and student total social skills. However, improvement was noted in mean scores of social skills measures for all students in the areas of cooperation and self-control as well as empathy for one student. Some scales of the Piers-Harris 2 (physical appearance and attributes, freedom from anxiety, happiness and satisfaction, and total score) improved for some students. CCPT did not appear to have an effect on academic achievement. Results of social validity surveys indicated positive impacts on the students from students, teachers, parents, principal, and school counselor. This was the first study of its kind measuring these variables using the CCPT intervention and

single case design. Implications of this study include providing school counselors with an appropriate measure for data collection, model for therapeutic service, and methodology for research in the schools. Additionally, implications for counselor educators regarding coursework on single case design methodologies that adhere to guidelines for evidence based practice and training on CCPT for school counselors are discussed. Recommendations include replication of this study using different instruments (direct observation), pre-intervention screenings, and longer intervention periods to discern possible impacts CCPT may have on social skills, academic achievement, and self-concept of students with LDs. Additionally, future research should examine how CCPT impacts academic engagement, expression of feelings, and confidence of students with and without LDs.

DEDICATION

First and foremost, I would like to thank God for the many blessings he has given me and for the strength to complete this process. Second, I lovingly dedicate this dissertation to my parents Cindy and Larry Geddes who have encouraged me in everything I have done and throughout the highs and lows of my life. You have been a model of strength, love, and inspiration to me and have instilled in me the importance of education. Both of you have given me many gifts including my hard work ethic, love of children, and creative spirit which have gotten me where I am today in my career. Next, I dedicate this dissertation to my amazing husband Tukuli. You have been by my side throughout this process providing me with encouragement, wiping my tears, and making me smile when I needed it most. You mean the world to me and have shown me what it means to be a true life partner. Without the support and guidance you all have given me, I would not have been able to achieve this goal. Finally, I would like to dedicate this achievement in memory of my sister Michelle who was taken from this earth too soon. We share a similar passion for helping children and connected with each other in so many ways, as only sisters can. I miss you everyday and hope to continue to touch the lives of others as you have through my continued work with children and through your foundation, Michelle's Ray of Hope. I love you all so much.

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CHAPTER I: INTRODUCTION

Schools must address the unique needs of all students. According to the National Center for Educational Statistics (NCES, 2014), 13% of the public school aged population was provided with services by special education professionals during the 2011-2012 school year. Of the total population served, 27.6% of these students were non-Caucasian students with specific learning disabilities. While many disabilities and special needs are included under the special education umbrella, the most prominent category is referred to as specific learning disability (LD). Students diagnosed with LDs contributed to the greatest portion, 36%, of the special education population. An LD is "a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations" (NCES, 2014, p.2). However, students diagnosed with LDs have average to above average intelligent quotients (IQ).

States have been given the option to develop their regulations regarding special education eligibility based on the federal guidelines developed by the U.S. Department of Education Office of Special Education Programs (2006) which will be discussed in greater detail in chapter two. Currently legislators in North Carolina, like the majority of the states, have adopted the criteria option in which the school district may decide whether to use the response to scientific, research-based intervention model or the severe

discrepancy in ability and achievement model to diagnose a student with an LD (Ahearn, 2008). Essentially, teachers and school counselors must provide research-based interventions to address learning issues students may be experiencing before referring them for special education testing. If students continue to struggle despite the interventions, then they can be diagnosed with an LD. An alternate way to diagnose students with LDs is if their academic performance does not match their potential academic achievement based on IQ and achievement tests. Students diagnosed with LDs are then provided with an Individualized Education Program (IEP) that is written by a team of education professionals, including the teacher, principal, school counselor and parent(s). The IEP is used as a guide to meet students' identified academic, social, and emotional needs within the school setting to best support them in their educational careers.

There is a need to address the academic achievement, social skills, and self-concept of elementary school students with LDs. Often students labeled with specific LD do not have positive school experiences at both social and academic levels. Currently, literature in the special education field regarding academic interventions fails to consider socio-emotional factors that may be contributing to learning issues presented by students diagnosed with LDs (Compton, Fuchs, Fuchs, Lambert, & Hamlett, 2012). Additionally, much of the research available specifically concerning students with LDs and social skills, academics, and self-concept appears to be outdated, as much of the research is over 15 years old (Axline, 1947; Bills, 1950; Durrant, Cunningham, & Voelker, 1990; Guerney, 1979; Siegel, 1970). Socio-emotional factors in relation to academics have not been addressed despite research which notes that social and emotional problems manifest

in 40% of people labeled with LDs (Kavale & Forness, 1996). Such issues may begin to impact abilities to adequately concentrate, learn, and perform in academic skills which creates a cycle that perpetuates issues with social skills, achievement, and self-concept.

The American School Counselor Association (ASCA, 2005) has begun to hold school counselors accountable for providing effective interventions to address social, academic, and emotional needs of all students, including those with special needs. They are expected to provide services that not only address emotional issues but those interfering with academic achievement as well. School counselors are also taking a greater role in identifying students and developing IEPs as well as implementing aspects of the IEP (Dunn & Baker, 2002; Milsom, Goodnough, & Askos, 2007). One intervention school counselors can use to address social skills, academic, and self-concept needs of students labeled with LDs is child centered play therapy (CCPT).

Child-Centered Play Therapy

Research in the field of play therapy has demonstrated that it is effective in addressing many different issues with a variety of populations of children (Bratton, Ray, Rhine, & Jones, 2005). Play therapy is defined by Landreth (2012) as:

> … a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development (p. 11).

Child-centered play therapy (CCPT) originated from client-centered theory developed by Carl Rogers (1949) based on a deeply embedded set of personal attitudes and beliefs regarding the worth and significance of individuals rather than a set of techniques. He advocated for a non-directive approach that has faith and respect for individuals' capacity in themselves for psychological growth and change. Counselors remain consistent in their beliefs and interactions of acceptance and competency of clients' self-direction, thus freeing the clients to explore experiences, self, and life in a new way with new goals and meaning in a safe environment.

Rogers (1957) also proposed six conditions that must be present for change to occur according to the client-centered theory. The conditions are as follows: (a) a relationship of psychological contact; without it the other conditions have no meaning; (b) an incongruent, anxious, vulnerable state of the client; (c) genuineness of the therapist; a congruent, integrated person who is able to feely be him/herself and who is free of deception; (d) therapist unconditional positive regard; warm acceptance of the whole client and experience; (e) therapist empathy; understanding the client's experiences and awareness as his/her own and able to communicate own understanding of the client's world, giving voice to that experience; and (f) client awareness and understanding of the therapist's empathy and acceptance. These conditions are thought to be both necessary and sufficient for client growth and change. Clients begin to move from what are viewed as negative to more positive/effective experiences and behaviors therefore, promoting greater integration and less internal conflict.

Counselors began examining client-centered theory, using these conditions, with children focusing on demonstrating understanding of how they relate to the world, their

experiences, and their development. Axline (1947) introduced applying the client centered theory with children. She used Rogers' (1957) principles in a more developmentally appropriate manner by incorporating specific toys for children to use and communicate with during therapy. The safe environment of the playroom allowed children to communicate both verbally and nonverbally to therapists in a meaningful way. Because children are generally less verbal, less insightful, and less able to identify and express their emotions than adults, they utilize play as their means of communication (Bratton, Ray, Rhine & Jones, 2005; Fall, Balvanz, Johnson & Nelson, 1999; Landreth, 2012; Landreth, Ray & Bratton, 2009; Phillips & Mullen, 1999; Ray, 2011). Play helps to bridge the gap between concrete experience and abstract thought of children (Landreth et al., 2009; Ray, 2004; Ray, Armstrong, Warren, & Balkin, 2005). Therefore, children often use inanimate objects, rather than words, to project their feelings, beliefs, and perceptions about themselves and the world (Bratton et al., 2005; Landreth, 2012). Like the principles outlined by Rogers, CCPT counselors model acceptance of the whole child, including cognitions, behaviors, and emotions, through an accepting, genuine, and empathetic relationship (Fall et al., 1999; Landreth, 2012; Post, 2001). This relationship is the basis for change. It is a way of being with children rather than a technique that is applied to them and their problems (Landreth, 2012; Landreth et al., 2009).

The principles of CCPT create a safe environment for children to express and explore their emotions, master tasks, and practice coping skills that lead to increasing feelings of empowerment and self-acceptance (Blanco & Ray, 2011; Landreth, 2012; Post, 2001). Therapists cultivate the above mentioned principles with children through the use of CCPT using interactions that include tracking (reflecting play behavior),

reflecting content/meaning, reflecting feeling, returning responsibility (facilitating decision making), encouraging (esteem building), and limit-setting (Landreth, 2012; Landreth et al., 2009; Ray, 2011).

Research related specifically to the effectiveness of CCPT spans over 60 years and addresses application of this intervention to diverse populations, settings, presenting problems, and ages (Ray, 2011). A meta-analysis revealed that on average a child receiving play therapy services performed more than three fourths of a standard deviation better on given behavioral/emotional outcomes as compared to those who did not participate in play therapy (Bratton et al., 2005). While CCPT has been found to positively impact social skills and self-concept, (Bratton & Ray, 2000; Bratton, et al., 2005; Leblanc & Ritchie, 2001) a need exists to further explore its effects on academic achievement, as well as its applicability to students identified with LDs.

Overview of Issues Associated with Learning Disabilities

Students with LDs have been rated by teachers as having significantly greater levels of activity, distractibility, and anxiety compared to those without LDs as well as problem behaviors which include aggression, temper problems, arguing, loneliness, and poor self-esteem (Bramlett, Smith, & Edmonds, 1994; Haager & Vaughn, 1995; Kavale & Forness, 1996). Repeated feelings of unacceptance can contribute to lack of prosocial behaviors, low self-concept, and poor self-confidence in these students (Bowen & Glenn, 1998). There is a need for school counselors to address these issues with the LD elementary school students they serve to make their school experiences and futures more positive.

Intervening with third grade students who are identified with LDs is of great importance due to the start of high-stakes testing required in many states for adequate yearly progress (AYP) and outlined in No Child Left Behind (NCLB; No Child Left Behind Act of 2001, 2001). If left unaddressed, these concerns could negatively impact social skills, academic achievement, and self-concept of students in this population, which are the variables for this study. The goal of the proposed CCPT intervention is to address these areas.

Social Skills

Students with LDs have demonstrated significant deficiencies in social skills as compared to peers without disabilities (Bramlett, et al., 1994; Bryan, Burstein, & Ergul, 2004; Forness & Kavale, 1996; Haager & Vaughn, 1995; Kavale & Forness, 1996; Nowicki, 2003; Walker & Nabuzoka, 2007). Several issues related to social skills deficits were uncovered in a meta-analysis conducted by Kavale and Forness (1996). Approximately 75% of students with LDs demonstrated a lack of social skills including poor adjustment and conflict resolution as well as a lack of interaction, empathy, and cooperation. Their review of research indicated that 8 out of 10 students with LDs were less likely to interact socially, more poorly adjusted, less accepted, and less likely to be identified as a friend than peers without disabilities. These peers rejected students with LDs more often and rated them as having lower levels of interaction, play, cooperation, and empathy. Disparities in social skills among students with LDs could lead to long-term concerns such as school drop-out, mental health issues, juvenile delinquency, and criminal behavior (Nowicki, 2003) as well as academic issues (Walker & Nabuzoka,

2007). Social skills deficits continue to be detrimental in adulthood causing students to be at-risk for behavioral issues and less resilient in their futures (Forness & Kavale, 1996).

Competent social skills may help to reduce negative effects caused by poor academic achievement (Forness & Kavale, 1996; Walker & Nabuzoka, 2007). Unfortunately, literature reviewed in regards to social skills training for students with LD provides information asserting that such interventions have not proven to be very effective. A meta-analysis of experimental studies containing social skills interventions among students with LD yielded an effect size of .211 (Forness & Kavale, 1996; Nowicki, 2003). Most of the studies reviewed used a social skills intervention with components of modeling and observation of the desired skill, shaping or demonstrating the skill with verbal cuing or reinforcement, and use of rehearsal and practice. About one out of five social skills intervention studies actually produced better gains in the control group than in the treatment group and children below 12 years old showed smaller effect sizes than older children. However, it was noted that when students assessed their own social skills following interventions, the largest effect size of .244 was obtained but remained comparatively small.

Cognitive functioning and understanding social cues are difficult for students with LDs to navigate, which may contribute to the lack of effectiveness in interventions thus far. Interventions that address social skills focus on cognitive understanding of social skills versus social application and experience (Bryan, et al., 2004; Forness & Kavale, 1996). Additionally, many interventions used to address difficulties with social skills and academics include a group teaching model such as peer tutoring, peer consultation/collaboration, bibliotherapy, and teams of students working on thematic

units and have produced weak results (Bryan, et al., 2004). It appears that these group models teach important social skills, but they are not addressing the individual social deficits and needs of students.

No traditional counseling interventions were mentioned in the literature concerning students with LDs, which may indicate a lack of training or perceived confidence of counselors working with this population. It has been noted that social skills are comprised of a complex set of constructs that may not be discretely addressed through discrete interventions (Forness & Kavale, 1996; Nowicki, 2003; Vaughn, Zaragoza, Hogan, & Walker, 1993). Individual CCPT may be a viable option that would address the specific needs of students with LDs as it an intervention that is not cognitively based and is a more holistic approach.

A group CCPT intervention was used in a study conducted by Kascsak (2012) to address the social skills needs of students in kindergarten. While this study did not find significant results, it did examine the use of a counseling intervention for social skill development. A dearth of literature exists on the impact of CCPT on social skills of children with and without LDs. The current study examined the effects of individual CCPT sessions on social skills with students who have been diagnosed with LD and will use student self-assessment with regard to social skills, as well as the observation of teachers.

Academic Achievement

Academic achievement of students is important to the success of students and their futures. Poor academic achievement has been linked with negative outcomes for future functioning such as school drop-out, suspension, behavioral issues, delinquency,

criminal activity, violence, substance abuse, and mental health issues (Darney, Reinke, Herman, Stormont, & Ialongo, 2013; Fleming, Harachi, Cortes, Abbott, & Catalano, 2004; Reinke, Herman, Petras, & Ialongo, 2008). Currently, literature in the special education field regarding academic interventions focuses on addressing underlying cognitive issues (Compton, et al., 2012). Interventions for these students aim to increase academic achievement by focusing on areas such as language, working memory, problem solving, concept formation, and processing speed. Unfortunately, these interventions fail to consider other socio-emotional factors that may be contributing to learning issues presented by students diagnosed with LDs. When compared to peers without disabilities, students with LDs indicate significantly lower levels of academic self-concept and academic achievement (Chapman, 1988).

Research in the field of play therapy has demonstrated that CCPT interventions may be one solution in addressing emotional and academic needs of children; however, no studies have specifically addressed the use of CCPT and the academic achievement of students diagnosed with specific LDs. The most recent studies addressing CCPT and academics have found that first graders who participated in treatment and were academically at-risk scored significantly higher on academic measures yielding an effect size that was twice the size of the control group (Blanco & Ray, 2010; Blanco, Ray, & Holliman, 2012). Blanco and Ray (2011) defined academically at-risk based on the school definition which included, being previously retained, receiving unsatisfactory scores on assessments or readiness tests, and/or being in the care of the state. Following the CCPT intervention 36% of the children improved to normal levels of academic functioning.

Students in many of the current CCPT studies that address learning issues are labeled as "at-risk" which is defined by some based on the percentage of children who are eligible for free or reduced lunches (Blanco & Ray, 2011; Blanco, Ray, & Holliman, 2012; Post, 2001) or having "learning problems" in reading (Axline, 1947; Bills, 1950). Student samples are not clearly defined in regards to their learning issues in the literature and do not discuss specific diagnoses or academic programming in special education. Similarly academic achievement has not been clearly defined or linked to curriculum-based assessments that are used regularly in schools. Therefore, a gap in the literature exists regarding how CCPT may impact the academic achievement of students identified with LDs.

Self-Concept

Research in the field of special education has demonstrated that a significant difference exists between the self-concept of students with disabilities and their non-disabled peers (Bryan, et al., 2004; Chapman, 1988; Elbaum & Vaughn, 2001; Forness & Kavale, 1996). Poor self- esteem and low self-concept are manifested in about 70% of students with LDs; an effect size of .508 was found when measured by the Piers Harris Self-Concept Scale (Kavale & Forness, 1996). Leaving these beliefs unchanged may have negative impact on future achievement as students may give up more easily when faced with difficult tasks.

A meta-analysis of intervention studies aimed at increasing the self-concept of students with disabilities found little support for the efficacy of interventions in the field of special education (Elbaum & Vaughn, 2001). Most of the intervention programs that were implemented were academically based and produced a mean effect size of .19.

Minimal counseling interventions were noted and were not clearly defined. These types of interventions, however, were the only ones that significantly impacted self-concept of students with LDs. Counseling interventions that appeared to be effective with elementary students contained a "game-like component" and produced larger effect sizes (.69 and .61).

Similarly, play therapy has demonstrated effectiveness in addressing low self-concept of students who are poor readers (Bills, 1950; Crow, 1994). Post (1999) found that 4th, 5th, and 6th grade at-risk students who participated in CCPT maintained levels of self-esteem, while those in the control group significantly decreased levels of self-esteem. These findings appear consistent with those of Chapman (1988) who stated that self-concept of students tends to decrease as they progress in school. Others who have studied the effects of CCPT on the self-concept of children who are homeless and who have been sexually abused have found promising results supporting of CCPT (Baggerly, 2004; Scott, Burlingame, Starling, Porter, & Lilly, 2003). Baggerly (2004) conducted group CCPT with homeless children and found significant increases in self-concept as well as increases in self-esteem. Scott et al. (2003) conducted a study using individual CCPT with children who were sexually abused and found increases in self-concept and self-esteem. It is therefore believed that utilizing CCPT as an intervention to raise the self-concept of students with LDs is a viable option. Currently, a gap in the literature exists in regards to addressing self-concept through the use of CCPT for students diagnosed with LDs. Similarly, given that some of the studies above used perceptions of adults about the children, there is a need to examine how CCPT may impact the self-

concept of 3rd grade students in this population through the use of a self-assessment measure rather than by report of adult perceptions.

Purpose of the Study

There is a lack of research in the special education and school counseling fields concerning interventions that address the academic, social skills, and self-concept issues of students diagnosed with LDs. To address this need, the purpose of this study was to examine the effect of CCPT on social skills, academic achievement, and self-concept of 3rd grade students labeled with learning disabilities (LD).

Significance of the Study

This study may provide information about an intervention that could be integrated into the elementary school setting to address both mental health and academic needs of students diagnosed with LDs. Addressing both of those needs is endorsed by the American School Counselor Association (ASCA, 2005). If school counselors seek out training in CCPT and utilize it as an intervention in the schools, it may be a way for school counselors to effectively address both academic and mental health issues simultaneously with a population of students with great needs. Play therapy has been found to positively impact self-concept and social skills of children (Bratton & Ray, 2000). It was therefore thought that CCPT would be a viable intervention for students diagnosed with LDs to address their social skills, academic achievement, and self-concept needs.

Currently, literature in special education regarding academic interventions fails to consider other socio-emotional factors that may be contributing to learning issues presented by students with LDs. This study added to the literature by assessing the impact

of CCPT on academic achievement using assessments that already exist within the special education curriculum.

Findings in this study may help to support the need for school counselors to best address socio-emotional, as well as academic needs of students diagnosed with a specific LD through the use of CCPT. Current experimental designs that are utilized for defining empirically based interventions are impractical for counselors due to resources, setting, and required statistical analysis (Lundervold & Belwood, 2000). Counselors, especially school counselors, need measurements of effectiveness that are relevant to counseling practice and the science of counseling and are easily implemented. More often than not, counselors are more concerned with the effectiveness of techniques used with individuals and the development of such interventions instead of experimental designs. Single-case design offers rigor of scientific methodology and research, as well as flexibility to be practically integrated into the usual counseling settings, without the application of complex statistical analyses (Lundervold & Belwood, 2000) and is described in greater detail in Chapter III.

Since the proposed research was the first study using single-case design to examine the effectiveness of CCPT on social skills, academic achievement, and self-concept of students labeled with LDs, it could have further established the effectiveness of CCPT as an evidence-based, comprehensive treatment intervention for children identified with LDs. CCPT has also been found to be an effective intervention to use with diverse populations including African American, Puerto Rican, and Japanese children (Bratton & Ray, 2000; Lin & Bratton, 2015). In their meta-analysis of CCPT, Lin and Bratton (2015), found that CCPT had a mean effect size of .76 with non-Caucasian

participants, which was much higher than the mean effect size for Caucasians (.33). The use of single-case design in this study helped to determine if and when change occurred in the students participating in CCPT sessions. None of the CCPT studies focusing on social skills and/or academic achievement have used single-case design methodology; therefore, individual growth had not yet been measured regarding the impacts of CCPT on social skills and/or academic achievement. Finally, the use of self-report measures in the current study added a different perspective to the literature in regards to social skills and self-concept of students labeled with LDs.

Research Questions

The following research questions were addressed in this study:

1. What are the effects of CCPT on the social skills of third grade students with LDs?
2. What are the effects of CCPT on academic achievement (reading and math) of third grade students with LDs?
3. What are the effects of CCPT on the self-concept of third grade students with LDs?

Assumptions

The assumptions made in this study were:

4. Third grade students are capable of self-assessing social skills and self-concept.
5. Participants taking the assessments will answer the questions to the best of their abilities.

6. The researcher will be able to demonstrate the CCPT skills reliably, demonstrating fidelity of the intervention.
7. Reviewers of CCPT skills will have high inter-rater reliability (average of at least 80%) when rating skills using the *Play Therapy Skills Checklist (PTSC)* for all videotaped sessions assessed.
8. The researcher will demonstrate an average of at least 80% inter-observer agreement (IOA) with the teachers when scoring the reading and math assessments used for academic achievement.
9. The researcher will demonstrate an average of at least 80% IOA with the school counselor when scoring SSRS measures for social skills.

Delimitations

The delimitations, which were factors that the researcher can control, in this study were:

1. Participants were limited to third graders.
2. Participants were limited to those who have a specific learning disability diagnosis.
3. Participants were limited to students in one southern elementary school in a small town.

Limitations

The following factors, which were beyond the control of the researcher, may have limited this study's findings:

1. The use of a convenience sample may not have adequately represented the population of students who are diagnosed with a specific learning disability.

2. The single-case design limited the application of findings across populations due to a small sample size. However, the use of a multiple baseline across participants design did allow for prediction, verification, and replication across participants, therefore strengthening experimental control.
3. The social skills and self-concept assessments used in this investigation were the subjective judgment of the participants. These measures assessed self-perceptions, which may be different from behaviors that are observed by others such as teachers, parents, and peers.
4. Outside influences that are beyond the researcher's control may have influenced performance on social skills, academic achievement, and self-concept measures (i.e., sickness, fatigue, family conflicts, breaks in the school schedule, end of grade testing).

Operational Definitions

Learning Disability (LD)

LD was defined by the school district, which in this case was evidenced by use of the discrepancy model in that the student's cognitive ability fell within normal limits but academic performance was below average. A disability category of Specific Learning Disability (LD) was documented in the student's IEP and evaluation report. The special education teacher provided the students' evaluation reports and IEPs to the researcher.

Social Skills

Social skills was defined as participants' scores on the adapted Social Skills Rating Scale (SSRS; Greshman & Elliot, 1990) that was developed by the researcher. Both total and subscale scores (cooperation, assertiveness, empathy, and self-control)

were tracked; however, the total social skills score were used to make determinations about introducing the next participant into the intervention phase of the study. These scores were collected by the researcher.

Academic Achievement

Academic achievement was defined as a measure of reading and math which was based on curriculum-based assessments of reading and math ability determined by the school and special education teacher. The Maze (Milone, 2008) reading assessment is widely used by schools as a way to determine how well children read silently. Every seventh word after the first sentence in the passage is substituted with the correct word and two incorrect words, which are used to complete the sentence. Additionally, a six problem math assessment was used by the special education teacher to monitor math achievement. Math assessments included six math problems on each student's ability level. Initial assessments were given at the beginning of the school year and were used to determine the level each student used throughout the school year for both reading and math. Computer-based assessments were used in the regular education classroom throughout the year, which included Reading 3D (NCDPI, 2015) and Discovery Education (Discovery Ed, 2015). The special education teacher provided the students' weekly Maze reading and six problem math scores to the researcher. The regular education teachers provided the computer-based assessments (Reading 3D and Discovery Ed) to the researcher at the end of the study.

Self-Concept

Self-concept was defined as the students' self-report on the overall and subscale scores (physical appearance, anxiety, intellectual and school status, behavior, happiness

and satisfaction, and popularity) on the Piers-Harris 2: Children's Self-Concept Scale (Piers & Herzberg, 2002). Total and subscale scores were reported. These scores were collected by the researcher during baseline and after the intervention phase of the study.

Summary

This chapter outlined issues facing students with LDs in the school as well as the need for school counselors to effectively address these issues. It provided an overview of LDs and CCPT related to past interventions that have been used to address social, academic, and personal deficits of LD students. There exists a dearth in current literature related to using CCPT as an intervention to address the social skills, academic, and self-concept issues faced by students with LDs.

Organization of the Study

This dissertation document contains five chapters. The first chapter provides information on the purpose and significance of the study. An overview of the variables used in this study as well as background information, research questions, assumptions, limitations, delimitations, and operational definitions are provided. A review of associated literature is presented in chapter two. Additional information about LDs, issues faced by students with LDs, and past practices to address the variables in this study is provided. Additionally, the role of the school counselor in providing support for students with LDs is discussed. This review provides information about the theory, history, and research of CCPT. Each of the variables (social skills, academic achievement, and self-concept) as they relate to students with LDs is also provided. Past research about CCPT as it relates to each of the variables is reviewed as well. Chapter three outlines the proposed research methodology (single-case design) including details

about participants, setting and materials, the researcher, data collection procedures, data analysis, experimental design, procedures, procedural fidelity, and analysis that was used in this study. Chapter four provides a review of the results of the study including information about Inter-observer Agreement (IOA) for measures used, procedural reliability of the CCPT intervention, results for each dependent variable (social skills, academic achievement, and self-concept) based on the research questions, and social validity information gathered from students, parents, teachers, the principal, and the school counselor. Finally, chapter five includes a discussion about results obtained, limitations of the study, implications of the findings, and recommendations for future research.

CHAPTER II: REVIEW OF LITERATURE

The purpose of this study is to examine the effect of individual child-centered play therapy (CCPT) on the social skills, academic achievement, and self-concept of students diagnosed with specific learning disabilities (LDs). This chapter contains a review of conceptual and empirical literature related to these areas and is intended to demonstrate a need for this research.

The chapter is comprised of seven main sections. The first section provides an overview of issues faced by students with LDs. The next section discusses the role of the school counselor in supporting students with LDs. The third section reviews the theoretical background of CCPT which is the independent variable in this study. The subsequent sections address each of the dependent variables. Social skills of students with LDs is reviewed first. Within this section, social skills issues and special education interventions are discussed as well as research related to social skills and CCPT. This will be the structure of the remaining sections about the variables of academic achievement and self-concept of students with LDs. Finally in the last section, a summary of the literature is provided that highlights the paucity of research on CCPT and students with LDs and the need for this study.

Overview of Issues Faced By Students with Learning Disabilities

During the 2011-2012 school year, 13% of the public school aged population was provided with services by special education professionals (National Center for

Educational Statistics; NCES, 2014). Of the total population served, 27.6% of these students were non-Caucasian students with specific learning disabilities. While many disabilities and special needs are included under the special education umbrella, the most prominent category is referred to as specific LD. Students diagnosed with LDs contributed to the greatest portion and comprise 36% of the special education population. Information about LD is provided on the website for the U.S. Department of Education in the Individuals with Disabilities Act (IDEA 2004) as follows:

> A) In general.--The term `specific learning disability' means a disorder in 1 or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations.
>
> (B) Disorders included.--Such term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.
>
> (C) Disorders not included.--Such term does not include a learning problem that is primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage ("Specific Learning Disability," para.1).

According to the U.S. Department of Education Office of Special Education Programs (2006), a specific learning disability (LD) is a federal mandate in which a state must adopt, consistent with 34 CFR 300.309, criteria for determining whether a child has a specific learning disability as defined in 34 CFR 300.8(c)(10). In addition, the criteria adopted by the State:

• Must not require the use of a severe discrepancy between intellectual ability and achievement for determining whether a child has a specific learning disability, as defined in 34 CFR 300.8(c)(10);

• Must permit the use of a process based on the child's response to scientific, research-based intervention; and

• May permit the use of other alternative research-based procedures for determining whether a child has a specific learning disability (p. 1).

The determination of whether a child suspected of having a specific learning disability is a child with a disability as defined in 34 CFR 300.8, must be made by the child's parents and a team of qualified professionals, which must include:

• The child's regular teacher; or if the child does not have a regular teacher, a regular classroom teacher qualified to teach a child of his or her age; or for a child of less than school age, an individual qualified by the State educational agency (SEA) to teach a child of his or her age; and

• At least one person qualified to conduct individual diagnostic examinations of children, such as a school psychologist, speech-language pathologist, or remedial reading teacher.

The group described in 34 CFR 300.306 may determine that a child has a specific learning disability, as defined in 34 CFR 300.8(c)(10), if:

• The child does not achieve adequately for the child's age or to meet State-approved grade-level standards in one or more of the following areas, when provided with learning experiences and instruction appropriate for the child's age or State-approved grade–level standards:

- o Oral expression.
- o Listening comprehension.
- o Written expression.
- o Basic reading skills.
- o Reading fluency skills.
- o Reading comprehension.
- o Mathematics calculation.
- o Mathematics problem solving.

• The child does not make sufficient progress to meet age or State-approved grade-level standards in one or more of the areas identified in 34 CFR 300.309(a)(1) when using a process based on the child's response to scientific, research-based intervention; or the child exhibits a pattern of strengths and weaknesses in performance, achievement, or both, relative to age, State-approved grade-level standards, or intellectual development, that is determined by the group to be relevant to the identification of a specific learning disability, using appropriate assessments, consistent with 34 CFR 300.304 and 300.305; and the group determines that its findings under 34 CFR 300.309(a)(1) and (2) are not primarily the result of:

- o A visual, hearing, or motor disability;
- o Mental retardation;
- o Emotional disturbance;
- o Cultural factors;
- o Environmental or economic disadvantage; or

o Limited English proficiency (p.2).

To ensure that underachievement in a child suspected of having a specific learning disability is not due to lack of appropriate instruction in reading or math, the group must consider, as part of the evaluation described in 34 CFR 300.304 through 300.306:

- Data that demonstrate that prior to, or as a part of, the referral process, the child was provided appropriate instruction in regular education settings, delivered by qualified personnel; and
- Data-based documentation of repeated assessments of achievement at reasonable intervals, reflecting formal assessment of student progress during instruction, which was provided to the child's parents (p. 3).

States have been given the option to develop their regulations regarding special education eligibility based on the federal guidelines outlined above. Currently the governing board in the southern state where the study takes place, like the majority of the states, has adopted the criteria option in which the school district may decide whether to use the response to scientific, research-based intervention model, or the severe discrepancy in ability and achievement model to diagnose a student with an LD (Ahearn, 2008).

Often students labeled with LDs do not have positive school experiences at both social and academic levels. Due to negative repeated feedback regarding their academic performance and/or negative behaviors, children with LDs may begin to internalize negative feedback from teachers or peers which could cause these students to feel unsure about themselves and the school environment (Bowen & Glenn, 1998; Guerney, 1979). Similarly, children with disabilities may begin to feel unaccepted by peers or teachers

and, therefore, respond with frustration which may increase displays of negative behaviors (Post, 2001). These behaviors may result in repeated critical feedback from teachers, school personnel, and family members, which further inhibit feelings of acceptance. Repeated feelings of unacceptance can contribute to dependency, lack of prosocial behaviors, low self-concept, anxiety, nonparticipation, poor self-confidence, behavioral problems, and depression (Bowen & Glenn, 1998; Bryan, Burstein, & Ergul, 2004). These issues, in turn, begin to interfere with students' abilities to adequately concentrate, learn, and perform in academic areas. Additionally, students with special needs, including those with LDs, are often stigmatized which can create negative experiences and social barriers for these students (Milsom, 2006; Scarborough & Deck, 1998). Therefore it becomes difficult to discern whether the behaviors or LDs came first, as students with low self-esteem struggle with concentrating, remembering, and problem-solving (Bowen & Glenn, 1998). Unsuccessful communication and feeling a lack of control over one's environment are often present in students with disability labels. Consequently, these students may display an external locus of control, view success and failures as luck rather than ability or effort, believe failure is frequent and expected, believe performance outcomes are something out of their own control, and do not ask questions or seek help.

Two studies in particular, addressed the impacts of self-concept and social skills on academic achievement. Durrant, Cunningham, and Voelker (1990) examined the interaction of self-concept (general self-concept, cognitive self-concept, and social self-concept) on behavioral factors (both externalizing and mixed symptomology) as related to academic achievement among 60 students labeled with LDs aged 8 to 13 years old.

Students were placed in groups categorizing them as LD or non-LD. Additionally students were assessed for behavioral disorders using the Child Behavior Checklist (CBCL) and grouped according to three groups: normal, externalizing, and mixed symptomology (exhibiting externalizing and internalizing behaviors). The outcome indicated that social self-concept was correlated with behavioral scores and that cognitive self-concept was primarily related to internalizing scale scores and arithmetic subtest scores. General self-concept was related to intelligent quotient (IQ) only. Non-LD students displayed higher self-concept scores than LD students. Therefore it can be said that behavioral variables are as important in self-concept development of LD students as achievement. The study showed that cognitive self-concept significantly predicted behavior scores and that the interaction between self-concept, behavior, and achievement among LD children is more complex than previously thought.

Similarly, Malecki and Elliot (2002) found that social skills were significantly predictive of academic achievement levels and future academic functioning of third and fourth grade students, including those labeled with LDs. Results were based on both student and teacher assessment of social skills using the Social Skills Rating Scale (SSRS), as well as academic performance. The study included 139 diverse students from two urban schools who were assessed twice during the school year for social skills, problem behaviors, academic competence, and academic achievement. Findings from this study support the idea that interventions that address social skills of students in elementary school may act to enhance current academic achievement and competence as well as future academic functioning.

Often in schools, there is a belief that addressing social skill deficits will take away valuable time needed to address academics during the school day. This belief continues despite the fact that past research has demonstrated a strong relationship between social and academic functioning. Due to the complexity of issues students with LDs may face, interventions must also be commensurate. Therefore, it is important to assess and address socio-emotional status of students with LDs when considering academic interventions. Additionally, it is important that school counselors are adequately trained in addressing these complex needs and are given opportunities to provide such services to students during the school day.

Role of School Counselors

School counselors are being held accountable for providing effective interventions to address both emotional and academic needs of all students, including those with special needs, in the school setting. The American School Counselor Association (ASCA, 2005) delineates components for responsive services in a school counseling program, which address both emotional wellness and academic success. ASCA states that school counselors are expected to provide services that not only address emotional issues but also those interfering with academic achievement. Additionally, school counselors must be prepared to function in a variety of roles to support the academic, career, and personal/social development of children in the school. It is important to address these needs as academic difficulties begin to not only affect students with LDs at an individual level, but also begin to affect school systems as a whole. The school may be impacted when adequate yearly progress is reported, as mandated by the widely known No Child Left Behind Act (NCLB) enacted in 2001. It has been estimated

that 10-18% of schools' populations are comprised of students who have been identified as appropriate to receive special education services and that this number will continue to grow (Dunn & Baker, 2002; McEachern, 2003). Research about school counselors and special education is dated and more needs to be done in the field to gather more current information.

Using school counselors to address the various needs of students' is a logical approach, due to the inevitable relationships they will form with students throughout their school careers. Throughout the daily school experience, school counselors are integrated into the students' environment by providing responsive services that address immediate student concerns as they work with students during stressful times to diffuse emotional situations (Phillips & Mullen, 1999; Ray, Armstrong, Warren, & Balkin, 2005). Because school counselors have an established positive rapport with the students in the school setting, they have access to students who require support and are able to track and follow them over the course of several years (Phllips & Mullen, 1999; Ray, Muro, & Schumann, 2004; Ray, 2011). Thus these long-standing relationships offer a sense of safety, trust, deep understanding, and continuity of care throughout the students' school career. School counselors are therefore taking a greater role in the process of identifying students and developing Individualized Education Programs (IEPs), as they are often required to implement aspects of the IEP to address emotional, social, and academic needs (Dunn & Baker, 2002; Milsom, Goodnough, & Askos, 2007). Literature in the field of school counseling encourages the use of developmental models in school counseling programs as an effort to appropriately and effectively meet the needs of all students and their issues (Phillips & Mullen, 1999; Ray, 2011).

Play therapy is designed to be responsive to the developmental needs of children and a developmentally appropriate way to address issues faced by children. Play therapy in the school setting has been supported in both the play therapy and school counseling literature, demonstrating effectiveness in meeting a variety of behavioral and emotional needs of children (Bratton, Ray, Rhine, & Jones, 2005; Ray, Bratton, Rhine, & Jones, 2001; Ray, et al., 2004; Ray, 2011). Additionally, research has shown that play therapy can have a large effect on behavior, social adjustment, and personally, all of which are areas that are relevant to school counseling services (Bratton et. al, 2005). The use of play therapy with students identified with having LDs may be a practical and effective intervention to address their personal, social, and academic needs simultaneously. Play therapy is defined based on Landreth (2012):

> … as a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development. (p. 11)

Students who live with a disability often need access to a safe outlet, such as play therapy, to express feelings and develop coping skills to prevent them from exhibiting physical and passive aggressive conflicts that could disrupt the educational process (Cochran, 1996). In addition to easy accessibility and the potential to build long-term relationships, school counselors are able to offer a familiar environment in which to conduct sessions (Ray, 2011). These conditions, along with the ability to provide mental

health services to students without having to rely on parents' ability to consistently bring children to appointments, makes school an ideal therapeutic setting (Ray, 2011). Play therapy has also been shown to be an effective intervention, regardless of setting and has demonstrated effectiveness with diverse and at-risk students in schools (Blanco & Ray, 2011; Bratton et al., 2005; Ray et al., 2001; Ray et al., 2004). In particular, humanistic approaches such as child-centered play therapy (CCPT) have demonstrated greater effectiveness than other approaches, producing better treatment outcomes (Bratton, et al., 2005).

Clearly, school counselors should provide comprehensive services, such as play therapy, to students with LDs in the school. Despite its demonstrated effectiveness, the researcher was not able to find any literature that discussed school counselors who applied individual play therapy interventions to students specifically diagnosed with LDs. Similarly, there was no literature found that addressed school counselors implementing play therapy to address academic achievement with older elementary aged students. Specifically, CCPT was not found to be used with this population to address the various needs of these students in schools.

Theoretical Background of Child-Centered Play Therapy (CCPT)

One solution in addressing the diverse needs of children is CCPT. This type of play therapy is based on the client-centered theory developed by Rogers (1949) and an understanding of child development. Rogers' theory maintains that humans have the innately ability for self-growth and actualization when give a safe, supportive, non-judgmental environment. This environment includes therapists who are accepting and genuine. They allow clients to determine the direction of the therapeutic process. Axline

(1947) took these non-directive principles and applied them to a more natural medium for children, play. The use of play allows for a non-threatening environment in which children can bring their emotions and issues to the surface where they are able to be dealt with in a developmentally appropriate manner.

Children are generally less verbal, less insightful and less able to identify and express their emotions than adults, because, developmentally, children under the age of 10 are not able to utilize abstract thinking skills. Play is a natural way for children to communicate (Axline, 1947; Bratton et al., 2005; Fall, Balvanz, Johnson, & Nelson, 1999; Landreth, 2012; Landreth, Ray, & Bratton, 2009; Phillips & Mullen, 1999; Ray, 2011). Therefore, play helps to bridge the gap between concrete experience and abstract thought, and it is the way they can both increase their self-awareness and communicate this awareness to others (Landreth et al., 2009; Ray, 2004; Ray, et al., 2005). Using inanimate objects rather than words, children show their feelings, beliefs, and perceptions about themselves and the world (Bratton et al., 2005; Landreth, 2012). Materials and toys are therefore used to directly or symbolically play out emotions, thoughts, or experiences that occur in their concrete and active world. Play provides an opportunity for the counselor to enter the world of children and for children to communicate at their level of understanding (Landreth et al., 2009; Landreth, 2012).

Child-centered play therapists model acceptance of and attention to the whole child, including cognitions, behaviors, and emotions based on Rogers' client-centered theory (Fall et al., 1999; Landreth, 2012; Post, 2001). These conditions and the therapeutic relationship are the basis for change and a way of being with children rather than techniques that are applied to them and their problems (Landreth, 2012; Landreth et

al., 2009). CCPT employs interactions with children that include both therapist behaviors and ways of being with children during the session. Therapist behaviors used include: (a) tracking (reflecting play behavior), (b) reflecting content/meaning, (c) reflecting feeling, (d) returning responsibility (facilitating decision making), (e) encouraging (esteem building), and (f) limit-setting (Landreth, 2012; Landreth et al., 2009; Ray, 2011). Therapists also display a way of being with children that reflects unconditional positive regard and acceptance of the child and his or her behaviors and expressions. Through these principles, CCPT creates a safe environment for children to express and explore their emotions, master tasks, and practice coping skills which lead to increased feelings of empowerment and self-acceptance (Blanco & Ray, 2011; Landreth, 2012; Post, 2001). Similarly, the freedom and control experienced by children involved in CCPT provides them encouragement and development of decision making and problem solving skills (Cochran, 1996; Johnson McLeod, & Fall, 1997).

During CCPT, children are validated in their feelings and actions that can help decrease anxiety and self-defeating coping mechanisms (Fall et al., 1999). This environment of acceptance, without a contingency of competence, projects a message that adults are just as concerned about children's feelings as they are about their performance. Thus, this environment creates feelings of belonging for the child from those who are influential in shaping self-concept such as teachers and parents (Guerney, 1979). Similarly, CCPT is based on a genuine respect for the integrity of the individual and the capacity within the self for growth and success. Respect and relationship are believed to be the prerequisite for change and learning (Axline, 1947; Landreth, 2012).

Empirical Research of CCPT

Research related specifically to CCPT spans over 60 years and had been found to be an effective intervention for diverse populations, settings, presenting problems, and ages (Ray, 2011). A review of research indicates that play therapy can be effective in addressing a variety of issues impacting children. Bratton et al. (2005) conducted a meta-analysis of 93 controlled outcome studies which were published between 1953-2000. The purpose of the meta-analysis was to assess overall efficacy of various play therapy modalities. Analysis revealed a large treatment effect size of .8 at the $p<.001$ level for play therapy. On average children who participated in play therapy sessions performed three fourths of a standard deviation better on measured outcomes than those who did not participate. Play therapy was shown to be effective regardless of environment or reason for referral, such as internalizing, externalizing, or other concerns including academic achievement. Optimal treatment duration was found to be 30-35 sessions and appeared to level off and decline as sessions increased from this range. However, it should be noted that moderate to large effect sizes were also demonstrated in 14 or fewer sessions for some studies examined. Additionally, the mean number of sessions for the studies reviewed was 16.9, which suggests that some children may have experienced optimal treatment without reaching the maximum level of 35 sessions. While the meta-analysis indicated that play therapy, regardless of therapeutic approach was effective, humanistic, non-directive approaches of play therapy, such as CCPT, produced higher treatment outcomes compared to other modalities of play therapy that were more directive in nature, such as behavioral, cognitive, and solution-focused play interventions.

Similarly, Leblanc and Ritchie (2001) conducted a meta-analysis of play therapy and found that on average children receiving play therapy services performed 25 percentile points greater on various outcome measures than children who did not receive treatment. An average effect size of .66 was estimated for play therapy treatments in as few as 13 sessions. One study included in the meta-analysis was a study done by Fall, Balvanz, Johnson, and Nelson (1999) which examined the effectiveness of CCPT on self-efficacy of students in kindergarten through third grade. The study results indicated that CCPT may have a positive influence on self-efficacy and decrease self-defeating coping mechanisms. Following the study, teachers rated significantly higher levels of self-efficacy in students who participated in six sessions of CCPT. Teachers also reported increases in confidence and ability to communicate in the students participating in the CCPT group. The study demonstrated that coping skills that hinder learning can be alleviated through six CCPT sessions.

CCPT and Children with Learning Problems

There is a paucity of literature addressing use of CCPT with learning problems. The studies that do exist are outdated, as the most recent studies are from 2003. Nevertheless, a relationship has been demonstrated between CCPT and personal adjustment, self-concept, confidence, empowerment, and communication of students displaying learning problems (Axline, 1947; Bills, 1950; Fall et al., 1999; Guerney, 1979). More recently, Packman and Bratton (2003) found that following group play/activity therapy sessions (modeled after CCPT), students with learning problems showed decreased behaviors such as aggression and delinquency, less hyperactivity, teasing, arguing, destruction of property, fighting, and generally being mean to others,

decreases in anxiety and depression. The study utilized a pre/post group design in which 15 fourth and fifth grade students participated in the intervention and 15 students were placed in the control group. Participants attended one hour sessions weekly for 12 weeks. The researchers collected data from parents about behavior using the Behavior Assessment System for Children (BASC)-Parent Report Form and the Child Behavior Checklist (CBCL)-Parent Report Form. Additional qualitative data was collected from the parents and teachers as well. Negative behaviors and emotional issues experienced by the children in the study are thought to interfere with learning and consequently academic achievement. An implication is that learning capacity may be enhanced when students are given the opportunity to be involved with CCPT interventions, as these other variables impeding achievement may be reduced. Unfortunately, the impact of CCPT on academic achievement in relation to behavioral and emotional dimensions was not measured in this study.

Only one study was found that specifically addressed the academic and emotional needs of students with LDs through play therapy. Siegel's (1970) dissertation research examined the effectiveness of play therapy with first through fifth grade students who had been diagnosed with LDs. She evaluated cognitive (recall or recognition of knowledge including IQ and achievement scores), affective (personal and social adjustment including attitudes and values), psychomotor (neuromuscular coordination, motor skills, and perceptual functioning), and environmental (home environment including parental attitudes and personalities) variables in relation to the non-directive play therapy treatment variable. This non-directive play therapy was similar to the current CCPT model in that, it included conditions of empathy, unconditional positive regard,

therapist congruence, and allowance for intrapersonal exploration. Results indicated that children receiving play therapy significantly improved in cognitive and affective domains which were evaluated based on the Borke Process Scale which observes the play behavior of children during session. Additionally, children who received the highest level of therapist conditions significantly differed in their play therapy process from those receiving fewer conditions as indicated by making more positive statements about themselves, spontaneous exclamations, insightful statements about themselves, and positive statements about family/school/things in the playroom. Therefore, it can be concluded from this body of research that non-directive play therapy is an effective treatment for children with LDs.

Johnson, et al. (1997) addressed the impact of CCPT on coping skills and expression of feeling of six children with special education diagnoses identified as having autism, attention deficit hyperactivity disorder, cerebral palsy, and/or developmental disabilities, but not specifically LD. The intervention lasted for six sessions and was comprised of 30-minute weekly meetings. Results indicated that CCPT facilitated children's expression of feelings, coping skills and feelings of control, as evidenced by language and actions in sessions. It was concluded that issues were best addressed through an environment of acceptance, relationship, and belief in their own abilities that is found in CCPT. These opportunities and experiences in the playroom could lead to increased ability to exert control over behaviors and emotions outside of the sessions. Similarly, issues faced by students labeled with LDs can best be addressed through an environment of acceptance, relationship, and fostering a belief in their own abilities (Johnson et al., 1997), which are all essential conditions of CCPT.

In conclusion, CCPT offers opportunities for increased self-esteem, security, and feelings of belonging which may also reduce fear of failure and promote optimal learning (Bowen & Glenn, 1998). Landreth et al., (2009) propose that CCPT has been supported in "helping reduce child behavior problems, improving self-efficacy, and enhancing the teacher-student relationship—all factors shown to impact school performance and academic success" (p. 287). Others in the field of play therapy agree that a link between the mental health of children, their ability to learn, and academic achievement does exist (Blanco & Ray, 2011; Blanco et al., 2012; Packman & Bratton, 2003).

Summary

This section has highlighted the lack of current research in utilizing CCPT with students who are diagnosed with LDs. Although some of the studies are dated, this body of research demonstrated that CCPT is an effective intervention to address emotional and behavioral issues of students with learning issues. Significant results have been reported related to impact on cognitive and affective domains, as well as coping skills, expression of feelings, and self-efficacy. It is believed that addressing these areas may increase students' ability to learn and therefore have a positive effect on academic achievement.

Social Skills and Students with Learning Disabilities

Social skills development becomes particularly important beginning in third grade when children undergo changes in social development, cognitive ability, and understanding of themselves and peers (Vaughn, Zaragoza, Hogan, & Walker, 1993). When compared to peers without disabilities, students with LDs have demonstrated significantly greater deficiencies in social skills (Bramlett, Smith, & Edmonds, 1994; Bryan, Burstein, & Ergul, 2004; Forness & Kavale, 1996; Haager & Vaughn, 1995;

Kavale & Forness, 1996; Nowicki, 2003; Walker & Nabuzoka, 2007). Within this population approximately 75% demonstrate issues with social skills (Kavale & Forness, 1996). A meta-analysis including 152 studies conducted by Kavale and Forness (1996) highlighted several social skills deficits among students diagnosed with LDs. The meta-analysis included studies conducted between 1957 and 1994 which contained research comparing students with LDs and those without and assessed dimensions of social skills. Their review indicated that 8 out of 10 students with LDs were less likely to interact socially, were more poorly adjusted, were less accepted, and less likely to be identified as a friend than non-disabled peers. Students with LDs were rejected more by peers without disabilities and were viewed as having lower levels of interaction, play, cooperation, and empathy. Additionally, 80% of students with LDs rated themselves as having difficulty with interpreting non-verbal communication, including interpretation of social situations, messages, and feelings. They also rated themselves as having deficiencies in social problem solving and resolving social conflict.

If left unaddressed, social skills issues can lead to negative consequences for students with LDs. Long-term concerns associated with poor social skills, such as low self-esteem, school drop-out, mental health issues, juvenile delinquency, lower career success, and criminal behavior (Kavale & Forness, 1996) as well as academic issues (Malecki & Elliot, 2002; Walker & Nabuzoka, 2007) are more likely to arise. Deficits continue to be detrimental in adulthood causing students to be at-risk for behavioral issues and less resilient in their futures (Forness & Kavale, 1996). More specifically, students with LDs are more likely to experience depression, anxiety, feelings of loneliness (Bryan et. al, 2004), attention problems, and withdrawal (Vaughn et al., 1993).

Compounding these issues are additional negative interactions with peers. Students with LDs are generally less accepted, facing more social rejection, by peers without disabilities (Nowicki, 2003; Vaughn, et. al, 1993). Students diagnosed with LDs have significantly lower peer acceptance and popularity ratings than their high achieving peers (Hager & Vaughn, 1995; Walker & Nabuzoka, 2007). Likewise, children with learning difficulties are viewed by peers as being more disruptive (Walker & Nabuzoka, 2007). Negative peer perceptions may be linked to the higher instances of behavior problems and social skills issues that are seen in students with LDs (Hager & Vaughn, 1995). Additionally, negative teacher perceptions may also have an influence on peer acceptance. It can therefore be said that students with LDs do not appear to be as socially competent or accepted in comparison to high achieving students.

Competent social skills may help to reduce negative effects on the lives of students with LDs outlined above which may be caused by poor academic achievement (Forness & Kavale, 1996; Walker & Nabuzoka, 2007). Unfortunately, literature reviewed in regards to social skills training for students with LDs indicated that such interventions have not proven to be very effective. Most of the studies reviewed used a social skills intervention with components of modeling and observation of the desired skill, shaping or demonstrating the skill with verbal cuing or reinforcement, and use of rehearsal and practice (Forness & Kavale, 1996; Nowicki, 2003). About one out of five social skills intervention studies actually produced better gains in the control group than in the treatment group and interventions involving children below 12 years old showed a small effect size. Additionally, teacher ratings did not indicate an increase in academic

competence or social interaction following interventions with students diagnosed with LDs; in fact, on average students only rose to the 58th percentile following intervention. Interventions to date which address social skills stress cognitive understanding of social skills versus social application and experience (Bryan et al., 2004; Forness & Kavale, 1996). Cognitive functioning and understanding social cues are difficult for students with LDs to navigate, which may contribute to the lack of effectiveness of the interventions. Similarly, negative affect and poor emotional regulation, which are controlled by the nervous system, influence children's perceptions and interpretations of others which cloud social interactions (Bryan et al., 2004). Bryan et al. (2004) found that when asked, children with LDs generated a variety of socially appropriate solutions to address difficult situations; however, they more often displayed less effective solutions and did not generalize positive social skills. Therefore, it is presumed that cognitive difficulties associated with LDs contributed to social skills issues which were associated with deficits in learning (Hager & Vaughn, 1995). These deficits may also extend to social learning which may impair the application of information learned during interventions.

Additionally, many interventions used to address difficulties with social skills and academics include a group teaching model such as peer tutoring, peer consultation/collaboration, bibliotherapy, and teams of students working on thematic units which have produced weak results (Bryan et al., 2004). These types of peer models were repeatedly used despite research which has demonstrated that students with LDs are viewed negatively by peers and have difficulty interacting with them. It appears that these group models teach important social skills but are not addressing the individual social deficits and needs of students.

No traditional counseling interventions were mentioned in the literature concerning students with LDs. It has been noted that social skills are comprised of a complex set of constructs that may not be discretely addressed through discrete interventions (Forness & Kavale, 1996; Nowicki, 2003; Vaughn et al., 1993). Counseling interventions, such as CCPT, may be a viable option that would address the specific needs of students with LDs, while utilizing interventions that are not cognitively based and can address complex needs.

Empirical Research Related to Social Skills and CCPT

Only one study was found in the literature concerning the use of CCPT to address social skills. A group CCPT intervention was used in a study conducted by Kascsak (2012) to address the social skills needs of students in kindergarten. The study included 49 participants with 26 children in the treatment group and 23 in the control group. The Social Skills Rating Scale (SSRS) teacher and parent rating assessments were used to measure social skills. Teacher rated subscales included cooperation, assertion, and self-control. Similarly, the parent rated subscales included cooperation, assertion, self-control, and responsibility. Students receiving higher scores were paired with students receiving lower scores for group CCPT sessions. Students participated in 30-minute sessions twice per week for five weeks. The intervention did not result in significant differences between the groups, because the control group also improved. Kascsak attributed these findings to a variety of factors. Improvements made by the treatment group may have carried over to the classroom and therefore effected the control group; the SSRS 3-point scoring protocol may not have been sensitive enough to detect changes in social skills; longer session length and intervention time may have been needed to see changes; and

bias of raters when completing assessments may have been present. There were no other studies found on the effects of individual CCPT sessions on social skills and none with students who have been identified with LDs.

Summary

In summary, this section has reviewed the impact poor social skills can have on students' lives. Much of the research in the field of special education has addressed social skills issues of students with LDs through cognitive measures, which may have impacted successful implementation. Additionally, only one study has been conducted in the field of CCPT that addresses the social skills needs of students. Although that study did demonstrate improvements of all children, significant differences between the experimental and control groups were not obtained. The impact of individual CCPT sessions on social skills has not been specifically studied with children or with students who have been diagnosed with a specific LD. When examining the effects of CCPT on social skills, only one study was conducted with students in kindergarten, despite the fact that social skills become important to personal, social, and academic development beginning in third grade. The current study seeks to address these gaps in literature by assessing the impact of CCPT on the social skills of third grade children with LDs.

Academic Achievement and Students with Learning Disabilities

Currently, literature in the special education field regarding academic interventions fails to consider socio-emotional factors that may contribute to learning issues presented by students labeled with LDs. This literature exclusively addressed underlying cognitive issues (Compton, Fuchs, Fuchs, Lambert, & Hamlett, 2012). Interventions for these students examine how language, working memory, problem

solving, concept formation, and processing speed impact academic achievement. Socio-emotional factors have not been addressed despite research which notes that social, emotional, and behavioral problems manifest in 40% of people with LDs (Mishna & Muskat, 2004). Repeated feelings of unacceptance can contribute to dependency, lack of prosocial behaviors, low self-concept, anxiety, nonparticipation, poor self-confidence, behavioral problems, and depression in these students (Bowen & Glenn, 1998). Such issues may impact abilities to adequately concentrate, learn, and perform in academic skills, therefore creating a cycle that perpetuates both learning and behavioral issues. Additionally, students who are diagnosed with LDs have a greater probability (.58) of dropping out of high school (Dunn, Chambers, & Rabren, 2004).

Empirical Research Related to Academic Achievement and CCPT

While research has demonstrated that CCPT was effective in addressing the academic needs of students with learning problems, only one study to date addressed academic achievement of students specifically diagnosed with LDs. Siegel (1970) did measure the impact of non-directive play therapy with students with LDs on cognitive measures. Cognitive measures used in the study included the Stanford Achievement Test and the Wechsler Intelligence Scale for Children. Her findings indicated that students who participated in play therapy significantly improved these cognitive domains. Similarly, literature demonstrates that students with and without learning problems, however not diagnosed with an LD, who participated in CCPT sessions demonstrated a significant increase in achievement, including reading ability as well as intelligence measures (Axline, 1947; Bills, 1950; Blanco & Ray, 2011; Blanco et al., 2012).

The first study to address the impact of CCPT on learning issues was done by Axline (1947). She conducted a mixed methods quantitative and qualitative study with outcome measures of reading and IQ scores. Teacher observations and observations of classroom behavior were also assessed. The study included 37 second graders who were selected from a list of poor or nonreaders. Those selected scored the lowest on the Gray Oral Reading Test and the Gates Primary Reading Test. These students were placed in a self-contained classroom that utilized CCPT principles and provided no additional reading remediation. Additionally, four of the children were involved in 30 minute CCPT weekly sessions over eight weeks. The teacher noticed that all of the children who scored low in reading ability had serious emotional and/or environmental problems and that these problems appeared to contribute to their reading issues. All children in the classroom were retested at the end of the semester using the same measures that were utilized before intervention. All students increased their IQs and improved reading scores beyond the expected 3.5 level. Those students that participate in the individual CCPT sessions improved their reading scores as well as IQ scores by 18 to 36 points. Although this study did not test for significance, it indicates that participation in a classroom using CCPT concepts was successful in solving some reading problems and that the addition of individual CCPT sessions resulted in improved IQ scores.

A more recent study examined the impact of participating in CCPT on academic achievement for students who displayed academic issues. Blanco and Ray (2011) examined the effectiveness of CCPT on academic achievement of 21 first graders who were considered academically at-risk as defined by their school. Students selected for the study participated in biweekly 30 minute sessions over 8 weeks (16 sessions). Findings

indicated statistically significant increases in Early Achievement Composite of Young Children's Achievement Test (YCAT) scores. Students scored significantly higher on the YCAT with an effect size that was twice as large as the control group. This study demonstrated that CCPT can potentially be a viable intervention in elementary schools to address academic achievement issues. CCPT provides a safe environment for children to express their emotions due to the counselor being accepting of children for who they are and their feelings. This sense of safety leads to the child having increased feelings of empowerment and self-acceptance. It is therefore logical to say that if children are more accepting of themselves, then they will be more open to accepting others, such as teachers and what knowledge they have to offer. Results of this study can assist with the promotion of best new practices for school counselors to include CCPT when providing services, as it addresses academic, as well as mental health issues as recommended by ASCA.

A follow-up study to the Blanco and Ray (2011) study was done to examine the long-term effects of CCPT with students who were considered academically at-risk. Blanco, Ray, and Holliman (2012) studied the effects of CCPT on the academic achievement of 18 academically at risk elementary students. Academic achievement on the YCAT was measured at pre-intervention, mid-intervention (16 sessions), and post-intervention (26 sessions). Students who participated in 16 CCPT sessions over 8 weeks scored statistically significantly higher on the YCAT achievement test than those in the control group. Post hoc measures indicated an effect size twice as large as the control group which indicates the practical significance of shorter term CCPT. After participating in the additional 10 sessions, participants displayed significant gains in

scores on the academic achievement measures. Gains in academic achievement appeared to continue to increase at an almost equal and steady rate over time throughout the 26 sessions. From measurement at times one, two, and three an effect size of .71 at a $p<.001$ level of significance was observed. This study demonstrated that CCPT is effective in increasing academic achievement in short term but is more effective in the longer term.

Summary

In summary, this section has reviewed the impact low academic achievement can have on student's lives. Much of the research in the field of special education has addressed the academic needs of students with LDs through cognitive measures, despite findings that emotional issues are prevalent in this population. Additionally, few studies have been conducted in the field of CCPT regarding addressing academics with students who have been diagnosed with a specific LD. However, a few studies do exist in which CCPT is used as an academic intervention for students with "learning problems." Consequently, the literature is void of research addressing the impact of individual CCPT on students who have been labeled with a specific LD with regard to their academic achievement based on curriculum-based measures used in schools. Curriculum-based measures that will be used in the current study will measure both reading and mathematics achievement for each student on a weekly basis. Also, the most current studies involving CCPT and academic achievement have been done with students in early grade levels such as first grade and below. It is important to determine the impact CCPT may have on students in the third grade and above when high stakes testing has been introduced to assess academic achievement. The current study sought to address these

gaps in literature by not only assessing the impact of CCPT on the academic achievement of students with LDs, but also by utilizing third grade students.

Self-Concept and Students with Learning Disabilities

Significant differences in self-concept exist among students with disabilities and their peers without disabilities (Bryan et al., 2004; Chapman, 1988; Elbaum & Vaughn, 2001; Forness & Kavale, 1996; Tabone, 2011). About 70% of students with LDs have demonstrated poor self-esteem and self-concept (Chapman, 1988; Kavale & Forness, 1996). Students labeled with LDs who had lower grades reported lower self-concept (Moller, Streblow, & Pohlmann, 2009). Additionally, students with LDs in kindergarten through sixth grade rated themselves significantly lower on self-concept measures than peers without disabilities at a greater level when compared to those in upper grade levels (Bear, Minke, & Manning, 2002). Changes in the social-cognitive thinking and understanding of children and their peers occur as they grow and develop, particularly starting in third grade and beyond (Vaughn, et al., 1993). Self-concept appears to solidify around third grade and may have an impact on achievement levels. It is therefore understandable that students with LDs begin to develop negative self-concepts by the third grade, which remains relatively stable throughout their schooling careers (Chapman, 1988). Leaving these beliefs unchanged may have negative impact on future achievement, as students may give up more easily when faced with difficult tasks.

Emenheiser (2013) conducted a study with adolescents diagnosed with LDs. Findings indicated that lower levels of academic achievement were significantly correlated to lower levels of self-concept over time. Self-concept is also correlated to other long-term outcomes. Students with lower self-concepts were more tolerant of

deviance and were more susceptible to peer pressure (Zimmerman, Copeland, Stope, & Dielman, 1997). Conversely, students with higher self-concepts have reported more positive peer and family relationships, better grades, and lower levels of alcohol and drug use, depression, and anxiety (Bear, Minke, & Manning, 2002; DuBois, Felner, Brand, & George, 1999; Whitley, 2008; Zimmerman, et al., 1997). Therefore it is important to address self-concept of students with LDs since it is significantly predictive of academic achievement levels and future academic functioning (Bear, et al., 2002; Emenheiser, 2013; Moller, Streblow, & Pohlmann, 2009; Whitley, 2008; Zimmerman et al., 1997) which begins to take on greater importance at this grade level.

O'Mara, Green, and Marsh (2006) completed a meta-analysis of self-concept interventions in school settings. The meta-analysis included 105 studies utilizing 152 self-concept interventions. Studies included in the analysis were published between 1960 and 2000 and contained participants who were under 18 years old and in a school setting. Studies were also required to have a control group from the same population and reported self-concept or self-esteem scores. Findings indicated that interventions produced a moderate effect on self-concept with an effect size of .51. Interventions provided in primary schools appeared to produce a similar effect size of .48; however, the authors attribute this to shorter exposure to the interventions as well as other factors. Interventions used were also more cognitively based and may not have been as appropriate for lower grade levels. A greater impact on self-concept was observed when interventions were provided by the school counselor and when they were more consistent.

Another meta-analysis of studies in the field of special education aimed at increasing the self-concept of students with disabilities found little support for the efficacy of current interventions (Elbaum & Vaughn, 2001). Studies included in the analysis were published from 1975 to 1997 and contained 64 interventions. These studies were also required to have a control group of students with LD and report of self-concept measures. Most of the school-based intervention programs that were implemented were academically based, utilized a teaching model, and produced a mean effect size of .19. Minimal counseling interventions were noted and were not clearly defined. These types of interventions, however, were the only ones that significantly impacted self-concept of students with LDs. Counseling interventions that appeared to be effective with elementary students contained a "game-like component" and produced larger effect sizes of .69 and .61.

Empirical Research Related to Self-Concept and CCPT

Similarly, research using play therapy has demonstrated effectiveness in addressing low self-concept of students who are poor readers (Bills, 1950; Crow, 1994). Bills (1950) chose a group of eight students, ages seven to nine, who demonstrated poor reading skills based on scores obtained from the Gates test of paragraph meaning, the Gray Oral Reading Paragraphs test and the Revised Stanford-Binet Form L assessment. These students were placed in an intervention consisting of non-directive play therapy sessions over 30 days. During the intervention students participated in six individual sessions and three group sessions lasting 45 minutes each. The participants acted as their own control following a schedule of 30 days without intervention, 30 days with intervention, and 30 days without intervention to determine lasting results of the

intervention. A non-therapy group was also formed; however, members were not matched to the treatment group. Students in the treatment group displayed greater and significant gains in reading scores during and after the intervention than while in the control period. Teacher observations were collected regarding emotional issues and displays of maladjustment during the study which were believed to be related to self-concept. It was determined that students participating in the intervention made improvements regarding their emotional maladjustment and this was hypothesized to be connected to the students' self-concept. The researcher suggested that changes in self-concept occur during the process of non-directive play therapy, which therefore allow for greater reading ability.

Crow (1994) further studied the interaction of reading ability and self-concept. The study included 24 first graders in which half were in the treatment group and the other half were in the control group. Students participated in weekly 30-minute CCPT sessions over 10 weeks. Reading ability was measured through the Gates MacGinite Reading Test (GMRT) and the Stanford Reading Achievement Test. Self-concept was measured through the self-report Piers-Harris Children's Self-Concept Scale. Students participating in the intervention demonstrated significant gains in self-concept when compared to the control group. Although no significant gains in reading ability were determined, anecdotal evidence suggested that behaviors and self-concept of the students were changing in a way that may impact reading ability over a greater period of time. It has been demonstrated that self-concept is an area that is significantly impacted by CCPT interventions (Bratton & Ray, 2000).

Bratton and Ray (2000) conducted a review of the play therapy literature from 1947 to 2000 in which they examined the effectiveness of outcome studies. Nine studies exploring the impact of play therapy on self-concept were included. Of the nine studies, eight demonstrated significant improvement in self-concept following a play therapy intervention and three reported significant decreases in the self-concept of control group members. Post (1999) found similar results regarding control group decline. Post also determined that 4th, 5th, and 6th grade at-risk students who participated in CCPT maintained levels of self-esteem, while those in the control group significantly decreased levels of self-esteem. These findings appear consistent with those of Chapman (1988) who stated that self-concept of students tends to decrease as they progress in school. Others who have studied the impact of CCPT on the self-concept of children who are homeless and who have been sexually abused have found promising results (Baggerly, 2004; Scott, Burlingame, Starling, Porter, & Lilly, 2003).

Baggerly (2004) conducted group CCPT with 25 homeless children having a mean age of eight years old living in a shelter. Children received 30-minute sessions with another child once or twice per week for up to 12 sessions. Originally a control group was in place, however due to ethical concerns and dropout rate, paired t-tests were used to examine effect sizes of pre and post measures. Significant increases were reported in self-concept as well as increases in self-esteem with moderate to large effect sizes. Scott et al. (2003) conducted a study using individual CCPT with 26 children ages three to nine years old who were sexually abused. Children participated in a mean of 10 individual CCPT sessions. No control group was used for this study, pre and post measure were

analyzed using a within-subjects ANOVA. Findings of that study indicated increases in self-concept and self-esteem.

Based on this body of research, CCPT could be an effective intervention to raise the self-concept of students with LDs. Currently, a gap in the literature exists in regards to addressing self-concept through the use of CCPT for students labeled with LDs. Similarly, there is a need to examine how CCPT may impact the self-concept of third grade students in this population through the use of a self-assessment measure rather than by report of adult perceptions.

Summary

In summary, this section has reviewed the impact poor self-concept can have on students' lives, both personally and academically. Much of the research in the field of special education has addressed self-concept issues of students with LDs through cognitive measures, which may have impacted successful implementation. Counseling interventions have been more effective in addressing self-concept, however they were poorly defined. Those with a "game-like" component were found to be most effective. No studies were found examining the impact of CCPT on the self-concept of students labeled with LDs. The current study sought to address these gaps in literature by assessing the impact of CCPT on the self-concept of children with LDs.

Summary

Play therapy is a developmentally appropriate intervention for children, as play is a child's natural way to communicate emotions and their thoughts about the world around them (Landreth et al., 2009; Ray, 2011). The principles of CCPT create a safe environment built on trust and a respectful relationship that allows children opportunities

to increase feelings of empowerment and self-acceptance, which are factors of learning and achievement (Blanco & Ray, 2011; Landreth, 2002; Post, 2001). Students diagnosed with special needs are not often afforded positive experiences in school with regards to academic success or teacher and peer interaction. Repeated negative feedback may lead to feelings of unacceptance which can contribute to internalized and externalized problems that affect school performance (Bowen & Glenn, 1998). The literature supports the idea that such issues faced by students with special needs can be effectively addressed through the use of CCPT in the school setting (Bratton & Ray, 2000; LeBlanc & Ritchie, 2001). School counselors are the most logical school professionals to provide these interventions, due to their accessibility and established rapport, as well as knowledge regarding effective counseling strategies for children (Bowen & Glenn, 1998; Phillips & Mullen, 1999).

Limitations to the current research do exist. There was no recent research that examined the effects of CCPT on social skills, academic achievement, and self-concept of students specifically identified with LDs. Students in many of the studies are labeled as "at-risk" or having "learning problems" (Axline, 1947; Bills, 1950; Blanco & Ray,, 2011; Blanco, Ray, & Holliman, 2012; Post, 2001) but have not been specifically diagnosed with having an LD. Likewise, student samples are not clearly defined in regards to their learning issues. Few academic studies utilizing CCPT as an intervention have been conducted with older school-aged children. The samples used mainly focused on students in pre-school and first grade, both of which do not place as much value on academic achievement or learning issues. None of the CCPT studies focusing on academic achievement have been done in single-case design methodology.

A gap exists in the literature addressing the relationship between academic achievement and CCPT. It is, however, believed that the personal, emotional, and social aspects addressed through CCPT may work to improve school performance and academic success (Landreth et al., 2009). Much of the research done with regards to school counselors and special education is dated and little has been done recently about therapeutic interventions with this population and the variables in this study, Therefore, the purpose of this study was to examine the effects of CCPT on social skills, academic achievement, and self-concept of students identified with LDs.

CHAPTER III: METHODOLOGY

The purpose of this study was to examine the impact of individual, child-centered play therapy (CCPT) on the social skills, academic achievement, and self-concept of third grades students who have been identified as having a specific learning disability (LD). The following sections of this chapter describe the experimental research methodology for this study including details about participants, setting and materials, the researcher, data collection procedures, data analysis, and experimental design that were used.

Participants

Participants of this study were third grade students who were identified as having an LD based on their most recent Evaluation Report (ER) and Individualized Education Program (IEP), as defined by the state and school district in which they reside. These students were identified as needing resource services (40-70% of the day with peers in the regular education classroom) in which they are provided support services for reading and math. Three students who fit the criteria were enrolled at the elementary school. These students were invited to participate in the study by the school counselor. The school counselor called the students' parents/guardians, explained the study, and obtained verbal agreement to participate. The researcher provided the school counselor with the consent form. The school counselor then sent the form home with the students and the

students returned the signed forms to her. Signed forms were then given to the researcher. Additionally, a developmentally appropriate assent form was signed by each participant that returned a signed parent consent form. Exclusion criteria for participants include other diagnoses, poor attendance (greater than 10 in past year), and receiving outside additional counseling or academic support services.

Student one was an 8-year-old African American male. According to his most recent evaluation data, student one had an IQ of 96, placing him in the average range (Wechsler Intelligence Scale for Children, WISC-IV, Weschler, 2003), and cognitive ability scores (Woodcock-Johnson Test of Cognitive Ability, 3rd Edition, WJ-III-COG, Woodcock, McGrew, & Mather, 2001) within normal limits for crystallized knowledge, fluid reasoning, auditory processing, short-term memory, long-term retrieval, and processing speed. Visual processing scores fell below normal limits. Achievement scores (Wechsler Individual Achievement Test-III, WIAT-III, Weschler, 2009) for word reading, pseudoword decoding, and reading fluency fell below average. The evaluation report noted that he had no discipline referrals, was friendly, and got along with teachers and peers but was shy. Additionally, the evaluator reported that student one struggled in most academic areas (particularly in language arts), could be distracted, fidgety, and appeared to be daydreaming at times.

His mother provided information on the report indicating delays in ability to walk and speak in phrases, difficulty with sustaining attention, difficulty with engaging in social activities due to shyness, and difficulty sleeping due to anxiety/frequent nightmares. His regular education teacher reported that at the beginning of the year he was reading at a level F which is below expected grade level (M). He did not have a math

goal on his IEP; however, the special education teacher supported his math achievement with weekly word problems. His regular education teacher reported that at the beginning of the year he was functioning at 1356 for math (Discover Ed), which is below the expected 1450. He had an IEP goal for reading. His accommodations included having tests read aloud, testing in a separate room in a small group, and shorter assignment length. His IEP indicated that he did not display behaviors that impeded his learning or the learning of others, did not have limited English proficiency, or require special communication needs.

Student two was a 9-year-old Caucasian female. According to her most recent evaluation data, student two had an IQ of 97 placing her in the average range (Wechsler Intelligence Scale for Children, WISC-IV, Weschler, 2003), and cognitive ability scores (Woodcock-Johnson Test of Cognitive Ability, 3rd Edition, WJ-III-COG, Woodcock, McGrew, & Mather, 2001) within normal limits for crystallized knowledge, fluid reasoning, auditory processing, visual processing, long-term retrieval, and processing speed. Short-term memory scores fell just below normal limits. Student two was given the Kaufman Test of Educational Achievement (KTEA-II, Kaufman & Kaufman, 2004) to assess achievement in basic reading, math, and written expression. Scores for her basic reading composite and written expression subtest indicated that she was performing at a delayed level. Her math composite scores were in the below average range.

Additionally, student two was evaluated by her guardian and teacher using the Adaptive Behavior Assessment System (ABAS-II, Harrison & Oakland, 2003) with measures daily, functional skills. Both her guardian and teacher rated her within normal limits for all composite scores. The evaluation report noted that she had no discipline

referrals, put forth good effort, and was quiet and friendly. Additionally, her grandmother (guardian) provided information on the report that indicated student two struggled to maintain attention, complete homework, and had difficulty with her bedtime routine. The regular education teacher reported that at the beginning of the year she was reading at a level B which is below expected grade level (M). Additionally, the regular education teacher reported that at the beginning of the year she was functioning at 1343 for math which is below expected grade level (1450). She had IEP goals for reading, math, writing, and speech. Her accommodations included having tests read aloud, testing in a separate room in a small group, preferential seating, shorter assignment length, and adapted assignments. Her IEP indicated that she did not display behaviors that impeded her learning or the learning of others, and she did not have limited English proficiency. However, it was indicated that she did require special communication needs and attended speech support for 30 minutes seven times per reporting period.

Student three was an 8-year-old African American male. According to his most recent evaluation data, student one had an IQ of 91, placing him in the average range (Wechsler Intelligence Scale for Children, WISC-IV, Weschler, 2003), and cognitive ability scores (Woodcock-Johnson Test of Cognitive Ability, 3rd Edition, WJ-III-COG, Woodcock, McGrew, & Mather, 2001) within normal limits for, fluid reasoning, auditory processing, visual processing, short-term memory, and processing speed. Crystallized knowledge and long-term retrieval scores fell below normal limits. Achievement scores (Wechsler Individual Achievement Test-III, WIAT-III, Weschler, 2009) for word reading, reading fluency, and reading comprehension fell below average. Pseudoword decoding fell in the average range. The evaluation report noted that he had several

administrative referrals at his previous school for noncompliant and disruptive behaviors, was frequently off-task, had difficulty sustaining attention, completing tasks, and following directions.

A Behavior Assessment System for Children Second Edition (BASC-2, Kamphaus & Reynolds, 2007) was completed by student three's mother and teacher due to behavior concerns at his previous school. Both his mother and teacher reported elevated scores in externalizing areas of hyperactivity, aggression, and conduct problems. His mother and teacher also reported elevated scores in internalizing areas of anxiety, depression, attention problems, and withdrawal and noted deficits in adaptability and social skills. Additionally, the evaluator reported that student three readily participated in the evaluation activities and put forth good effort, but he was fidgety and impulsive with responses at times. He also required some encouragement to attempt difficult items. His mother provided information on the report indicating delays in ability to walk, difficulty engaging in social activities, difficulty adapting to transitions, difficulty completing homework and morning/dinner routines, and difficulty with getting along with teachers and peers.

His regular education teacher reported that at the beginning of the year he was reading at a level F which is below expected grade level (M). He did not have a math goal on his IEP, however the special education teacher supported his math achievement with word problems. His regular education teacher reported that at the beginning of the year he was functioning at 1342 for math which is below expected grade level (1450). He had IEP goals for reading and behavior/social skills. However, at the time the study began, his special education teacher stated that he was not displaying any behavioral

issues during the current school year. By the time the intervention phase began, student three's behavior had deteriorated resulting in several administrative referrals and suspensions. His accommodations included having tests read aloud, testing in a separate room in a small group, and modified assignments. His IEP indicated that he did not display behaviors that impede his learning or the learning of others, did not have limited English proficiency, and did not require special communication needs.

Setting and Materials

This study was conducted in the southeastern United States in rural, public elementary school. The school's population consisted of 537 students, and 84 were in third grade. The student population included 181 (33.71%) Caucasian, 255(47.49%) African American, 73 (13.59%) Hispanic, 40 (7.45%) multiracial, 6 (1.11%) American Indian/Alaska Native, and 9 (1.68%) Asian background. Of the student population, 411 (76.54%) of students received free lunch and 28 (5.21%) received reduced lunch. Students in special education comprised 16.95% of the student population. Of those, 14 (2.61%) were in self-contained classrooms and 8 (1.49%) split time between self-contained classrooms and regular education classrooms. Pull-out services for special education were provided to 7.64% of students. Kindergarten through fifth grades attended classes in the building.

A room with play therapy materials was created according to Landreth's (2012) guidelines for conducting the play therapy sessions. There were three categories of toys outlined in the guidelines that were utilized in the sessions. Examples of the categories and some of the toys that were included were real life (baby doll, doll family, toy phone, cash register), aggressive release (plastic knife, toy gun, dinosaurs, snake), and creative

(paper, crayons, paints, play-doh) toys. The room was carpeted with no windows, had a sink and mirror, plain white walls, and was approximately 196 square feet. It was located near the front office and lobby in a relatively quiet area.

Researcher

The researcher and interventionist was a former special education teacher with five years of experience in the classroom. She taught students with LD and more significant cognitive disabilities. She was also an elementary school counselor for three years in a public school. The researcher was a fourth year doctoral student in the Department of Counseling at an accredited university at the time of the study and worked as a child therapist using CCPT for the past four years. She also had a total of 11 years of experience as a counselor working with children in various settings. Her training included completion of three graduate courses in CCPT, as well as attending several conference sessions on CCPT and play therapy. She also had experience supervising counselors working with children and supervising play therapy. The researcher was a Licensed Professional Counselor (LPC) in two states and was a Nationally Certified Counselor (NCC). She received her undergraduate degree in elementary and special education and had a Master of Arts degree in Community Counseling, as well as a post-master's certification in elementary school counseling.

Data Collection Procedures

Dependent Variables

Two of the dependent variables for this study were social skills and self-concept. Measures for these variables were self-report in nature and were gathered in alignment with accommodations outlined in each student's IEP. Social skills were measured at least

twice per week, immediately following the CCPT sessions and were be administered by the experimenter in the school counselor's office when available. When the school counselor's office was in use, the researcher gave the students a choice of two quiet areas to complete the measures. The self-report social skills assessment consisted of a questionnaire which was a shortened version of the Social Skills Rating System (SSRS) (See Appendix A). Additionally, the special education teacher completed an SSRS about each of the students in the study weekly (See Appendix B). The special education teacher was not aware of when each student was in the intervention phase receiving the CCPT intervention. The original SSRS demonstrates excellent internal consistency and test-retest reliability and is one of the most widely used social skills measures in schools internationally (Gresham, Elliot, Vance, & Cook, 2011). This questionnaire was used as it is closely related to the concepts found in CCPT that create growth and change. Additionally, the domains of the questionnaire were closely linked to skills used in CCPT such as, limit-setting, esteem-building, returning responsibility, reflection of feeling and meaning, as well as empathetic understanding and unconditional positive regard which are conditions found in CCPT. The students' self-assessment SSRS total score used to make decisions about introduction into the CCPT treatment sessions. Students could obtain a maximum score of 48 for total social skills, 12 for each of the four domains outlined below.

Statements on the rating scale assessed levels of assertiveness, cooperation, empathy, and self-control. There were three statements reflecting each of the four domains which equaled a total of 12 questions. Students rated each statement by answering "never, a little (one time per week), sometimes (2 to 3 times per week), often

(4 to 5 times per week), or very often (6 to 7 times per week)." Three practice items, unrelated to this assessment, were administered so that students could acclimate to the procedure. A script for this practice is outlined in Appendix C. Additionally, items were chosen if they only assessed one of the domains, as some of the original items assessed two domains simultaneously. Wording of the questionnaire items was not altered in any way. The assessment took approximately five minutes to complete and was administered after each CCPT session. Each week the 12 questions were randomly ordered to further inhibit memorization of responses. This assessment was field tested on two third graders, of typical development, before the study to determine appropriateness of the questionnaire. The questionnaire appeared to be appropriate for use based on the field test results.

The next variable measured in this study was academic achievement, which included reading and math skills. Reading and math achievement was measured based on scores obtained from the school's designated curriculum-based assessments which were utilized by the special education teacher for progress monitoring. These assessments were part of the participants' regular academic schedule and were administered weekly by the special education teacher. The Maze (Milone, 2008) reading assessments, which were used to monitor reading comprehension, were administered to students based on their reading levels. The Maze reading assessment is widely used by schools as a way to determine how well children read silently. Every seventh word after the first sentence in the passage is substituted with the correct word and two incorrect words, which are used to complete the sentence. Students circle the word they feel best completes the sentence. The passage lengths are 150 to 400 words and are chosen based on the grade level and

reading ability of the student. Students are given three minutes to complete the passage and scores are based on correct words circled during the three minutes. Initial assessments were given at the beginning of the school year and were used to determine the level that each student used throughout the school year. Reading levels were determined by the special education teacher. Students read baseline probes and procedures for determining level were followed in the Maze administration materials. Levels remained the same through the course of the study; however, passages and content varied according to the Maze program materials.

Math assessments included six math problems on students' ability levels each week as regularly done for progress monitoring purposes of all students. Again, initial assessments were given at the beginning of the school year and were used to determine the level the each student used throughout the school year. Math levels were determined by the special education teacher. Baseline probes were developed based on the third grade math curriculum and were administered to the students. Scores on the baseline determined what types of problems would be included in each student's weekly assessment. Problems included on the assessment were created by the special education teacher and consisted of word problems that included addition, subtraction, multiplication, and division computation. The types of computation required for students to complete remained the same throughout the duration of the study, however content of the problems varied.

The regular education teacher for each student also made additional academic measures, which were completed throughout the school year through use of computer-based programs, available. Computer programs that were used were third grade level

Reading 3D (NCDPI, 2015) which included Text Reading and Comprehension (TRC, Amplify Education, 2015) and Dynamic Indicators of Basic Early Literacy Skills (DIBELS, Good & Kaminski, 2002) Oral Reading Fluency (DORF) fluency and accuracy scores. Reading 3D is a formative early literacy assessment that combines the DIBELS with the TRC measures. DIBELS measures included in the study were DIBELS DORF and DORF Accuracy. DORF measures were gathered by having students read standardized passages based on their reading levels aloud for one minute and errors were recorded. TRC measures were gathered by having students read short books based on their reading levels. After reading the story, students completed follow-up tasks such as answering questions related to oral comprehension and recalling/retelling the story. Additionally, Discovery Ed (Discovery Education, 2015) was used. Discovery Ed measures were gathered by having students complete computer-based probes in the areas of reading and math that were curriculum-based and developed in alignment with state standards. Reading measures included literature, information, foundations, writing, and language. Math measures included operations, base ten, fractions, measurement and data, and geometry.

The last dependent variable for this study was self-concept. Self-concept was measured during the first day of baseline for all students and during maintenance for students one and two. Posttest measures were gathered for student three following his last intervention session due to not having a maintenance phase as a result of absences and the last day of school. Self-concept was measured using the Piers-Harris 2, the Children's Self-Concept Scale (Piers & Herzberg, 2003). The Piers-Harris 2 is a 60-item self-report questionnaire that has been used with children ages seven years and older and took

approximately 15 minutes to complete. Self-concept was measured because it was an area that had been determined to be positively impacted by CCPT interventions in past research (Bratton, Ray, & Jones, 2005). Additionally, students with LDs struggle with self-concept issues and the Piers-Harris 2 was a widely utilized measure in the field when studying these issues (Bear, Minke, & Manning, 2002). The Piers-Harris 2 was found to be both a valid and reliable measure of self-concept in children with LDs and in regards to measuring impact of therapeutic interventions (Piers & Herzberg, 2003). All measures were administered in accordance with any adaptations for test taking that were indicated in the students' IEPs, such as material read aloud.

Inter-Observer Agreement

Social skills measures. Inter-observer agreement (IOA) was collected for the social skills assessments to ensure correct recording of scores. IOA was collected for 30% of the measures in the study by randomly selecting SSRS probes. After students and the special education teacher completed the social skills measures, the researcher gave copies of the SSRS that were not scored to the school counselor to score. The researcher then scored the original assessment and compared it to the copy that was scored by the school counselor to determine IOA. The assessments met at least 80% inter-rater reliability. An item-by-item comparison was done for the social skills assessment. The formula for agreement was Items in Agreement/Total Items x 100% = IOA. IOA training took place before the start of the study. The researcher trained the school counselor on scoring the SSRS through practice of mock SSRS sheets together. The researcher and school counselor then independently scored additional mock SSRS sheets until at least 80% IOA was achieved.

Academic measures. IOA was also collected for academic measures (reading and math) and measures were randomly selected to be reviewed for accuracy for at least 30% of the measures. After students have completed the reading and math measures, the teacher gave a copy that was not scored to the researcher. The researcher then scored the copy of the assessments and compared it to the original that was scored by the teacher to determine IOA. An item-by-item comparison was done for their reading and math assessments. The formula for agreement of academic measures was Items in Agreement/Total Items Scored x 100% = IOA. The assessments met at least 80% inter-rater reliability. The researcher and special education teacher agreed on a way of scoring the six problems by giving one point for each correct step for solving the problem with a total of five points for each problem (30 total points for the assessment). Each correct word for the Maze was scored as one point. The researcher and special education teacher completed practice sessions of scoring sheets from weeks prior to the study together. The researcher and special education teacher then independently scored additional mock reading and math sheets until at least 80% IOA was achieved. The computer-based assessments used to track reading and math achievement do not require collection of IOA data.

Social Validity Data

Social validity data was gathered to measure the social acceptability of procedures and outcomes within the study. As outlined in Wolf (1978) and Horner, Carr, Halle, Mcgee, Odom, and Wolery (2005), social validity is necessary to determine an evidence based practice in single-case design and must assess the social significance and appropriateness of goals, procedures, and/or effects of the intervention. This data was

measured through completion of a questionnaire, which was given to teachers (See Appendix D) administrator/school counselor (See Appendix E), and parent(s) (See Appendix F). Stakeholders (teachers, parents, principal, and school counselor) were asked to complete a questionnaire to gather their perceptions about CCPT and components of the study (procedures and outcomes). The regular education teacher and parent were asked to complete social validity measures following the intervention phase for each student. The special education teacher and school counselor completed their questionnaires at the end of the study to ensure that the raters continued to be blinded to the participation of students in the intervention phase. The principal of the school left his position as principal approximately four months into the study. His questionnaire was completed before he left with the researcher. Questionnaires were completed following the procedures outlined below.

The researcher met with the teachers, school counselor, and principal individually. Each person read the first 16 questions of the questionnaire to him/herself and answered them independently to reduce social desirability. The researcher then read the last four questions to each person in an interview fashion. The questionnaire consisted of 16 questions in which a 5-point Likert rating scale (i.e. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree) were used to determine their perceptions about the CCPT intervention and impact on social skills, academics, and self-concept of students. There were three open-ended questions at the end of the structured questionnaire in which they described their perceptions in more detail and one in which they could provide any other insight desired. The parents of the students were given a similar assessment using the same scale and organization. Their questionnaire contained

nine Likert scale questions and three open-ended questions. Parent interviews took place individually on the phone, as this was more accessible for parents. All questions from the parent questionnaire were read to them over the phone. Parent questionnaires were completed during the maintenance phase for students one and two. Due to absences and the last day of school, the parent questionnaire for student three was done during the end of his intervention phase.

Additionally, an interview was done with students who participated in the CCPT sessions during the maintenance phase (See Appendix G). Due to absences and he last day of school student three completed his questionnaire after his last intervention session. The researcher conducted the interview. The interview consisted of six questions which could be answered with "yes," "maybe," and "no." There were five open-ended questions included in the interview in which students were able to provide additional information about their perceptions regarding the social importance of the CCPT intervention. The social validity measure was administered individually in the school counselor's office according to accommodations stated in the students' IEPs.

Data Analysis

Representing data graphically and visual analysis of the data is used in single subject design research (Cooper, Heron, & Heward, 2014). The graphed data is used to communicate results and is also used monitor progress throughout the research. Graphs provide the researcher with the ability to make valid and reliable decisions about intervention. This study used a line graph to represent total social skills scores obtained after each CCPT session (See p. in chapter 4). As recommended, the graph included a

labeled vertical and horizontal axis, clearly placed and connected data points, appropriately placed labels for condition, and descriptive figure captions.

The meaningfulness of change was evaluated by visually looking at the graph to determine if a functional relation existed between the intervention and behavior change. This was determined by visually analyzing the graph to examine if prediction, verification, and replication were present. This was done by visually inspecting the graph for changes in level, trend, and variability both across and within conditions and or participants. Level was defined as the mean performance during a phase, trend was the rate of change (increase or decrease) otherwise known as the slope of a best-fit line for the dependent variable data points on the graph, and variability was the degree of fluctuation of the data points around the mean/slope during a phase (Horner, Carr, Halle, McGee, Odom, & Wolery, 2005). For example, participant one's baseline phase was compared to the intervention phase to analyze level, trend, and variability. Additionally, participant one's phases were also compared to participant two's phases to determine if prediction and replication were present as well. Specifically, a functional relation was defined by:

> …the occurrence of the phenomena under study as a function of the operation of one or more specified and controlled variables in the experiment in which a specific change in one event (the dependent variable) can be produced by manipulating another event (the independent variable), and that the change in the dependent variable was unlikely the result of other factors (confounding variables)… (Cooper et al., 2014, p.8).

For further explanation regarding single-case design, refer to Horner, et al., (2005). Additionally, the average range for SSRS total scores was be reported as well as scores for each domain scale. Ranges for scores are also reported in Chapter IV.

Experimental Design

The experimental design for this study was a multiple baseline across participants design (Cooper et al., 2014). This design is recommended for use in research in which a desired target behavior is selected for more than one subject and when the behavior can not be reversed. It is the most widely used design and allows for the verification that improvements demonstrated are a direct result of the applied intervention. The order of participants entering the intervention phase was based on severity of need, students with consistently lower scores on their social skills measures were introduced first. The first student began the CCPT intervention after a baseline of six data points on the social skills measure (must have at least five points) in a stable or descending predictable trend. The length of the intervention phase was 16 sessions (two or three times per week) based on a similar study (Blanco & Ray, 2010). New participants were to be added when the prior participant demonstrated at least three consecutive data points on the social skills measure progressing in an upward trend. This was determined by visual analysis of the graphed data points, which were documented in an Excel spreadsheet and graphed. However, the participants in this study did not meet the definition of improvement and completed the 16 sessions before the next participant began the intervention. After the conclusion of 16 sessions, the participants moved to the maintenance phase. The third participant did not enter maintenance phase due to absences and the end of the school year.

In the intervention phase, participant one and two did not demonstrate positive change (as measured by three consecutive data points) in the total social skills score after completion of eight sessions of CCPT, therefore another weekly CCPT session (CCPT Revised) was introduced. Participants one and two attended three, 30-minute CCPT sessions per week during the last eight sessions of the intervention phase. Participant three's intervention phase consisted of three, 30-minute sessions, three times per week for his 16 sessions due to lack of progress seen with the two session per week intervention with the other participants.

Procedures

Informed consent. After students were selected to participate in the study, the school counselor contacted their parents/guardians via a phone call. During this phone call the study was explained and verbal consent to participate was obtained from the parents/guardians. The parents/guardians were invited to meet with the researcher at the school to discuss the study further and ask any questions; however, none of the parents wanted to meet with the researcher. The informed consent letter (See Appendix H) was sent home with the student in a sealed envelope to the parent for signature with a return envelope to bring it back to the researcher. The study did not begin until the researcher had all signed informed consent letters. Additionally, informed consent was gathered from the teachers, school counselor, and principal for their input on social validity measures (See Appendix I). After all consents were received, the researcher also met with the students to obtain assent (See Appendix J) before baseline data was gathered.

Pre-baseline. Immediately before administration of the social skills assessment for baseline, the researcher provided a practice assessment to acclimate students to the

procedure. The practice assessment (See Appendix C) was designed to look similar to the social skills assessment; however, questions contained examples for students to score that were unrelated to the actual social skills assessment. The example assessment contained three practice questions. The researcher followed a script to begin the assessment (also found in Appendix C). The researcher conducted this practice assessment according to accommodations outlined in the students' IEPs in the school counselor's office.

Baseline. Participants were given the Piers-Harris 2 individually in the school counselor's office on the first day of the baseline phase. This assessment was administered by the experimenter according to accommodations outlined in the students' IEPs (e.g. read aloud, items below the one being read were covered). During baseline, the academic curriculum-based assessments were administered weekly by the special education teacher as normally done for progress monitoring of skills in the special education classroom. The researcher administered the social skills questionnaire (SSRS) to the students twice per week during the week(s) of the baseline phase. The researcher read the instructions for completion of the SSRS before administering each assessment. Baseline data was collected until there was a minimum of five data points collected that produced a stable or decreasing predictable trend. This assessment was also administered by the researcher in the school counselor's office according to accommodations outlined in the students' IEPs. The special education teacher completed an SSRS for each student selected for the study one time per week.

Intervention. During intervention, 30-minute CCPT sessions were provided for participant one and two twice per week (eight sessions), and then three times per week (eight sessions). Participant three attended 30-minute sessions, three times per week

during his intervention phase (16 sessions). The sessions took place in the designated playroom and were conducted by the researcher following procedures described in the treatment manual written by Ray (2011). Again, curriculum-based measures were administered weekly by the special education teacher as normally done for progress monitoring of academic skills (reading and math) in the special education classroom. Likewise, the researcher administered the SSRS to the students following each play therapy session. The researcher read the instructions for completion of the SSRS before administering each assessment. This assessment was administered by the experimenter in the school counselor's office according to accommodations outlined in the students' IEPs. The special education teacher also completed an SSRS for each student selected for the study one time per week.

Maintenance. The maintenance phase occurred for students one and two after 16 sessions. At that time the CCPT sessions came to an end. The math and reading weekly academic assessments continued to be collected for the remainder of the study. The researcher administered the SSRS assessment to students one and two during their maintenance phase at least twice per week during the first two weeks following intervention. Additional SSRS assessments were gathered for students one and two during the last two weeks of school for a total of nine SSRS maintenance measures per student. The Piers-Harris 2 (Children's Self-Concept Scale, Piers & Herzberg, 2003) was given within the first two days of the maintenance phase for student one and two and following student three's final CCPT session. These assessments were administered by the researcher in the school counselor's office according to accommodations outlined in the students' IEPs. The special education teacher also completed an SSRS for each

student selected for the study one time per week for the duration of the study to ensure blindness of student participation in intervention.

Procedural reliability. Procedural reliability was gathered through the use of the Play Therapy Skills Checklist (PTSC) (See Appendix K) which was found in Ray (2011). The checklist evaluates specific skills and techniques used by child-centered play therapists. Utilization of the PTSC followed the guidelines that were given in Ray (2011) and was used to evaluate taped sessions to ensure fidelity of the CCPT intervention. Videos of the CCPT sessions (30%) were randomly selected for each student throughout the intervention stage and five minutes of the sessions that were selected were assessed, as outlined by Ray. The researcher and a tenured professor at the university who has experience providing CCPT and supervising CCPT completed the evaluation using the PTSC. The professor and researcher practiced scoring the PTSC by scoring other CCPT clips not associated with the study according to instructions provided by Ray. Practice continued until at least 80% inter-rater reliability was achieved. Assessment levels fell within 80% to 100% for inter-rater reliability and response categories rated as "Non-CCPT Responses" did not exceed 20% to ensure fidelity of the CCPT intervention.

Summary

The purpose of this chapter was to outline the research methodology that was utilized in this study. The previous sections detailed the intended participants, setting and materials, researcher, data collection procedures, data analysis, and experimental design for this study. Visual analysis of the graphed data will be used in Chapter IV to determine if a functional relation is demonstrated, indicating that CCPT has an effect on students' social skills. Academic achievement and pre and post intervention self- concept scores

(total and subscales) are reported in Chapter IV to analyze any change that may have occurred.

CHAPTER IV: RESULTS

The purpose of this study was to examine the impact of individual, child-centered play therapy (CCPT) on the social skills, academic achievement, and self-concept of third grades students identified with a specific learning disability (LD). The impact of CCPT was examined by answering three research questions related to variables of particular importance to students with LD. The first question examined the effects of CCPT on the social skills of third grade students with LD. The second question examined the effects of CCPT on academic achievement, both reading and math, of third grade students with LD. And the third question examined the effects of CCPT on the self-concept of third grade students with LD.

The following sections of this chapter present the results of the study based on the three questions outlined above. The first section of this chapter describes inter-observer agreement (IOA) of administration of the Social Skills Rating Scale (SSRS) and academic assessments (reading and math). The second section discusses procedural reliability of the CCPT intervention. The third section outlines results for each dependent variable: social skills, academic achievement, and self-concept. Lastly, social validity results are discussed for students, parents, teachers, administrator, and school counselor. This chapter concludes with a summary of findings based on the information provided.

Results

IOA Social Skills Rating Scale (SSRS)

Inter-observer Agreement (IOA) data were collected for 30% of SSRS administered to students to ensure correct recording of scores. IOA was determined by completing an item-by-item comparison of SSRS scored by the researcher and SSRS scored by the school counselor. The mean IOA of student SSRS was 100%. IOA was also collected for 30% of SSRS completed by the special education teacher. The mean IOA for SSRS completed by the special education teacher was 100%.

IOA Reading

IOA data was collected for 30% of the Maze reading assessment, which was administered weekly by the special education teacher. IOA was determined by completing an item-by-item comparison for each word chosen to complete sentences in the passage for each student. The mean IOA for reading assessments was 100%.

IOA Math

IOA data was collected for 30% of the six-question math assessment, which was administered weekly by the special education teacher. IOA was determined by completing an item-by-item comparison for each of the five parts required in calculating answers for each problem for each student. The mean IOA of the math assessment was 100%.

Procedural Reliability for Play Therapy Skills

Procedural reliability data for the CCPT intervention was collected throughout the intervention phase or 30% of the sessions for all participants. Procedural fidelity was measured using the Play Therapy Skills Checklist (PTSC) found in Ray (2011) and is

located in Appendix K. The mean procedural reliability for implementation of the CCPT intervention was calculated to be 94% (range 87-100). Response rates of "non-CCPT responses" were also calculated to ensure treatment fidelity. Data for responses rated "non-CCPT responses" was collected for 30% of the sessions for all participants. The mean for "non-CCPT responses was calculated to be 1%, indicating that 99% (range 90-100) of responses used were CCPT responses for the reviewed sessions.

Analysis of Effects of CCPT on Dependent Variables

Question 1: What are the effects of CCPT on the social skills of third grade students with LDs? Results demonstrating the effects of CCPT on social skills are shown in Figure 1. The graph indicates the total social skills score from the student-completed SSRS and the weekly SSRS completed by the special education teacher for each student. Additionally, mean scores for each of the four domains (cooperation, assertiveness, empathy, and self-control) of the SSRS self-report and teacher-completed assessments are shown in Table 1. Overall results for all students regarding the total SSRS scores will be presented followed by individual results for each student below.

During baseline probes, all students demonstrated variability in their total SSRS scores for the self-assessment. Following the introduction of the CCPT intervention twice per week, scores for student one and two initially increased but did not increase three consecutive data points in a row which was defined as improvement for starting the next student in intervention. Following the introduction of the CCPT Revised sessions, both students one and two appeared to stabilize their self-assessment total SSRS scores. Student three responded to the CCPT Revised intervention by indicating an initial increase and stabilization in total SSRS self-assessment scores following the second

session, meeting the defined improvement criteria of three increasing points. However, as the intervention progressed his self-report SSRS scores began to drop and remained variable throughout the intervention. Although he met the criteria for improvement, his remaining scores decreased and displayed variability. Visual inspection of the graph (See Figure 1) indicated that there was not a functional relation for the CCPT or CCPT Revised intervention despite a slight increase and stabilization in total self-assessment SSRS social skills scores for all participants. Therefore, there was no cause and effect between CCPT and the social skills of students in the study.

Additionally, teacher-reported SSRS were gathered for all students. SSRS total scores completed by the teacher dropped then increased for students one and two. Teacher scores for student three initially increased slightly as well. However as the intervention progressed, teacher SSRS scores began to drop and continued to be variable as well. Individual self-report SSRS and teacher reported SSRS scores throughout each phase are described below for each student. Reported ranges indicate the lowest and highest score during each phase for each student. Norms are not provided for these scores, as the SSRS measure for this study was adapted from the original SSRS (Gresham & Elliott, 1990).

Student one. Student one's baseline total SSRS self-assessment data was not the lowest of the three participants; however, he was chosen to begin the intervention because his scores were the only ones to drop after collection of six data points. During baseline probe sessions, student one's mean self-assessment total SSRS score was 35.5 (range 29-43). Scale scores for the SSRS self-assessment during baseline had the following mean scores: cooperation 8.2 (range 8-9); assertiveness 8.0 (range 4-11);

empathy 10.8 (range 7-12); and self-control 8.5 (range 4-12). The teacher-completed total SSRS mean score during baseline was 24.7 (range 22-28). Scale scores for the teacher assessment during baseline had the following mean scores: cooperation 8 (range 7-10); assertiveness 5.7 (range 4-7); empathy 5.7 (range 5-6); and self-control 5.3 (range 5-6).

After the CCPT intervention was introduced, his self-assessment total SSRS scores immediately showed a positive change in level by increasing to 44 after the first session. As the intervention continued, student one's self-assessment scores continued to be variable but remained above the mean baseline score for six of the eight CCPT sessions during intervention at a mean score of 38 (range 35-44). Scale scores for the SSRS self-assessment during the CCPT intervention had the following mean scores: cooperation 8.5 (range 8-11); assertiveness 7.6 (range 5-12); empathy 12.0 (range 12); and self-control 9.9 (range 8-12). The mean total SSRS teacher-completed score during intervention was 24.2 (range 14-27), which was slightly below the baseline mean. Scale scores for the SSRS teacher assessment during the CCPT intervention had the following mean scores: cooperation 8.2 (range 8-9); assertiveness 8.0 (range 4-11); empathy 10.8 (range 7-12); and self-control 8.5 (range 4-12). After eight sessions, the CCPT Revised intervention was introduced due to not meeting criteria of demonstrating three consecutive instances of total SSRS self-assessment increased scores. His self-assessment score immediately increased from the previous two probes to 38 and appeared to stabilize at a mean score of 36.1 (range 35-38) during the CCPT Revised intervention demonstrating a slight change in trend. Scale scores for the SSRS self-assessment during the CCPT Revised intervention had the following mean scores: cooperation 8.0 (range 8); assertiveness 7.5 (range 6-9); empathy 12.0 (range 12); and self-control 8.6 (range 8-11).

Total SSRS teacher-completed scores during CCPT revised were calculated to be at a mean of 28.5 (range 26-31), which was slightly higher than the mean score during the initial CCPT intervention (twice per week model). Scale scores for the SSRS teacher assessment during the CCPT Revised intervention had the following mean scores: cooperation 8.0 (range 8-10); assertiveness 7.5 (range 7-8); empathy 6.0 (range 6-7); and self-control 5.5 (range 5-6).

During the maintenance phase, student one's mean self-assessment total SSRS score was 35.8 (range 34-38). Initially there was an increase in his self-assessment total scores during maintenance (two days after the end of intervention) but then scores appeared to stabilize at 34 three weeks following the end of intervention. However, when measured 11 weeks after the end of intervention, the mean total SSRS self-assessment scores slightly increased. Scale scores for the SSRS self-assessment during maintenance had the following mean scores: cooperation 8.2 (range 8-9); assertiveness 8.0 (range 4-11); empathy 10.8 (range 7-12); and self-control 8.5 (range 4-12). The special education teacher's mean SSRS total score was 24.3 (range 18-28). The teacher-completed total SSRS scores were variable during the maintenance phase, with an increase during the first week after the intervention ended. The last maintenance probe was also collected from the special education teacher at 11 weeks after the intervention ceased. Scale scores for the SSRS teacher assessment during maintenance had the following mean scores: cooperation 7.5 (range 5-9); assertiveness 7.0 (range 5-8); empathy 5.0 (range 3-6); and self-control 4.8 (range 3-6).

Student two. Student two's baseline total SSRS self-assessment data was the lowest and most stable of the three participants with a mean self-assessment SSRS score

of 31 (range 29-42). Scale scores for the SSRS self-assessment during baseline had the following mean scores: cooperation 9.6 (range 9-11); assertiveness 4.1 (range 2-10); empathy 12.0 (range 12); and self-control 5.3 (range 2-9). The teacher-completed total SSRS mean score during baseline was 23.3 (range 15-28). Scale scores for the SSRS teacher assessment during baseline had the following mean scores: cooperation 6.1 (range 5-9); assertiveness 7.2 (range 4-8); empathy 5.4 (range 3-9); and self-control 4.6 (range 3-6).

After the CCPT intervention was introduced, student two's self-assessment total SSRS score immediately demonstrated a positive change in both level and trend, increasing to 35 after the first session with a mean score of 32.8 (range 29-35). As the intervention continued, the student's self-assessment scores remained variable and even began to drop at sessions seven and eight. Scale scores for the SSRS self-assessment during the CCPT intervention had the following mean scores: cooperation 11.0 (range 10-12); assertiveness 3.5 (range 2-5); empathy 11.6 (range 9-12); and self-control 6.6 (range 5-8). The teacher-completed total SSRS mean score during the CCPT intervention was 26.5 (range 24-29). Scale scores for the SSRS teacher assessment during the CCPT intervention had the following mean scores: cooperation 7.5 (range 6-8); assertiveness 8.3 (range 6-9); empathy 6.0 (range 6); and self-control 4.8 (range 3-6). The CCPT Revised intervention was then introduced due to the decrease in scores and not meeting the criteria for improvement of at least three consecutive increasing total SSRS self-assessment scores. Upon introduction of the CCPT Revised intervention, student two's total SSRS self-assessment scores immediately showed a positive change in level and trend from the previous two probes and appeared to become more stable. Her self-

assessment total SSRS score immediately increased from the previous probe (29) to 32 and 34 with a mean score of 31.5 (range 30-34). Although this was slightly lower than the mean score from the initial CCPT intervention, the range of scores was smaller and therefore scores were more stable. Scale scores for the SSRS self-assessment during the CCPT Revised intervention had the following mean scores: cooperation 10.0 (range 9-12); assertiveness 2.8 (range 2-4); empathy 11.9 (range 11-12); and self-control 6.9 (range 6-8). During the CCPT Revised intervention, the teacher-completed total SSRS scores were at a mean of 22.5 (range 22-23). Scale scores for the SSRS teacher assessment during the CCPT Revised intervention had the following mean scores: cooperation 5.5 (range 5-6); assertiveness 8.5 (range 8-9); empathy 5.5 (range 5-6); and self-control 3.0 (range 3).

Maintenance phase self-assessment total SSRS scores remained rather stable at first, then increased at one and two weeks following the end of intervention and were variable when collected at four and five weeks following intervention. The self-assessment total mean score was 33.2 (range 30-37), which was above the baseline mean and more stable. Scale scores for the SSRS self-assessment during maintenance had the following mean scores: cooperation 10.7 (range 9-12); assertiveness 2.7 (range 2-4); empathy 11.8 (range 10-12); and self-control 7.9 (range 7-10). The teacher-completed total SSRS mean score was 19.3 (range 17-25) and was variable during the maintenance phase. Scale scores for the SSRS teacher assessment during maintenance had the following mean scores: cooperation 5.7 (range 5-7); assertiveness 6.7 (range 6-9); empathy 4.0 (range 3-6); and self-control 3.4 (range 3-5).

Student three. Student three's baseline total SSRS self-assessment data was the most variable of the three participants with a mean self-assessment total SSRS score of 34.3 (range 19-44). Scale scores for the SSRS self-assessment during baseline had the following mean scores: cooperation 8.2 (range 5-12); assertiveness 11.8 (range 11-12); empathy 8.6 (range 4-12); and self-control 5.6 (range 0-12). The teacher-completed total SSRS mean score during baseline was 18.9 (range 10-27), which was the lowest for all students. Scale scores for the SSRS teacher assessment during baseline had the following mean scores: cooperation 4.8 (range 3-7); assertiveness 7.2 (range 4-9); empathy 3.6 (range 1-6); and self-control 3.9 (range 1-6). The CCPT Revised intervention was introduced as the initial intervention for this student, due to the appeared stabilization effects demonstrated for students one and two. There was no immediate effect after session one on his self-assessment SSRS scores, however scores increased after session two with a score of 34 and a mean of 33.9 (range 29-41). Total SSRS self-assessment scores were variable throughout the intervention phase. Scale scores for the SSRS self-assessment during the CCPT Revised intervention had the following mean scores: cooperation 8.3 (range 5-12); assertiveness 11.3 (range 10-12); empathy 7.5 (range 3-12); and self-control 6.9 (range 3-12). The special education teacher's total SSRS mean score was 13.6 (range 5-18), the lowest for all students. Scale scores for the SSRS teacher assessment during the CCPT Revised intervention had the following mean scores: cooperation 3.2 (range 2-5); assertiveness 6.6 (range 3-9); empathy 2.0 (range 0-4); and self-control 1.8 (range 0-3). Maintenance data were not collected for student three due to absences and the end of the school year.

Summary

As previously mentioned, there was not a functional relation for the CCPT or CCPT Revised intervention in regards to social skills for students in this study despite a slight increase and stabilization in total self-assessment SSRS social skills scores for all participants. Therefore, there was no cause and effect between CCPT and the social skills of student in the study. However, scales scores for all students in the domains of cooperation and self-control increased as indicated by the self-report measures. Teacher-reported scores for two of the three students increased in all domains.

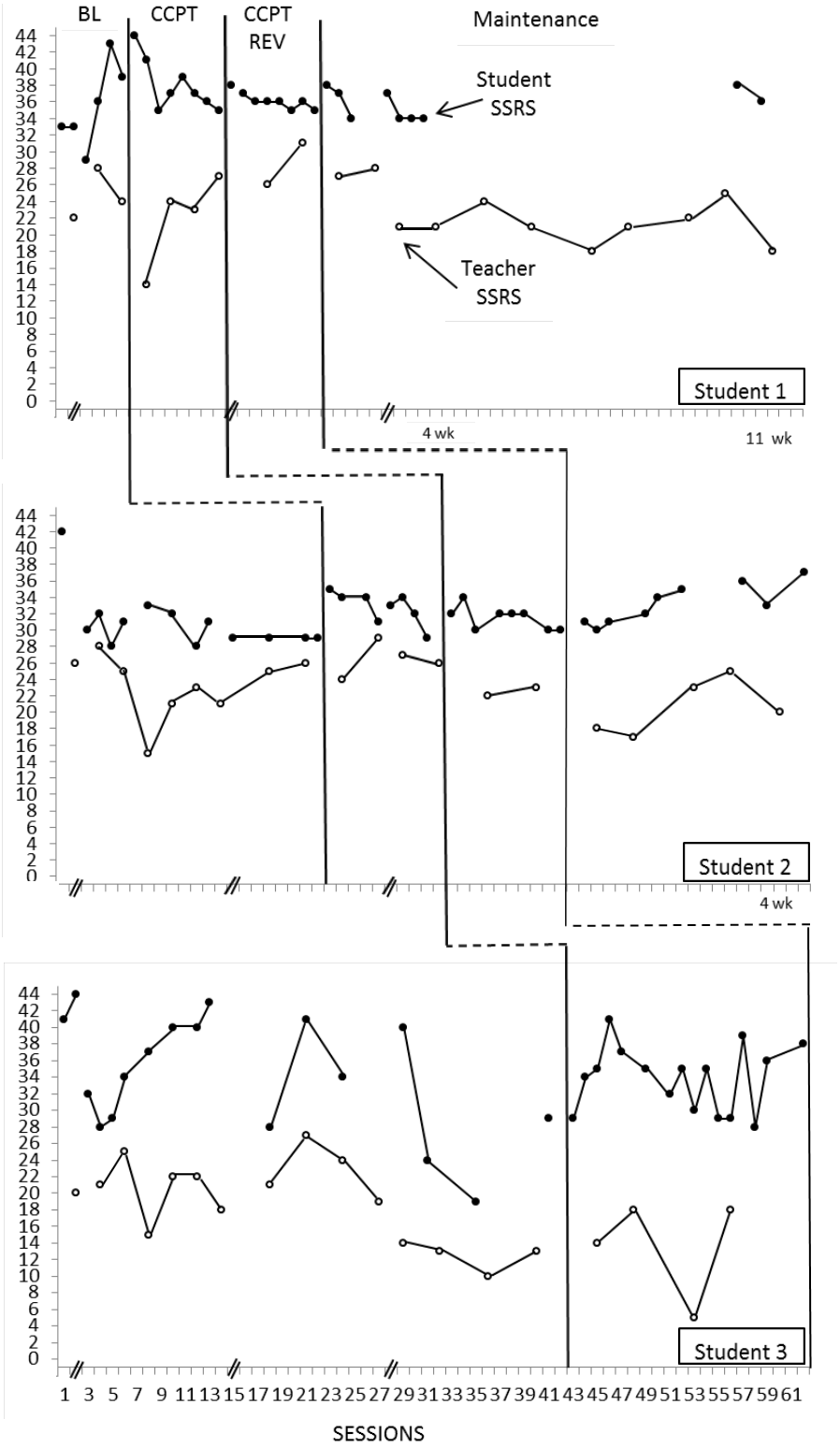

Figure 1: Students' and special education teacher's Total SSRS scores following CCPT sessions.

Table 1: SSRS mean data (n = 3)

	Student 1				Student 2				Student 3	
Domain Scales	B	I	IR	M	B	I	IR	M	B	IR
Self-Assessment										
Cooperation	8.2	8.5*	8.0	8.0	9.6	11.0*	10.0	10.7*	8.2	8.3*
Assertiveness	8.0	7.6	7.5	8.1	4.1	3.5	2.8	2.7	11.8	11.3
Empathy	10.8	12.0*	12.0	12.0	12.0	11.6	11.9	11.8	8.6	7.5
Self-Control	8.5	9.9*	8.6	8.0	5.3	6.6*	6.9*	7.9*	5.6	6.9*
Total Social Skills	35.8	38.0*	36.1	35.8	31.0	32.8*	31.5	33.2*	34.3	33.9
Special Education Teacher Assessment										
Cooperation	8.0	6.0	8.0*	7.5	6.1	7.5*	5.5	5.7*	4.8	3.2
Assertiveness	5.7	6.0*	7.5*	7.0	7.2	8.3*	8.5*	6.7	7.2	6.6
Empathy	5.7	4.8	6.0*	5.0	5.4	6.0*	5.5	4.0	3.6	2.0
Self-Control	5.3	4.0	5.5*	4.8	4.6	4.8*	3.0	3.4*	3.9	1.8
Total Social Skills	24.7	24.2	28.5*	24.3	23.3	26.5 *	22.5	19.3	18.9	13.6

Note. B = baseline; I = CCPT intervention; IR = CCPT intervention revised; M = maintenance. Possible scale scores range from 0-12 for each domain. * = positive change from the previous phase

*Weeks during data collection for baseline vary for self-assessment and teacher assessment based on order introduced into the intervention. Weeks during data collection for maintenance of self-assessment are equal for students one and two. Student three was only present for one day of maintenance. Weeks during data collection for maintenance of teacher assessments vary for all students due to order of exit from intervention and teacher blinded to the study.

Question 2: What are the effects of CCPT on academic achievement (reading and math) of third grade students with LDs? Results demonstrating the effect of CCPT on academic achievement are shown in Table 2. Overall, based on the weekly progress monitoring data provided from the special education teacher, CCPT did not appear to have an impact on academic achievement (reading and math). Additionally, computer-based reading and math data (Reading 3D which includes TRC and DIBELS as well as Discovery Education) provided by the regular education teacher was collected at three and four times throughout the year. Data indicated slight improvement for some students and was variable for other students in the study, therefore no effect was demonstrated

Student one. During baseline, student one's mean Maze (Milone, 2008) reading score was 8 (range 8-8). His mean math score from the special education teacher was 28 (range 26-30). There was no computer-based assessment data available for reading or math during baseline due to students not being assessed during that time. During the CCPT intervention his Maze reading score actually decreased to a mean of 6.75 (range 6-7). His computer-based assessments for reading indicated a Text, Reading, and Comprehension (TRC) score of I, DIBELS Oral Reading Fluency (DORF) fluency score of 36, DORF accuracy score of 88, and Discovery Education (DE) score of 1365. All of these scores were below the expected achievement level for third grade (O, 86, 96, 1454). His math scores remained relatively stable with a mean of 28.8 (range 28-30) and his computer-based assessment for math indicated a DE score of 1461, which was within the achievement target for third grade (at least 1450). During the CCPT Revised intervention, there were no data provided for the Maze reading or computer-based assessments due to students not being assessed during that time. Math scores from the

special education teacher remained relatively the same at a mean of 29 (range 28-30). Maintenance data for the Maze reading appeared to actually increase to a mean of 10 (range 7-15). The computer-based reading assessment data indicated an increased TRC score of L, DORF fluency 66, and DORF accuracy 96, which were all still below expected achievement levels for third grade (P, 100, 97). Reading data gathered from DE slightly decreased during maintenance to 1363, which remained below expected third grade levels (1454). Data for the math assessment from the special education teacher remained stable at 28.8 (range 28-29). Computer-based DE math scores were reported to be 1393, which was a decrease from intervention and fell below the expected achievement target for third grade (1450).

Student two. During baseline, student two's mean reading score was 1.7 (range 0-3) for the Maze. Her the computer-based assessments for reading indicated a TRC of C, a DORF fluency of 3 and a DORF 23, which were all significantly below expected levels for third grade (O, 86, 96). Two assessments were done for DE reading and the mean score was 1340, which was below the achievement target for third grade (1454). Her mean math score from the special education teacher was 23.9 (range 20-26). The DE computer-based math assessment indicated a mean score of 1433, slightly below expected achievement for third grade (1450). During the CCPT intervention her Maze reading score was variable but did increase to a mean of 4 (range 1-7). There were no data gathered for TRC or DIBELS during intervention due to students not being tested during that time period. Her computer-based reading scores for DE were 1324, which was a decrease from baseline and remained below achievement target (1454). Her math scores remained relatively stable with a mean of 25.3 (range 24-27) and computer-based

DE math scores increased to 1460, which fell within expected third grade achievement levels (at least 1450). During the CCPT Revised intervention, student two's Maze reading score was 2 (range 1-3). Only one math score from the special education teacher was provided due to limited assessment during that time which was a 25. There were no data provided for computer-based assessments for reading or math due to students not being assessed during that time. There was only one score given during the maintenance phase for reading and math. Due to end-of-grade testing for all students and the end of the school year, progress monitoring for students in the special education classroom ended. The Maze reading score for student two was 5. The computer-based reading assessment data during maintenance indicated a TRC score of E, DORF fluency score 11, DORF accuracy score 58 which remained significantly below expected third grade levels (P, 100, 97). There was not DE reading data gathered during maintenance due to student not being tested during that time. The math assessment score from the special education teacher during maintenance was 24 and there was no DE math data gathered during maintenance due to students not being tested.

Student three. During baseline, student three's mean reading score was 11.5 (range 8-16) for the Maze. His computer-based reading assessments indicated a TRC score of H, DORF fluency 70, and DORF accuracy 92, which were all below expected third grade achievement levels (O, 86, 96). During baseline, three DE computer-based reading assessments were given. The mean DE reading score was 1312, which was below the achievement target (1454). His mean math score from the special education teacher was 24.7 (range 22-26). During baseline, three DE computer-based math assessments were given. The mean DE math score was 1404, which was below the achievement target

(1450). During the CCPT Revised intervention, his mean Maze reading score dropped to 9.5 (range 8-11). His computer-based reading scores indicated a decreased TRC of D.and increased scores for DORF fluency (82) and DORF accuracy (92) which all remained below expected achievement levels for third grade (P, 100, 97). There was not DE reading scores gathered due to all students not being assessed during that time. His mean math score also dropped to 22.5 (range 20-25). There were no DE computer-based math scores gathered during the Revised CCPT due to all students not being assessed during that time. Student three did not have any maintenance data due to the end of the school year.

Table 2: Academic Achievement mean data (n = 3)

	Student 1				Student 2				Student 3	
Domain Scales	B	I	IR	M	B	I	IR	M	B	IR
Special Education Teacher Progress Monitoring Assessment										
Maze Reading	8.0	6.8	8.0	10.5	1.7	3.3	2.0	5.0	11.5	9.5
Norms	15	15	16	16	4	8	8	8	16	16
Math Problems	28.0	29.0	29.0	28.2	23.7	25.3	25.0	24.0	24.7	22.5
Computer-Based Assessment (Grade 3)										
TRC Score**	-	I	-	L	C	-	-	E	H	D
Goal	-	O	-	P	O	-	-	P	O	P
DORF (Fluency)	-	36	-	66	3	-	-	11	70	82
Goal	-	86	-	100	86	-	-	100	86	100
DORF (Accuracy)	-	88	-	96	23	-	-	58	92	92
Goal	-	96	-	97	96	-	-	97	96	97
DE Reading SS	1362	1365	-	1363	1340*	1324	-	-	1312*	-
Target	1454	1454	-	1454	1454	1454	-	-	1454	-
% Correct	32	35		32	28*	24	-	-	23*	-
DE Math SS	1497	1461	-	1393	1433*	1460	-	-	1404*	-
Target	1450	1450	-	1450	1450	1450	-	-	1450	-
% Correct	69	63	-	47	53*	66	-	-	47*	-

Note. B = baseline; I = CCPT intervention; IR = CCPT intervention revised; M = maintenance. Special education teacher math problem scores have a range of 0-30. TRC = Text Reading & Comprehension; DORF = DIBELS Oral Reading Fluency; DE = Discovery Education; SS = Scale Score. * = mean of scores during phase. ** = level of reading books used which are ordered based on the alphabet A-Z; norms not reported for math because teacher-created, total possible score 30

*Weeks during data collection for baseline vary based on order introduced into the intervention. Weeks during data collection for maintenance vary due to order of exit from intervention and teacher blinded to the study. Academic information was not gathered during the last two weeks of school due to end-of-grade testing.

Question 3: What are the effects of CCPT on the self-concept of third grade students with LDs? Results for the Pier-Harris 2 pre and post measures are shown in Table 3. Prior to intervention, all of the students rated themselves as having an average total score, which is a measure of general self-concept. All of the scale scores were rated in the low average to above average range. After intervention, student scores did change but remained in the low average to above average range. Therefore, overall student self-concept scores did change slightly but CCPT did not appear to have a significant effect on scores. Post intervention scores for each student are presented below.

Student one's self-concept measurements increased on six scales and remained the same (62 above average) on one scale, behavioral adjustment (52). He increased levels on three scales including physical appearance and attributes (52 average), happiness and satisfaction (59 above average), and total self-concept (60 high average).

Student two's self-concept measurements decreased on five scales: behavioral adjustment (43 low average), intellectual and school status (40 low average), physical appearance and attributes (42 low average), popularity (41 low average), and total self-concept (44 low average). One scale measure remained the same, happiness and satisfaction (51 average), and one increased a level, freedom from anxiety (51 average).

Student three's self-concept measurements decreased on five scales: behavioral adjustment (43 low average), intellectual and school status (54 average), physical appearance and attributes (58 above average), popularity (47 average), and total self-concept (52 average). One scale measure remained the same, happiness and satisfaction (51 average), and one increased, freedom from anxiety (48 average).

Table 3: Piers Harris 2 Children's Self-Concept Scale t scores data (n = 3)

	Student 1		Student 2		Student 3	
Domain Scales	Pre	Post	Pre	Post	Pre	Post
BEH	62	62	62	43	49	43
INT	46	51	48	40	59	54
PHY	42	52*	52	42	65	58
FRE	58	65	41	51*	46	48
POP	50	54	47	41	50	47
HAP	51	59*	51	51	51	51
TOT	52	60*	49	44	55	52

Note. BEH = Behavioral Adjustment; INT = Intellectual and School Status; PHY = Physical Appearance and Attributes; FRE = Freedom from Anxiety; POP = Popularity; HAP = Happiness and Satisfaction; TOT = Total Score. Domain scores indicate the following: below 29 = very low; 30-39 = low; 40-44 = low average; 45-55 average; above 56 = above average. Total (TOT) scores indicate: below 29 = very low; 30-39 = low; 40-44 = low average; 45-55 = average; 56-59 = high average; 60-69 = high; 70 or above = very high

*Indicates a positive change in level (e.g. average to above average; low to average)

Session Observations

Session observation notes (Play Therapy Progress Worksheet) were collected by the researcher to document changes in behavior and interactions over the course of CCPT intervention. The session notes format was adapted from a format found in Ray (2011). Behaviors for each session are rated on a continuum and patterns can be observed over the course of intervention. Behaviors that are measured include aggression, self-directed play, energy level, sustainability of play, constructiveness of play, cleanliness during play, verbalizations, response to limits, therapist (researcher) involvement in play, meaningfulness of play, affect, age appropriateness, presence of mastery play, frustration tolerance, and perseverance of play when difficulty arises. All CCPT sessions were recorded and following each session, the researcher completed the Play Therapy Progress Worksheet. The researcher used the same worksheet each time for each student and noted where on the continuum behaviors fell in relation to the previous session. This method was used so that the researcher could use the previous session's rating as a point of reference when determining measures for the current session. Qualitative information presented is based on information from the Play Therapy Progress Worksheets and researcher session notes. A summary of overall researcher observations is presented below followed by individual observations for each student.

Overall, based on the session worksheets for all children (described above) all students demonstrated positive changes in all areas of in-session behavior from the first session to the last session (See Figures 2, 3, and 4). From information recorded on the worksheet, all participants were able to sustain play behaviors and participate in age appropriate, self-directed play throughout all sessions. All participants also ended the

intervention phase with more constructive play and thematic play as well as mastery play. Additionally, all students ended intervention demonstrating more verbalizations and including the researcher in verbalizations more often than in past sessions. All students displayed positive affect throughout all sessions. Shifts in play appeared to occur around sessions five through seven for all students. The students varied in other behaviors during sessions throughout the intervention phase which are described below.

Student one. Student one quickly engaged the researcher in play and exhibited relatively high energy during sessions. During his first CCPT session, his play was somewhat aggressive and had themes of winning and good versus bad. The aggression decreased over the next five sessions but the "winning" theme continued until session 11, when protection and rescue themes emerged. During session 11 his play appeared to become more meaningful and he began playing "with" the researcher instead of playing "against" the researcher. Limits needed to be set every few sessions and he demonstrated self-control by appropriately responding to the limits that were set. When frustration arose in session, he demonstrated higher levels of tolerance and persistence with difficult play during later sessions in intervention.

Student two. Student two played alone for the first six sessions, displaying relatively low energy and somewhat of a flat affect. These sessions contained mainly nurturing and relationship themes about family. During sessions seven through ten, more protective themes emerged and she became very interactive with the researcher during play. Her intensity and expression of affect increased as well as her energy level. Themes changed to self-sufficiency and increased confidence was displayed during sessions 10 through 12, as most of her play involved fixing or building. The last few

sessions contained family and relationship themes and she returned to playing mostly alone, however verbal engagement remained high.

Student three. Student three played alone during the first session and asked many questions about the toys and playroom. His play appeared to be very meaningful, expressing difficulty with peers and schoolwork. Until session five, his play began in the sandbox. During session five his play switched to using creative materials to build things and his in session behaviors were more energetic, constructive, and his verbalizations increased. He also began to talk about his family during the next several sessions. During session seven, mastery and thematic play began to solidify. His play during this session became messier and the intensity of his affect was expressed when he talked about an issue that was painful to him. It was also during this session where a limit was set and he was able to respond appropriately to the limit. Over the next several sessions he continued to play alone, displayed his emotions, and expressed himself verbally. His play displayed themes of aggression and being "stuck". Towards the end of session 11 and throughout sessions 12 through 15 aggressive play was reduced and continued to be constructive. Play returned to more mastery themes in which he began "fixing" and "building". Verbalizations about issues at home and school were prevalent during sessions 15 and 16. Student three demonstrated an in increase in frustration tolerance and persistence when play became difficult.

Summary

Overall all students appeared to demonstrate positive changes over the course of the 16 session intervention. All students began to display increased confidence and greater expression of feelings inside their sessions. Two of the three students appeared to

be working though home and family issues as demonstrated by their play and verbalizations during sessions as well.

Play Therapy Progress Worksheet

Child/Age: Student 1 1st Session Date: 1/22/15 Final Session: 3/17/15 # of Sessions: 16

ASSESSMENT OF IN-SESSION PROGRESS

Continuum of Play Therapy Progress (Rate the characteristic for each session by session number)

	<						>	
Aggressive					1 10 11 12 13	23469 14	578 15 16	No Aggressive Behaviors
Self-Directed Play	8 10 11 12 13 14 15 16	5679	34	1 2				Dependence on Therapist for Play Initiative
Low Energy			11 12 14 15	2 4 13	137 10	689 16	5	High Energy
Sustained play behaviors	12345678 9 10 11 12 13 14 15 16							Inability to sustain play or carry out play scene
Destructive				1	11 12 13 14	23456789 10	15 16	Constructive
Messy		9 14	568 13	4 12	3	7 10 11	1 2 15 16	Clean
Highly Verbal	12345678 9 10 13 14 16	11 12	15					No verbalization
Responds to limits appropriately	158 10 13	14						Breaks limits
Involves therapist in play	35789 10 14 15 16	1246 13	11	12				Plays alone
Involves therapist in verbalization	12345678 9 13 14 15 16	10 11 12						No verbalization or verbalizes as narrative without therapist interaction
Play is thematic, seemingly meaningful	16	11 12 13 14 15	689 10	1357	24			Play is rote, and seemingly meaningless to child
No affect observed						11 12	12345678 9 10 13 14 15 16	Intensity of affect expressed
Positive affect (laugh, smiles, content)	12356789 10 11 12 13 14 15 16							Negative affect (anger, cries, sadness)
Age-appropriate play	12345678 9 10 11 12 13 14 15 16							Regressed play
Mastery play		11 12 13 14 15 16	689 10	3457	1 2			No mastery play
Inability to tolerate frustration				678	12345	10	14	High level of frustration tolerance
Keeps trying when play is difficult	14		10	678	12345			Gives up when play gets difficult

Figure 2: Student one CCPT session observation chart.

Note: numbers equate to session number, if not displayed no session number written

Play Therapy Progress Worksheet

Child/Age: Student 2 1st Session Date: 3/19/15 Final Session: 5/5/15 # of Sessions: 16

ASSESSMENT OF IN-SESSION PROGRESS

Continuum of Play Therapy Progress (Rate the characteristic for each session by session number)

	<						>	
Aggressive						4 8 13	123569 10 11 12 14 15 16	No Aggressive Behaviors
Self-Directed Play	1234567 89 10 11 12 13 14 15 16							Dependence on Therapist for Play Initiative
Low Energy			2 3 12	1 56 11	4 15 16	789 10 13 14		High Energy
Sustained play behaviors	1234678 910 11 12 13 14 15 16							Inability to sustain play or carry out play scene
Destructive							1234678 910 11 12 13 14 15 16	Constructive
Messy						6 11 13 14 15 16	1234578 9 10 12	Clean
Highly Verbal	4678 10 13 14 15 16	59	1 11	2	3 12			No verbalization
Responds to limits appropriately								Breaks limits
Involves therapist in play	789	10	13		15	4 14	12356 11 12 16	Plays alone
Involves therapist in verbalization	789 10 13 14	6 16	5 11 15	1 4	2 3 12			No verbalization or verbalizes as narrative without therapist interaction
Play is thematic, seemingly meaningful	1234567 89 10 11 12 13 14 15 16							Play is rote, and seemingly meaningless to child
No affect observed					12	2356 11	14789 10 13 14 15 16	Intensity of affect expressed
Positive affect (laugh, smiles, content)	1234567 89 10 11 12 13 14 15 16							Negative affect (anger, cries, sadness)
Age-appropriate play	1234567 89 10 11 12 13 14 15 16							Regressed play
Mastery play	1234567 89 10 11 12 13 14 15 16							No mastery play

Inability to tolerate frustration						79		High level of frustration tolerance
Keeps trying when play is difficult				79				Gives up when play gets difficult

Figure 3: Student two CCPT session observation chart.
Note: numbers equate to session number, if not displayed no session number written

Play Therapy Progress Worksheet

Child/Age: Student 3 1st Session Date: 5/6/15 Final Session: 6/9/15 # of Sessions: 16

ASSESSMENT OF IN-SESSION PROGRESS

Continuum of Play Therapy Progress (Rate the characteristic for each session by session number)

	<						>	
Aggressive				10	9	1 7 8 13 16	23456 11 12 14	No Aggressive Behaviors
Self-Directed Play	123456789 10 11 12 13 14 15 16							Dependence on Therapist for Play Initiative
Low Energy		12348 13 14	69 10	57 12	16	11 15		High Energy
Sustained play behaviors	123456789 10 11 12 13 14 15 16							Inability to sustain play or carry out play scene
Destructive						12347 10 11 13	5689 12 14 15 16	Constructive
Messy		27	39 10	1	4 12 15	568 11 13 14	16	Clean
Highly Verbal		5679 11 16	1238 12 15	4 10		13 14		No verbalization
Responds to limits appropriately	7 10		6			15		Breaks limits
Involves therapist in play			15		2 12	3 4 9 10 13 16	1 5 6 7 8 11 14	Plays alone
Involves therapist in verbalization	789 12 16	123456 11 15		10 13 14				No verbalization or verbalizes as narrative without therapist interaction
Play is thematic, seemingly meaningful	10 12 13 15 16	1 7 8 11 14	234569					Play is rote, and seemingly meaningless to child
No affect observed				13 14	1235	46 10 15 16	789 11 12	Intensity of affect expressed
Positive affect (laugh, smiles, content)	123456 8 11 12	10 15 16	7 14	13	9			Negative affect (anger, cries, sadness)
Age-appropriate play	123456789 10 11 12 13 14 15 16							Regressed play
Mastery play	79 10 11 12 13 15 16	1234568 14						No mastery play
Inability to tolerate frustration		9		237 13	48 11	6 16		High level of frustration tolerance
Keeps trying when play is difficult		16	11	237 13	48	6	9	Gives up when play gets difficult

Figure 4: Student three CCPT session observation chart.

Note: numbers equate to session number, if not displayed no session number written

Social Validity

Individual social validity data were gathered for all participants, their parents and teachers which are shown in Tables 4, 5, 6, and 7. General social validity information was gathered from the school principal and school counselor shown in Table 8. Social validity information is presented below for all stakeholders in the study.

Students. All students answered social validity interview questions. The interview included questions related to (a) their preference about going to the playroom, (b) if the time was helpful to them personally, socially, and academically, (c) if they would return to the playroom if able, and (d) if they would recommend their friends go to the playroom if they needed assistance. All students responded either "yes" or "maybe" to all of the closed questions (See Table 4). All students indicated that they liked going to the playroom, that going to the playroom helped them to feel better about themselves, that they would return to the playroom again if given, the opportunity, and that they would recommend friends to the playroom. Students had differing views on if the play therapy sessions helped them deal better with classmates and if sessions helped them in reading and math.

Students also answered additional open-ended questions about (a) what they learned from going to the playroom, (b) what they liked best about going to the playroom, (c) what they did not like about the playroom, (d) what they would change if they were in charge, and (e) anything else they wanted to add about the playroom or play time. Student one expressed that he had fun in the playroom and "started feeling happy every time you (the researcher) came to pick me up." Student two said that she learned that "you should be happy when you play with somebody and to be nice to other people."

Student three explained that he learned that “if I am mad I can come in here an play. I can ask you (the researcher) to help me if I don’t know how to do something.” All students expressed liking the playroom, especially the sandbox. All of the students responded that there was nothing they did not like about the playroom. Two of the three students said they wanted more time in the playroom. When asked if there was anything else to add about their experience, student two said “I hope more people can come in here because it helped me.” Overall, student comments indicated they had positive experiences in the playroom.

Table 4: Student Social Validity Data (n = 3)

Questions	Student 1	Student 2	Student 3
1. I like going to the play-room and playing with my counselor.	Y	Y	Y
2. The play time helped me to feel better about myself.	Y	Y	Y
3. The play time helped me to get along better with my classmates.	Y	Y	M
4. The play time helped me to do better in reading and math.	Y	M	M
5. I would go to the play-room again if I am able to.	Y	Y	Y
6. I would tell my friends to go to the playroom if they needed to feel better about themselves or do better in school.	Y	Y	Y

Note: Y = Yes; N = No; M = Maybe

Parents. All of the students had a parent or guardian provide the researcher with social validity information about their (a) perceptions of the need for their child to have emotional and academic support at school, (b) perceptions of the effectiveness of CCPT sessions in addressing their child's emotional and academic needs (d) thoughts on referring other parents to the CCPT program for their children's needs, (e) impression of how the child enjoyed the CCPT sessions, (f) and feelings on having their child participate in the CCPT program and continuing with CCPT services if made available. All parents responded "agreed or "strongly agreed" to all of the statements on the questionnaire (See Table 5) indicating the CCPT was a positive and effective experience for their children and that other children should participate in CCPT. Specific feedback from parents for each child is presented below.

The parents were also asked to (a) describe any specific changes they noticed in self-concept, social skills, and/or academics, (b) explain any suggestions they may have for improving the use and availability CCPT in the school, (c) explain if they feel CCPT should continue to be offered in the school, and (d) provide any other comments they had about the study or CCPT and their children. The parent of student one described changes in her son by saying "He was more able to talk things out than in the past, he communicates more. He is doing a lot better (with school work) and is able to study by himself more. I notice a difference in him, he made honor roll two times and never have before. It (CCPT) has made him set his goals higher and believe in himself more. He has come out of his shell & asks more questions (when doesn't understand)." Student two's guardian described her changes in the following way "Getting her homework done, she seems to feel a lot better about herself and I think her grades have improved. She is

getting along better with other kids, not as bossy to younger children, especially with her sister. Her self-esteem and confidence in herself has gotten better." Student three's parent said that he has changed in that "He tries and talks more to me (his mom) about things he has learned. He is more open and has more conversations with me (mom) and tries to speak out more. Our relationship has improved. The end of the year has been the better part of the year, he has gotten into some trouble but he tried to manage better (go to the office to cool down instead of getting angry with the teacher). His communication skills improved, he talked more about what he worked on at school. He puts more effort in his academics and finishing classwork at school more often (not getting work sent home as much). He may have shown more overall improvement if he had more time." Overall, all of the parent/guardians felt that CCPT was a positive experience for their children in that their confidence and expression of feelings increased as well as academic tasks. Specific feedback from parents about suggestions and additional comments is presented below.

None of the parents had suggestions for making the CCPT sessions more available, except the parent of student three suggested offering summer sessions for students so that they could continue in the therapy. Additionally, all of the parents expressed that CCPT should continue to be offered in the school. The parent of student one stated "Yes, it is a great program for young people, overall it has a lot of positives. It has greatly changed him" and the parent of student three said, "Yes, they should definitely continue. I hope it can become available to more schools and districts." Additional comments from the parents were also positive. Student one's parent expressed that "It was a great experience and made a difference" and student two's guardian said, "I would like for her to continue next year and for her sister to do it too." Student three's

parent stated, “I did see positive changes in my son. I was getting called (by the school) everyday to pick him up because of behavior but that went down considerably (1 time a week or less).”

Table 5: Parent social validity data (n = 3)

Questions	Parent 1	Parent 2	Parent 3
1. At the beginning of the school year I felt that my child needed some emotional support to be more successful at school.	A	SA	SA
2. At the beginning of the school year I felt that my child needed some academic support to be more successful at school.	A	SA	SA
3. I feel that CCPT sessions are useful and appropriate ways to improve my child's academic achievement.	A	SA	SA
4. I feel that CCPT sessions helped to improve my child's self-concept and social skills.	A	SA	SA
5. The CCPT program was appropriate and beneficial for my child to participate in at school.	A	SA	SA
6. I would recommend to other parents that their children with similar issues be involved in the CCPT program at school.	A	SA	SA
7. My child talked about the CCPT program at home in a positive way.	A	SA	SA
8. I am glad my child participated in the CCPT program.	A	SA	SA
9. I would like for my child to continue participating in CCPT sessions if possible.	A	SA	SA

Note. SA = Strongly Agree; A = Agree

Teachers. Student one and two were in the same regular education teacher's classroom and student three was in a different classroom. All students were in the same special education teacher's classroom for support services. The regular education teachers completed social validity questionnaires for the participating students in their classes and the special education teacher completed social validity measures for all three participating students. All three teachers were asked to rate the same statements for each student in their class related to (a) importance of academic, social skills, and self-concept of students, (b) adequacy of assessment instruments in the study (c) usefulness and appropriateness of the assessments, (d) value of assessing the domains targeted in the study, (e) their views on utilizing the assessments in the future with other students (e) the importance and adequacy of the CCPT intervention, (f) impact of CCPT on the students and the domains measured in the study, and (h) if they would consider having other students participate in CCPT sessions in the future. Teacher responses were varied (See Table 6). Feedback regarding these areas is summarized below.

Teacher opinions were mostly positive regarding the variables, assessment, and CCPT intervention used in the study. However, some discrepancies existed between the ratings of the regular education teacher and the special education teacher, particularly in regards to student three. The regular education teacher "strongly disagreed" with statements indicating that meaningful increases in academic achievement and social skills were observed following the intervention while the special education teacher responded "neutral" to these statements. This discrepancy regarding this student may have been due to the ability of the teachers to separate these variables from the disruptive behaviors student three was exhibiting in the regular education classroom. Overall, the teachers all

"strongly agreed" or "agreed" that academic, social skills, and self-concept were important aspects for intervention with their students. Similarly, all "strongly agreed" or "agreed" that time spent assessing these aspects of the students was a good investment in time, was important, and that information gathered was helpful in better understanding the students. All of the teachers "strongly agreed" or "agreed" that assessing students' social skills and self-concept were valuable practices and helped them better understand the students' academic achievement. Additionally, all of the teachers "strongly agreed" or "agreed" that they were considering using the social skills and self-concept assessment measures for other students. All of the teachers also "strongly agreed" or "agreed" that the CCPT intervention was useful and appropriate in addressing social skills and self-concept for the students and that they are considering using CCPT with other students who have similar needs.

All teachers were also given the opportunity to answer some open-ended questions related to (a) specific changes in student self-concept and social skills, (b) suggestions for making the CCPT sessions more available and useful, (c) how disruptive the sessions were to their schedules, and (d) any other information they wished to contribute about CCPT, the playroom, and/or the study. Overall, the teachers indicated that positive changes occurred in students' self-confidence, academic tasks, and interactions with peers. Specific feedback for each student is presented below.

The regular education teacher noted changes in student one and said "He was not as timid when joining groups or starting something new, and more confident when presenting in front of the class and asking questions. He was more involved. Today he was able to pick a group to join when the activity was already started and was able to

decide who he wanted to work with when given a choice. He showed greater self-awareness and confidence has impacted and improved his academics. He is more willing to ask questions when he doesn't understand a task which has also helped with academic improvements. He is more apt to raise his hand in class and contribute and works better with his peers." The special education teacher noted, "He came to me (the special education teacher) more to tell what someone else had done than in the past (not tattling, just something I should know). The regular education teacher for student two noted changes and reported she was, "more interactive with the students, asking more questions, not afraid to ask questions (hesitant before) with teachers and students. Before she wouldn't complete centers or she would pretend she was doing it. Now she is not afraid to get help." The special education teacher also said, that student two "seemed to 'blossom' and gained more friends." The regular education teacher for student three noted changes and said, "He was better able to communicate to his peers about his wants and needs. He improved in self-calming when upset (would take a while sometimes but able to do it which he was not able to do earlier in the year. He communicated more about what he was thinking and feeling." The special education teacher said she did not see any changes in student three and that it was "hard to tell because of regression to beginning of the school year behaviors towards the middle of the school year (before intervention)." Additional feedback about suggestions and other thoughts they would like to share are presented below.

Overall, the teachers felt that a longer intervention period would have been more beneficial for students, if other students could have participated, and that it was not disruptive to have students out of class for CCPT sessions. The regular education teacher

noted that for student three, “longer sessions would be great because he could do better academically if had time let out what he was feeling. I (teacher) wish I could connect what to do in the classroom with what you (researcher) do in CCPT.” Student two’s regular classroom teacher stated the sessions were, “not disruptive to either (of our schedules), it was beneficial and time well-spent. Two to three times per week was ok to have her pulled from class because I saw changes so I was more accepting to have her out of class.”

The teachers shared other thoughts such as, “It seems it would be beneficial for students with anger issues especially those who don't want to talk about it or doing say something about it which leads to behavior issues” and “She become more open about her family life (mom, not able to see dad) and sharing how she felt with me (teacher). She showed more emotions about her family and was more in touch with her feelings/emotions that she didn't show before. It was a great experience for students, they looked forward to the time. Having this constant in their life is important.” Overall, all of the teachers thought the participation in CCPT was a good experience for students and they saw the benefits of it in the classroom.

Table 6: Regular Education and Special Education Teacher Social Validity Data (n = 3*)*

	Student 1		Student 2		Student 3	
Questions	Regular	Spec Ed	Regular	Spec Ed	Regular	Spec Ed
1. The academic, social skills, and self-concept concerns that were selected for intervention with this student are important.	SA	A	SA	A	SA	A
2. Using his/her individual academic (reading & math) progress as a measure for success for this student is adequate (weekly probes, test scores).	SA	A	A	A	A	A
3. The time spent in the assessment of the student's current self-concept, social skills, and academic achievement was a good investment in understanding this student.	SA	A	SA	A	SA	A
4. The information gathered from the assessment of the student was useful in understanding his/her current state of self-concept, social skills, and academic achievement.	SA	A	SA	A	SA	A

Table 6: (Continued)

Questions	Student 1		Student 2		Student 3	
	Regular	Spec Ed	Regular	Spec Ed	Regular	Spec Ed
5. The curriculum-based assessment procedures that were used to measure academic achievement were appropriate and easy to implement (weekly probes, test scores).	SA	A	SA	A	N	A
6. Assessing the student's self-concept and using the assessment information to better understand the student and his/her academic achievement are valuable practices.	SA	A	SA	A	SA	A
7. Assessing the student's social skills and using the assessment information to better understand the student and his/her academic achievement are valuable practices.	SA	A	SA	A	SA	A
8. I am considering using the social skills and self-concept assessment procedures (such as the SSRS and Piers-Harris2) to better understand my other students.	SA	A	SA	A	SA	A

Table 6: (Continued)

Questions	Student 1		Student 2		Student 3	
	Regular	Spec Ed	Regular	Spec Ed	Regular	Spec Ed
9. Assessing the student's self-concept and social skills are important aspects for understanding this student and his/her academic achievement.	SA	A	SA	A	SA	A
10. The CCPT intervention program for this student was important and adequate.	SA	A	SA	A	SA	SA
11. I noticed meaningful increases in the student's academic skills after the implementation of the intervention.	SA	A	A	N	SD	N
12. I noticed meaningful increases in the student's social skills after the implementation of the intervention.	SA	A	SA	N	SD	N
13. I noticed meaningful increases in the student's self-concept after the implementation of the intervention.	SA	A	SA	N	D	N

Table 6: (Continued)

Questions	Student 1 Regular	Student 1 Spec Ed	Student 2 Regular	Student 2 Spec Ed	Student 3 Regular	Student 3 Spec Ed
14. Individual CCPT is a useful and appropriate intervention to increase the student's self-concept and social skills.	SA	A	SA	N	SA	A
15. Individual CCPT is a useful and appropriate intervention to increase the student's academic achievement.	SA	A	SA	N	A	A
16. I am considering the use of CCPT with other students who have similar social skills, academic, and/or self-concept issues in my classroom.	SA	A	A	A	SA	A

Note. SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree

Administrator and School Counselor. The principal and school counselor also provided social validity data about the (a) importance of measuring academics, social skills, and self-concept of students, (b) the adequacy and usefulness of assessments, (c) thoughts about the use of time to assess students in those areas and use of time in the playroom, (d) use of the assessments and CCPT in the future, (e) usefulness and appropriateness of CCPT as an intervention for social skills, academics, and self-concept. The principal and school counselor had similar responses for several of the items, especially those related to the usefulness and appropriateness of CCPT in the schools which they both rated "strongly agree" (See Table 7). They also "strongly agreed" that schools should gather social skills and self-concept information about students in order to better understand them and their academic achievement. All other areas were rated as either "agree" or "strongly agree." An exception was that the principal responded "neutral" for using the social skills and self-concept measures with other students and using CCPT in the school in the future with other students. Both principal and school counselor commented that teacher response to having CCPT in the school was positive and that there was a need for more mental health services like CCPT in the school. Overall, the principal and school counselor thought that addressing social skills, academic achievement, and self-concept were important and that having CCPT available in the school was an asset for student.

Table 7: Administrator and school counselor social validity data (n = 2)

Questions	Principal	School Counselor
1. The academic, social skills, and self-concept concerns that were selected for intervention with these students are important.	A	SA
2. Using individual academic (reading & math) progress as a measure for success for there students is adequate (weekly probes, test scores).	A	A
3. The time spent in the assessment of the students' current self-concept, social skills, and academic achievement was a good investment in understanding these students.	A	SA
4. The time spent in the playroom was a good investment in supporting their self-concept, social skills, and academic achievement concerns.	A	SA
5. The curriculum-based assessment procedures that were used to measure academic achievement were appropriate and not disruptive (weekly probes, test scores).	SA	A
6. Assessing these students' self-concept and using the assessment information to better understand them and their academic achievement are valuable practices.	A	SA
7. Assessing these students' social skills and using the assessment information to better understand them and their academic achievement are valuable practices.	A	SA
8. I would consider using the social skills and and self-concept assessment procedures (such as the SSRS and Piers-Harris2) to better understand other students in the school.	N	SA
9. Schools should gather self-concept and social skills information from students in general, as they are important aspects for understanding students and their academic achievement.	SA	SA

Table 7: (Continued)

Questions	Principal	School Counselor
10. The CCPT intervention program for these students was important and adequate.	A	SA
11. Individual CCPT is a useful and appropriate intervention to increase social skills of these students.	SA	SA
12. Individual CCPT is a useful and appropriate to increase academic achievement of these students.	SA	SA
13. Individual CCPT is a useful and appropriate intervention to increase self-concept of these students.	SA	SA
14. I would encourage other schools to implement CCPT services in their schools to address academic concerns.	SA	SA
15. I would encourage other schools to implement CCPT services in their schools to address social skills and self-concept concerns.	SA	SA
16. I am considering the use of CCPT with other students who have similar social skills, academic, and/or other self-concept issues in my school.	N	SA

Note. SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree

Summary

This chapter reviewed the IOA of administration of the SSRS and academic assessments (reading and math). High IOA was obtained for all measures as well as treatment fidelity for CCPT. Findings for the effect of CCPT on the dependent variables of this study (social skills, academic achievement, and self-concept) were reported for each student in the study. Although CCPT appeared to have a positive effect on social skills for two of the students, the findings were not significant. Only one student appeared to demonstrate increases in self-concept but findings were not significant. There appeared to be no effect on the academic achievement of students in the study. Additional information about in-session behaviors and changes were presented for each student as well. Finally, social validity results were reported for students, parents, teachers, the administrator, and the school counselor. All involved in the study reported positive changes as a result of the CCPT and the value of CCPT in addressing the social skills and self-concept needs of students. There were mixed thoughts on the effectiveness in addressing academic achievement.

CHAPTER V: DISCUSSION

The purpose of this study was to determine if child centered play therapy (CCPT) was effective in increasing the social skills, academic achievement, and self-concept of third grade students with specific learning disabilities (LD). A multiple baseline across participants single case design was used to determine impact of the independent variable on the dependent variables. This chapter will provide an overview of the study, results and conclusions, contributions of the study, limitation of the study, implications of the findings, recommendations for future research, significance of the study, and concluding remarks.

Overview of the Study

Increasingly, school counselors are required to meet the needs of students in special education (ASCA, 2005) and about 13% of public schools' population is being served by special education (NCES, 2014). Students with LDs contribute to the largest portion of those in special education and present with learning challenges. As a result, students with LDs face unique issues and have unique needs that must be appropriately addressed within the school. Often, these students display socioemotional issues in addition to academic struggles (Kavale & Forness, 1996; Walker & Nabuzoka, 2007). Currently, special education and counseling researchers are not adequately addressing the social and emotional needs of students with LDs, as much of the research is outdated or nonexistent. It is therefore imperative that school counselors have access to current

research that can guide them in appropriate interventions to address the needs of students with LDs.

One type of therapy that has proven to be effective in addressing the social, emotional, and academic needs of various types of children is CCPT (Bratton et al., 2005; Bratton & Ray, 2000; Ray, 2011). However, the impact of CCPT specifically with students with LDs has not been explored. The purpose of this study was to add to the literature about effectiveness of CCPT in addressing the social skills, academic achievement, and self-concept of third grade students wit LDs. The following section will discuss the results and conclusions drawn from this study.

Results and Conclusions

The following outcomes were found based on the research questions that guided the investigation. With regard to the first research question investigating the effects of CCPT on the social skills of third grade students with LDs, visual inspection of the data (See Figure 1) revealed that a functional relation was not present between the introduction of CCPT and the social skills of the participants. Although the data indicated slight positive changes and stabilization of Social Skills Rating System (SSRS) total scores, it was not enough to demonstrate an effect (change in level, trend, and variability both across and within conditions and or participants). Therefore, there was no cause and effect relationship established between the variables. This may be due to the already elevated scores provided by the students (possibly attributed to social desirability) which created a ceiling effect on the data.

These findings seem to be consistent with those found in Kascsak (2012) in which increases in SSRS scores were noted for kindergarten students following a group CCPT

participation but scores were not significant. Kascsak attributed the lack of significance to the lack of sensitivity of the instrument, the timing of measure, and carry over effects into the control group. These issues were addressed by the researcher of this study by adjusting the Likert scale for the SSRS to five points, measuring social skills throughout intervention and postintervention (for students one and two), and by utilizing a single case design in which the participant serves as his or her own control. However, lack of demonstration of significant effect of CCPT on social skills in this study may be attributed to the appropriateness of this instrument (SSRS) for single case design and the ability of this population to utilize self-report measures.

Typically, single case design utilizes observational behavioral measures (Cooper, Heron, & Heward, 2014) and the adapted SSRS measures were perceptual (student and teacher report). Additionally, lack of significant findings may be due to the fact that students with LDs require more repetition and longer time periods for new learning and remediation (intensive intervention) (Fuchs and Fuchs, 2009). Therefore, it is a possibility that the number of sessions or session length may have not been intensive enough for this population. Similarly, CCPT literature indicates that optimal effects are seen in longer treatment periods such as 30 to 35 sessions (Bratton, et al., 2005). There has not been any other literature published that specifically examined the impacts of CCPT on social skills.

In regards to the second research question that examined the effects of CCPT on academic achievement (reading and math) of third grade students with LDs, inspection of the data indicated that CCPT did not appear to have an impact on reading and math scores. Reading and math scores, both for weekly measures and computer-based

measures, remained variable and below expected norms throughout the study. This variability in scores was possibly due to the inconsistent learning patterns of students with LDs (Beattie & O'Brien, 2011). Also, academic measures were not done on a consistent basis due to changes in school schedules and student absences. Additionally, computer-based assessments were only done four times per school year. Therefore, scores were not readily available during all phases of the intervention. It is further difficult to discern whether changes in academic achievement were due to the intervention or other academic learning/classroom interventions that naturally occurs over the course of the school year. It should also be noted that qualitative data gathered from teachers and parents, through social validity measures, indicated that CCPT had some positive impact on academic achievement for most students. Therefore, it warrants further investigation to determine if consistently collecting student academic measures immediately following each CCPT session would produce different results..

Findings from this study do not match those of similar studies found in the CCPT literature. Blanco and Ray (2011) reported that academic achievement (measured by the Young Children's Achievement Test, YCAT at pre and post intervention) indicated statistically significant increased scores following biweekly, 30 minute, CCPT sessions over eight weeks for at-risk first grade students. Blanco, Ray, and Holliman (2012) extended the biweekly, 30 minute CCPT sessions to 26 sessions and found statically significant increases in academic achievement (measured by the YCAT preintervention, midintervention, and postintervention) as well. Differences in findings may be due to the differences in population and varying academic expectations and upper grade levels. Students with LDs display brain-based disruptions in cognitive processing that impact

learning and ultimately academic achievement. These biological deficits may not be impacted by the conditions and skills used during CCPT in relation to academic achievement. Additionally, as students progress in school, differences in achievement levels and expected achievement levels widen (Fuchs & Fuchs, 2009). Therefore, achievement gaps displayed in third grade may have more of an impact than in first grade and may be more difficult to remediate. Similarly, it is expected that third graders will have greater and more complex academic skills to master than students in first grade. These complex academic skills could be more difficult to address through CCPT as well. The Blanco and Ray (2011) and Blanco et al. (2012) studies also used the YCAT to measure academic achievement instead of classroom curriculum-based measures, which may not have accurately measured the academic achievement of students in comparison to their classroom performance.

With regard to the final research question about the effect of CCPT on self-concept of third grade students with LDs, inspection of the data (See Table 3) indicated that CCPT did not appear to have an impact on self-concept. Student scores remained in the low average to above average range. Although positive changes were noted in some areas, they did not appear to have an impact on others. One explanation may be due to initial self-concept scores falling within average limits, which is consistent with the literature. As noted by Elbaum and Vaughn (2003), self-concept scores that are at an acceptable or normal level are less likely to be changed by intervention. Previous studies also indicated that when students with LDs had lower self-concept scores during pre-intervention, greater increases in self-concept scores were noted at post-intervention (Elbaum & Vaughn, 2003; Therrien, Zaman, & Banda, 2010). Additionally, the most

significant gains were noted in self-concept of middle school students who initially had low self-concept. Therefore, the level of initial self-concept, as well as age and grade level of the students may have been a factor in impacting the effectiveness of CCPT as an intervention for the self-concept of this population.

Length of the CCPT intervention may also be a factor in the lack of significant self-concept findings. Fall, Navelski, and Welch (2002) conducted a group design study with students in first through fourth grades who were enrolled in special education with various diagnoses (including LD). Students met for 30 minute individual CCPT sessions once per week over the course of six weeks. They did not find support for a relationship between the CCPT intervention and increases in self-efficacy of children identified by the special education system. It was noted that the students in the study exhibited an extreme external locus of control and that developing trust in themselves may have required a longer intervention. However, past CCPT research indicated that CCPT had a medium to large effect size on self-esteem/self-efficacy measures (Lin & Bratton, 2015) and that self-concept is one of the most significant areas positively impacted by CCPT (Bratton & Ray, 2000). This difference between the past CCPT research and the current study may be attributed to the population used for the past studies and the current study. The majority of studies done to measure self-concept used participants that were not identified for special education services and/or identified with LDs. Therefore, impact of CCPT on the self-concept of students with LDs has not yet been accurately measured and the presence of LDs may impact the effectiveness of CCPT in addressing self-concept.

Additional findings from in session observations found in Chapter IV (see Figures 2, 3, and 4) indicated that changes in sessions were also seen outside of sessions by teachers and parents. All students began to display increased confidence and greater expression of feelings both inside and outside of their sessions. For example, during the last few sessions student one began directing the therapist in play more and appeared more confident, which was consistent with teacher reports of increased confidence in the classroom during social validity interviews. Similarly, student two began playing out scenes related to family and relationship while in session. Her teachers noted during social validity interviews that they observed increased confidence in the classroom and that she was expressing her feelings more about family issues. Student three also verbalized more about his family and relationships within session and displayed play about "fixing" things and becoming "unstuck." During one session he became visibly upset but was able to calm himself down. This is consistent with teacher reports during social validity interviews which indicated that he was better able to calm himself down in class when upset and expressed his feelings more appropriately. It is therefore important to measure changes in behavior both inside and outside of the session, which has not yet been done in the literature.

Contributions of the Study

This was the first multiple baseline study in counseling to be done that followed the guidelines for evidence-based practice in single case design set forth by Horner et al. (2005). It is important to follow these guidelines when conducting single case design research because if these specifications are not followed, then conclusions cannot be drawn about cause and effect relationships among variables. Also, since these guidelines

are the standard for single case research in special education, it is imperative to follow their specifications when conducting research with children in special education. Therefore, following these guidelines ensures that fidelity of the design is met which allows for counselors to make reputable and impactful contributions to both the special education and counseling literature.

Additionally, this study addressed the call for more experimental research with children that has specific measures (Bratton & Ray, 2000), has the ability to monitor individual trajectories of growth (Zimmerman, et al., 1997), and is easily replicated and analyzed (LeBlanc & Ritchie, 2001). The multiple baseline design used in this study met all three of these recommendations and can be used as a model for future counseling research. Specifically, this study addressed the need to enhance the rigor of experimental designs and examination of treatment integrity of CCPT in research, which was a concern in the CCPT literature (Lin & Bratton, 2015).

This study was also the first to explore the impact of CCPT on social skills, academic achievement, and self-concept of third grade students with LDs. Past literature called for a need to address effectiveness of social skills interventions on academic achievement (Malecki & Elliot, 2002) as well as more comprehensive approaches to address self-concept and academic achievement of students with LDs (Emenheiser, 2013).

Additionally, this study addressed the need for school counselors to address the social, academic, and emotional needs of students, and in particular the needs of students in special education (ASCA, 2005). It provided a means for exploring the effectiveness of a holistic approach, such as CCPT, in appropriately meeting these needs in a school

setting. This study provided a foundation for future research in this area and contributed to the dearth of current related literature.

Finally, this study addressed the need to conduct empirical CCPT research in conjunction with treatment integrity measures. This study was the first to use the Play Therapy Skills Checklist (PTSC, Ray, 2011) and document treatment fidelity measures using two highly trained observers throughout the intervention. This is important because fidelity measures are a requirement for single case research and also help to strengthen the body of research literature in CCPT. Additionally, a positive relationship has been demonstrated between treatment integrity and treatment outcomes (Lin & Bratton, 2015). Therefore, it is important that researchers conducting CCPT studies and school counselors be adequately trained to appropriately implement CCPT, as well as measure fidelity of the treatment model.

Limitations of the Study

This section will discuss limitations of the current study that may have impacted results. Specifically, the use of the adapted SSRS as a measure, the intervention length and timing, and student and teacher bias will be discussed.

The SSRS as a Measure of Social Skills

The first limitation is the use of the SSRS as a measure for social skills. The SSRS was specifically selected for this study due to the focus on social skills and the alignment of item scales with the components of CCPT, as discussed in Chapter III. Additionally, the SSRS was adapted for this study based on the recommendations of Kascask (2012) and those outlined for single case design measures (Cooper, Heron, & Heward, 2014). Kascak (2012) suggested that the original three point Likert scale was not

sensitive enough to differentiate positive changes in behavior. Therefore, the researcher expanded the scale to include five points (Never = 0, A Little = 1, Sometimes = 2, Often = 3, and Very Often = 4). Additionally, the researcher included criteria explanations for each point on the scale which was also a criticism of the original scale. The researcher allowed students to practice completing the scale using unrelated examples to the study to enhance participant understanding of instrument completion. Different assessments may need to be used to address these limitations due to student developmental levels and learning issues associated with LDs.

The use of a perceptual and not a behavioral measure of social skills is another limitation of this study. The SSRS and adapted version used in this study are self-report (student) and teacher-reported perceptual measures which are not usually used in single case design research. In applied behavioral analysis, which is the foundation of single case design research, the researcher must use procedures that accurately measure observable, behavioral changes (Cooper, Heron, & Heward, 2014). Behavioral measures in single case research must have the ability to be observed and counted repeatedly through time (repeatability), measured over a duration of time (temporal extent), or measured in a point in time when it occurred (temporal locus). Merrell (2001) discussed the importance of using naturalistic behavioral observation when assessing social skills and suggests that it is unclear to what extent self-report evaluation accurately assesses the social skills of children. He also questioned the ability of children with significant social/behavioral problems to accurately report their social skill deficits. Merrell also recommended that direct naturalistic observational assessment be combined with

behavioral rating scales and that a variety of settings and raters be used during assessment.

The Sixteen Session Intervention and Timing

Another limitation of this study is the number of play therapy sessions used during intervention. A two session per week, 16 session CCPT intervention model was used in this study in accordance with a recent study done in the school setting (Blanco & Ray, 2011). Three sessions per week were added due to the lack of significant change observed in student SSRS scores to determine if a more intensive approach was needed for this population. The literature indicated that CCPT provided significant results in many different problem areas (including social skills, academic achievement, and self-concept) in as little as 12 to 13 sessions (LeBlanc & Ritchie, 2001; Ray, et al., 2015) which suggests its effectiveness as a short-term intervention for schools. Additionally, Landreth (2012) discussed the use of intensive play therapy to accelerate the therapeutic process and the use of short-term play therapy with special populations. Research in both types of "non-traditional" CCPT have demonstrated significant positive results in problems related to learning, behaviors, and self-concept. Therefore this limitation could be addressed by implementing a more intensive approach (four or five days per week CCPT model) with this population.

Another limitation in this study is the timing of the intervention within the school year and interruptions in attendance of students. The study took place after the winter holiday break throughout the end of the school year. There were times in which the students were not able to attend due to weather or holiday breaks; therefore, the researcher was unable to collect data or conduct CCPT sessions during those times. There

were also times throughout the study in which students were absent from school and could not be seen on their regular session day. Also, due to the location of the playroom and alternative uses for the room when not in session, adults working in the building for various reasons sometimes interrupted CCPT sessions. This change and disruption in routine may have had an impact on effectiveness of the CCPT sessions, as structure and predictability promote safety and strengthen the therapeutic relationship (Landreth, 2012).

Student Issues

There are also limitations related to student issues. One limitation is that students completing the self-report self-concept measures during baseline reported average to above average scores (See Table 3). Similarly, initial baseline SSRS self-report scores were also high (see Figure 1 and Table 1). These elevated pre-intervention scores may be partially due to social desirability of the students in their responses. In particular, students often rated statements such as "I follow the teacher's directions, I listen to the teacher when a lesson is being taught, and I disagree with adults without arguing or fighting" as "very often;" however, the teacher rated the students lower in those areas. It is possible that students responded to statements on the SSRS according to what they thought was the socially appropriate answer instead of what was really occurring in their lives.

Another limitation is that over the course of the study, students met with the researcher to collect baseline data, intervention data, and maintenance data. It is possible that during these times, rapport and relationship were built between students and researcher. Students may have initially reported "more positive" scores due to not knowing the researcher and wanting to maintain a positive image. Scores may therefore

have decreased as students became more trusting of the researcher and more open within the therapeutic relationship. This could have had an impact when using student self-report measures.

The last limitation is that it was impossible to know or measure how the emotional issues of the students impact their social skills or perceptions of social skills. After the study began it was brought to the researcher's attention that students two and three had considerable challenges in their lives outside of school that likely impact their social, academic, and emotional functioning. Student one, who demonstrated the greatest improvement in self-concept and in other areas according to teacher and parent reports, did not have any of these outside issues present. It is believed that due to the additional emotional issues they were dealing with, students two and three may have required additional sessions to successfully make improvements. For example, towards the end of intervention, student two appeared to be working through feelings surrounding family issues that may not have been resolved by the time the intervention phase ended and may have impacted self-report social skills scores. Student two's teacher and guardian also reported that she was talking more about family issues and feelings at home and in the classroom. It is the opinion of the researcher that the student would have benefited from continued CCPT sessions, which may have increased self-concept scores and SSRS scores. Similarly, student three was not diagnosed with a behavior disorder but it was noted in his evaluation report that he displayed behavioral problems in school and at home. As the school year progressed, these behavioral difficulties began to escalate in the classroom often resulting in removal from the classroom and/or school. Therefore, when CCPT began with student three, he was exhibiting elevated levels of aggression and other

non-compliant behaviors which may take longer to address than is capable during the 16 session model and may have impacted social skills scores. Once CCPT began, student three also began expressing feelings about family and home issues and these issues may also have impacted treatment.

Implications of the Findings

The purpose of this study was to measure the effectiveness of CCPT on addressing the unique social, academic, and emotional needs of students with LDs, as recommended by ASCA (2005). The results indicated that although some positive impacts were demonstrated and noted by participants and other stakeholders, a cause and effect relationship was not established. This has several implications that will be discussed below.

School Counselors

The first implication from this study for school counselors is that school counselors need to utilize appropriate measures and screen students before beginning individual interventions. First, this study confirmed that the area of social skills is a complex construct (Kavale & Forness, 1996) that is difficult to address and measure. Therefore, school counselors need to use a variety of interventions and measurement tools when addressing social skill development of students with LDs. Second, this study confirmed that not all students with LDs have below average self-concept. All of the students in this study rated themselves within average limits for self-concept before the study began. School counselors should do adequate screening before implementing an intervention designed to address either social skills or self-concept, and more importantly, school counselors must be certain that the students they serve are actually in

need of intervention and not assume that they require intervention simply due to having an LD diagnosis.

Another implication is that this study provided an appropriate model of service that future counselors could use in their schools. The intensive (30 minute, two or three session per week) CCPT model appeared to be appropriate for the school setting based on teacher, administrator, and school counselor feedback. They all indicated that this model did not disrupt student or teacher schedules and did not interfere with their school day. All of the stakeholders expressed positive impressions about the CCPT sessions and actually thought that students could benefit from additional time. They felt that the time spent in the sessions helped to increase academic student engagement rather than impede students academically by missing class time. This information is important because school counselors are often hesitant to pull students from class for counseling interventions due to the fear of interfering with student learning.

The last implication for school counselors is that this study provided an applicable model for research in schools that can be done by school counselors. Schools are generally concerned with the growth and development of individuals and seek individualized approaches to meet LD students' educational needs. School counselors are required to gather data to drive interventions, monitor existing practices, and utilize evidence-based practices (ASCA, 2005) when working with students. This study demonstrated the applicability of the multiple baseline, single case design methodology in the school setting for counselors to not only measure progress but also conduct research. School counselors may be hesitant to perform experimental design studies in schools due to the complex nature of statistical analysis required by traditional

methodology. This design could be easily implemented in the school and data was not difficult to analyze. This study has provided a model for school counselors to perform experimental studies that adhere to guidelines for evidence-based practices, allow for progress monitoring of individual growth, and produce data that is easily analyzed with minimal training and can be analyzed without expensive statistical packages or statistical knowledge.

Counselor Educators

The first implication for counselor educators is that school counseling students be taught to use the multiple baseline, single case design methodology and guidelines for evidence based practice (Horner, et al., 2005). It is important for school counselors to conduct experimental research that adequately measures the individual impacts of counseling interventions for all students. Counselor education programs should seek to partner with experts in single case design (special education departments) to ensure adequate training in this type of research. This is imperative because effect sizes have been shown to be greater when school counselors are the primary interventionist instead of an outside mental health professional (O'Mara, Green, & Marsh, 2006). Additionally, counselor educators should consider allowing future school counselors (and all future counselors) to complete a single case design course as part of their required research programming for both master's and doctoral degrees. Similarly, another implication is that school counselors be adequately trained in CCPT so that they are able to adequately provide the intervention and are able to measure treatment fidelity which also impacts effectiveness of CCPT (Lin & Bratton, 2015).

Recommendations for Future Research

This study has provided a foundation for future research about using CCPT to address social skills, academics, and self-concept of students with LDs. While the findings in this study were not significant, positive changes in scores combined with positive stakeholder observations and past research indicate that using CCPT with students with LDs is a viable intervention and continues to be an area that should be considered for future research.

The first recommendation is that future single case design research in the field of counseling utilize naturalistic behavioral observation tools instead of or in conjunction with perceptual measures. Several factors in this study may have impacted the perceptions of students and teachers in their ratings. It has been noted that divergence exists in self-reported social skills and direct measures of social skills and that naturalistic observation is preferred for social skills assessment purposes (Merrell, 2001). Additionally, direct behavioral observation is the standard in single case research (Cooper, Heron, Heward, 2014), therefore it is believed that utilizing such measures is warranted. Therefore, future researchers should seek out or develop measures for social skills that can be easily observed and recorded. For example, many of the SSRS items could be changed into behavioral measures such as, “the student asks classmates to join in an activity or game, the student follows the teachers directions, the student disagrees with adults without arguing or fighting.” The measure would be created based on the areas of concern noted in the initial screening (full original SSRS). An outside observer could keep a tally of how many times the student does the specific behaviors within a time period (i.e. 5 minute intervals for 30 minutes) during various times of his or her day

(classroom, lunch, recess, special class). Additionally, future researchers should seek to replicate this study using the multiple baseline design with similar participants. Single case research is strengthened the more it is replicated. Replicating single case CCPT research would add to the empirical support of CCPT interventions with children and generalizability of results.

Another recommendation is that researchers conduct pre-intervention screenings for students to determine the level of emotional issues that may confound results. It is recommended that the researcher use a tool such as the Child Behavior Checklist (CBCL, Achenbach & Rescorla, 2001) to conduct screenings of both externalizing and internalizing behaviors which may be linked to emotional issues of children. If elevated levels are indicated, this may be used as exclusionary criteria when measuring social skills. Similarly, future research may want to examine the relationship between emotional issues of children and social skills.

Additionally, future research may also want to examine not only the academic achievement of students but also the level of academic engagement. It is recommended that researchers continue to measure academic achievement using curriculum-based measures, as these types of measures are utilized in schools and serve as the measure for academic success of students. Curriculum-based measures are not only the standard in schools, they are also readily available and are less intrusive to the teacher and student, as well as the learning environment. Students and teachers do not have to be disrupted to conduct additional assessments for research about academic achievement since the curriculum-based measures already exist as part of the school schedule. Therefore, it makes sense to measure impact on academic achievement through the use of classroom

measures, which are used on a regular basis in schools and are readily available versus packaged achievement scales. How CCPT impacts academic engagement is another area to be explored by future research. Many of the teachers commented that the students in the study displayed behaviors that indicated greater engagement in their learning and in the classroom such as, raising their hands to contribute or ask questions, joining work groups in the classroom without prompting or direction, and task completion. These areas could easily be transformed into a naturalistic observation tool that may be used to record behaviors that are associated with academic engagement. After transformed into an observational tool, researchers could measure the changes in academic engagement during a multiple baseline single case design study.

Given that teachers (and parents) reported improved confidence and expression of feelings in students following CCPT, it is recommended that further research be done about impact of CCPT on changes in confidence and expression of feelings as well as the relationship between behaviors displayed inside and outside of CCPT sessions. Therefore, further research is warranted in measuring impacts of CCPT on these areas as well.

Finally, it is recommended that continued research be conducted utilizing CCPT as an intervention for students with LDs. There is a dearth of literature concerning the use of CCPT with students with LDs. The current study indicated positive impacts of CCPT on students with LDs, however findings were not significant due to a wide array of possible factors previously discussed including session length. Since 30 to 35 sessions has been reported as the optimal treatment length for CCPT in past literature (Bratton, et al., 2005), it may be advantageous to examine how increased sessions may impact

students with LDs. It is therefore, recommended that future research continues to investigate how increased intervention length (longer than 16 sessions) or more intensive (four or five session per week) models impact the significance of results with student with LDs.

Concluding Remarks

A review of research indicated that there was a paucity of research in the area of effectiveness of CCPT in addressing the social skills, academic achievement, and self-concept needs of students with LDs. Additionally, there was no research measuring the individual growth of students with LDs following participation in a CCPT intervention. This study utilized an experimental design, followed standards for evidence-based practice in single case research, and maintained treatment integrity in providing a CCPT intervention for students with LDs. Although this study did not demonstrate a functional relation between CCPT and social skills of third grade students with LDs, findings from this study have provided a foundation for future research in regards to new methodology (multiple baseline design), research and intervention models for school counselors, and impacts of CCPT for students with LDs. Continued research along with adequate training and appropriate research design methodology in these areas could have great impact for school counselors and the students they serve.

REFERENCES

Achenbach, T. M., & Rescorla. (2001). *Manual for the ASEBA school- age forms and profiles.* Burlington: University of Vermont, Research Center for Children, Youth, & Families.

Ahearn, E. M. (July, 2008). *State eligibility requirements for specific learning disabilities.* [web document]. Retrieved from http://www.nasdse.org/Portals/0/Documents/StateEligibilityRequirementsforSpecificLearningDisabilities.pdf

Amplify Education (July, 2015). *Text Reading and Comprehension*. Retrieved from https://www.mclasshome.com/wgenhelp/DN3DM/desktop/Reading_3D/Assessment_Scoring/TRC/Text_Reading_and_Comprehension.htm

American School Counselor Association. (2005). *The ASCA national model: A framework for school counseling programs (2nd ed.).* Alexandria, VA: American School Counselor Association.

Axline, V. M. (1947). Nondirective therapy for poor readers. *Journal of Consulting Psychology*, *11*, 61-69.

Baggerly, J. (2004). The effects of child-centered group play therapy on self-concept, depression, and anxiety of children who are homeless. *International Journal of Play Therapy, 13*, 31-51. doi:10.1037/h0088889

Baggerly, J. & Bratton, S. (2010). Building a firm foundation in play therapy research: Response to Phillips (2010). *International Journal of Play Therapy, 19*, 26-38. doi: 10.1037/a0018310

Bear, G., Minke, K., & Manning, M. (2002). Self-concept of students with learning disabilities: A meta-analysis. *School Psychology Review, 31*, 405-427.

Beattie, J. & O'Brien, C. (2011). *Teaching students with special needs: A guide for future educators.* Dubuque, IA: Kendall Hunt Publishing Co.

Bills, R. E. (1950). Nondirective play therapy with retarded readers. *Journal of Consulting Psychology, 14*, 140-149.

Blanco, P. J., & Ray, D. C. (2011). Play therapy in elementary schools: A best practice for improving academic achievement. *Journal of Counseling & Development, 89*, 235-243.

Blanco, P. J., Ray, D. C., & Holliman, R. (2012). Long-term child centered play therapy and academic achievement of children: A follow-up study. *International Journal of Play Therapy, 21*, 1-13. doi: 10.1037/a0026932

Bowen, M. L., & Glenn, E. E. (1998).Counseling interventions for students who have mild disabilities. *Professional School Counseling, 2*, 16-25.

Bramlett, R.K., Smith, B.L., & Edmonds, J. (1994). A comparison of nonreferred, learning-disabled, and mildly mentally retarded students utilizing the social skill rating system. *Psychology in the Schools, 31*, 13-19. doi: 10.1002/1520-6807(199401)31:1<13::AID-PITS2310310103>3.0.CO;2-E

Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 1*, 47-88.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L.(2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36*(4), 376-390. doi: 10.1037/0735-7028.36.4.376

Bryan, T., Burstein, K. & Ergul, C. (2004). The social-emotional side of learning disabilities: A science-based presentation of the state of the art. *Learning Disability Quarterly*, 27, 45-51. doi: 10.2307/1593631

Chapman, J.W. (1988). Learning disabled children's self-concepts. *Review of Educational Research, 58(3)*, 347-371.

Cochran, J. L. (1996). Using play and art therapy to help culturally diverse students overcome barriers to school success. *School Counselor,* (4), 287-298.

Compton, D., Fuchs, L., Fuchs, D., Lambert, W. & Hamlett, C. (2012). The cognitive and academic profiles of reading and mathematics learning disabilities. *Journal of Learning Disabilities, 45*, 79-95. doi: 10.1177/0022219410393012

Cooper, J., Heron, T., & Heward, W. (2014). *Applied behavior analysis*. London: Pearson.

Crow, J. C. (1994). *Play therapy with low achievers in reading.* (Doctoral dissertation, University of Louisville, 1994).

Darney, D., Reinke, W., M., Herman, K.C., Stormont, M., & Ialongo, N.S. (2013). Children with co-occurring academic ad behavior problems in first grade: Distal outcomes in twelfth grade. *Journal of School Psychology, 51*, 117-128. doi: 10.1016/j.jsp.2012.09.005

Discovery Education (July, 2015). *Discovery education assessment.* [web document]. Retrieved from http://www.discoveryeducation.com/pdf/assessment/Discovery_Education_Assessment_Research.pdf

Dubois, D.L., Felner, R.D., Brand, S., & George, G.R. (1999). Profiles of self-esteem in early adolescence: Identification and investigation of adaptive correlates. *American Journal of Community Psychology, 27*(6), 899-932. doi: 10.1023/A:1022218810963

Dunn, N. & Baker, S. (2002). Readiness to serve students with disabilities: A survey of elementary school counselors. *Professional School Counseling, 5*(4), 277-284.

Dunn, C., Chambers, D., & Rabren, K. (2004). Variables affecting students' decisions to drop out of school. *Remedial and Special Education, 25*(5), 314-323.

Durrant, J. E., Cunningham, C. E., & Voelker, S. (1990). Academic, social, and general self-concepts of behavioral subgroups of learning disabled children. *Journal of Educational Psychology*, *82*(4), 657-663. doi: 10.1037/0022-0663.82.4.657

Elbaum, B. & Vaughn, S. (2001). School-based interventions to enhance the self-concept of students with learning disabilities: A meta-analysis. *The Elementary School Journal, 101*(3), 303-329.

Elbaum, B. & Vaughn, S. (2003). For which students with learning disabilities are self-concept interventions effective? *The Journal of Learning Disabilities, 36*(2), 101-108.

Emenheiser, D. (2013). *Relations between academic achievement and self-concept among adolescent students with disabilities over time.* (Doctoral dissertation, The George Washington University, 2013).

Fall, M., Balvanz, J., Johnson, L., &Nelson, L. (1999). A play therapy intervention and its relationship to self-efficacy and learning behaviors. *Professional School Counseling, 2*(3), 194-204.

Fall, M. Navelski, L. & Welch, K. K. (2002). Outcomes of a play intervention for children identified for special education services. *International Journal of Play Therapy, 11*(2), 91-106.

Fleming, C. B., Harachi, T.W., Cortes, R. C., Abbott, R. D., & Catalano, R. F. (2004). Level and change in reading scores and attention problems during elementary school as predictors of problem behavior in middle school. *Journal of Emotional and Behavioral Disorders, 12*(3), 130-144.

Forness, S.R. & Kavale, K. A. (1996). Treating social skill deficits in children with learning disabilities: A meta-analysis of the research. *Learning Disability Quarterly, 19*, 2-13. doi: 10.2307/1511048

Good, R.H., & Kaminski, R.A. (2002). *Dynamic indicators of basic early literacy skills. 6th edition.* Eugene, OR: Institute for the Development of Educational Achievement. [web document]. Retrieved from https://dibels.uoregon.edu/docs/materials/admin_and_scoring_6th_ed.pdf

Gresham, F. M. & Elliot, S. N. (1990). *Social Skills Rating System*. Circle Pines, MN: American Guidance Service.

Gresham, F.M., Elliot, S.N., Vance, M.J., & Cook, C.R. (2011). Comparability of the social skills rating system to the social skills improvement system: Content and psychometric comparisons across elementary and secondary levels. *School Psychology Quarterly, 26*, 27-44. doi: 10.1037/a0022662

Guerney, L. F. (1979). Play therapy with learning disabled children. *Journal of Clinical Child Psychology, 9*, 242-244.

Haager, D. & Vaughn, S. (1995). Parent, teacher, peer, and self-reports of the social competence of students with learning disabilities. *Journal of Learning Disabilities, 28*(4), 205-215.

Harrison P. & Oakland T. (2003). *Adaptive behavior assessment system manual. 2nd ed*. San Antonio, TX: Harcourt Assessment.

Horner, R. H., Carr, E. G., Halle, J., Mcgee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practices in special education. *Council for Exceptional Children, 71*(2), 165-179.

Johnson, L., McLeod, E. H., & Fall, M. (1997). Play therapy with labeled children in the schools. *Professional School Counseling, 1*, 31-34.

Kamphaus, R. W., & Reynolds, C. R. (2007). *Behavior assessment system for children—2nd ed. (BASC–2): Behavioral and emotional screening system (BESS)*. Bloomington, MN: Pearson.

Kascsak, T. (2012). *Impact of child centered group play therapy on social skills development of kindergarten children*. (Doctoral dissertation, The University of North Carolina at Charlotte, 2012).

Kaufman, A. S., & Kaufman, N. L. (2004). *Kaufman Test of Educational Achievement–Second Edition (KTEA-II)*. Circle Pines, MN: American Guidance Service.

Kavale, K. A. & Forness, S. R. (1996). Social skill deficits and learning disabilities: A meta-analysis. *Journal of Learning Disabilities, 29*(3), 226-237.

Landreth, G. L. (2012). *Play therapy: The art of the relationship.* New York: Routledge.

Landreth, G. L., Ray, D. C., & Bratton, S. C.(2009). Play therapy in elementary schools. *Psychology in the Schools*, *46*(3), 281-289.

Leblanc, M. & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counselling Psychology Quarterly, 14*(2), 149-163.

Lin, Y-W. & Bratton, S. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling and Development,* 93, 45-58. doi: 10.1002/j.1556-6676.2015.00180.x

Lundervold, D. A. & Belwood, M. F. (2000). The best kept secret in counseling: Single-case (N = 1) experimental design. *Journal of Counseling & Development, 78*, 92-101.

Malecki, C. K. & Elliot, S. N. (2002). Children's social behaviors as predictors of academic achievement: A longitudinal analysis. *School Psychology Quarterly, 17*, 1-23. doi: 10.1521/scpq.171.1.19902

McEachern, A. (2003). School counselor preparation to meet the guidance needs of exceptional students: A national study. *Counselor Education & Supervision, 42*, 314-325.

Milone, M. (2008). *Core reading maze comprehension test*. Ann Arbor, MI: Academic Therapy Publications.

Milsom, A. (2006). Creating positive school experiences for students with disabilities. *Professional School Counseling, 10*, 66-72.

Milsom, A., Goodnough, G., & Askos, P. (2007). School counselor contributions to the individualized education program (IEP) process. *Preventing School Failure, 52*, 19-24.

Mishna, F. & Muskat, B. (2004). School-based group treatment for students with learning disabilities: A collaborative approach. *Children & Schools, 26*(3), 135-150.

Moller, J., Streblow, L., & Pohlmann, B. (2009). Achievement and self-concept of students with learning disabilities. *Social Psychology of Education, 12*, 113-122. doi: 10.1007/s11218-008-9065-z

National Center for Educational Statistics (NCES, January, 2014). Children and Youth with Disabilties. Retrieved from http://nces.ed.gov/programs/coe/indicator_cgg.asp

No Child Left Behind Act of 2001 (NCLB, January, 2002). Retrieved from http://www2.ed.gov/policy/elsec/leg/esea02/index.html

North Carolina Department of Public Instruction (NCDPI) (June, 2015). mCLASS© Reading 3D™ executive summary. [web document]. Retrieved from http://www.ncpublicschools.org/docs/superintendents/messages/2014/0217/addendum-attachment03.pdf

Nowicki, E. A. (2003). A meta-analysis of the social competence of children with learning disabilities compared to classmates of low and average to high achievement. *Learning Disability Quarterly*, *26*, 171-188.

O'Mara, A., Green, J., & Marsh, M. (2006). Administering self-concept interventions in schools: No training necessary? A meta-analysis. *International Education Journal, 7*(4), 524-533.

Packman, J. & Bratton, S. C. (2003). A school-based group play/activity therapy intervention with learning disabled preadolescents exhibiting behavior problems. *International Journal of Play Therapy, 12*(2), 7-29. doi: 10.1037/h0088876

Phillips, E., & Mullen, J. (1999).Client-centered play therapy techniques for elementary school counselors: Building the supportive relationship. The Journal for the Professional Counselor, *14*, 29-40.

Piers, E. V., & Herzberg, D. B. (2002). *Piers-Harris 2 Children's Self-Concept Scale, Second Edition.* Los Angeles: Western Psychological Services.

Post, P. (1999). Impact of child-centered play therapy on the self-esteem, locus of control, and anxiety of at-risk 4th, 5th, and 6th grade students. *International Journal of Play Therapy, 8*, 1-18. doi: 10.1037/h0089428

Post, P. (2001). Child-centered play therapy for at-risk elementary school children. In A. A. Drews, L. J. Carey, & C. E. Schaefer (Eds.), *School-based play therapy* (pp. 105-121). New York: Wiley.

Ray, D. (2004). Supervision of basic and advanced skills in play therapy. *Journal of Professional Counseling: Practice, Theory, & Research, 32*(2), 28- 41.

Ray, D. (2011). *Advanced play therapy: Essential conditions, knowledge, and skills for child practice*. New York: Routledge.

Ray, D., Armstrong, S. A., Warren, S. E., & Balkin, R. S. (2015). Play therapy practices among elementary school counselors. *Professional School Counseling, 8*(4), 360-365.

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy, 10*, 85-108.

Ray, D., Muro, J., & Schumann, B. (2004). Implementing play therapy in the schools: Lessons learned. *International Journal of Play Therapy, 13*, 79-100. doi:10.1037/h0088886

Reinke, W.M, Herman, K. C., Petras, H., & Ialongo, N.S. (2008). Empirically derived subtypes of child academic and behavioral problems: Co-occurrence and distal outcomes. *Journal of Abnormal Child Psychology, 36*, 759-770.

Rogers, C. (1949). The attitude and orientation of the counselor in client-centered therapy. *Journal of Consulting Psychology, 13*(2), 82-94. doi: 10.1037/h0059730

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology, 21*(2), 95-103. doi: 10.1037/0033-3204.44.3.240

Scarborough, J. & Deck, M. (1998). The challenge of working for students with disabilities: A view from the front lines. *Professional School Counseling, 2*, 10-16.

Scott, T. A., Burlingame, G., Starling, M., Porter, C., & Lilly, J. P. (2003). Effects of individual client-centered play therapy on sexually abused children's mood, self-concept, and social competence. *International Journal of Play Therapy, 12*, 7-30. doi: 10.1037/h0088869

Siegel, C. (1970). *Effectiveness of play therapy with other modalities in the treatment of children with learning disabilities*. (Doctoral dissertation, Boston University, 1970).

Tabone, F. (2011). *Academic self-concept, self-efficacy, and achievement among students with and without learning disabilities*. (Doctoral dissertation, Fordham University, 2011).

Therrien, W. J., Zaman, M., & Banda, D. R. (2011). *How can meta-analysis guide practice?* A review of the learning disability research base. *Remedial and Special Education, 32*(3), 206-218. doi: 10.1177/0741932510361266

Vaughn, S., Zaragoza, N., Hogan, A., & Walker, J. (1993). A four-year longitudinal investigation of the social skills and behavior problems of students with learning disabilities. *Journal of Learning Disabilities, 26*(6), 404-412. doi: 10.1177/002221949302600606

Walker, A. & Nabuzoka, D. (2007). Academic achievement and social functioning of children with and without learning difficulties. *Educational Psychology, 27(*5), 635-654.

Wechsler, D. (2009). *Wechsler Individual Achievement Test (3rd ed.).* San Antonio, TX: Pearson.

Wechsler, D. (2003). *Wechsler Intelligence Scale for Children, 4th edition (WISC-IV).* San Antonio, TX: The Psychological Corporation.

Whitley, J. (2008). A model of general self-concept for students with learning disabilities: Does class placement play a role? *Developmental Disabilities Bulletin, 36*, 106-134.

Woodcock, R. W., McGrew, K. S., & Mather, N. (2001). *Woodcock-Johnson tests of achievement.* Itasca, IL: Riverside Publishing.

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11*, 203-214. doi: 10.1901/jaba.1978.11-203

U.S. Department of Education Office of Special Education Programs (2006, October 4). Identification of Specific Learning Disabilities [web document]. Retrieved from http://idea.ed.gov/explore/view/p/,root,dynamic,TopicalBrief,23,

U.S. Department of Education (n.d.) Building the Legacy: IDEA 2004. Retrieved from http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2CI%2CA%2C602%2C30%2C

Zimmerman, M., Copeland, L., Shope, J. & Dielman, T. (1997). A longitudinal study of self-esteem: Implications for adolescent development. *Journal of Youth and Adolescence, 26*(2), 117-141. doi: 10.1023/A:10234596313925

APPENDIX A: ADAPTED CHILD SOCIAL SKILLS RATING SCALE

Child ID: _____ Session #: _____ Date:_____

Adapted Child Social Skills Rating Scale (Self-Report)

	NEVER	**A LITTLE** (1 time /week)	**SOMETIMES** (2 to 3 times/week)	**OFTEN** (4 to 5 times/week)	**VERY OFTEN** (6 to 7 times/ week)
1. I make friends easily.	0	1	2	3	4
2. I start talks with class members.	0	1	2	3	4
3. I ask classmates to join in an activity or game.	0	1	2	3	4
4. I tell others when I am upset with them.	0	1	2	3	4
5. I listen to the teacher when a lesson is being taught.	0	1	2	3	4
6. I follow the teacher's directions.	0	1	2	3	4
7. I feel sorry for others when bad things happen to them.	0	1	2	3	4
8. I listen to friends when they talk	0	1	2	3	4

about problems they are having.					
9. I try to understand how my friends feel when they are angry, upset, or sad.	0	1	2	3	4
10. I control my temper when people are angry with me.	0	1	2	3	4
11. I disagree with adults without fighting or arguing.	0	1	2	3	4
12. I talk things over with classmates when there is a problem or an argument.	0	1	2	3	4

COLUMN TOTAL					
TOTAL SCORE					

NOTE: items 1-3 (A); 4-6 (C); 7-9 (E); 10-12 (SC)

Adapted from: Gresham, F. M., & Elliot, S. N. (1990). Social Skills Rating System, Circle Pines, MN: American Guidance Service.

Adapted Child Social Skills Rating Scale (Self-Report) SCRIPT

Today, I am going to read some statements about things that may have happened to you throughout your week and about the way you think or feel about those things. You will circle either 0 (never), 1(a little; 1 time per week), 2 (sometimes; 2-3 times per week), 3(often; 4 to 5 times per week), or 4 (very often; 6-7 times per week) to tell how often you do, think, or feel a certain way about the things that are read. Remember, there are no right or wrong answers, just be truthful and mark the one that sounds most like you.

APPENDIX B: ADAPTED TEACHER SOCIAL SKILLS RATING SCALE

Child ID: _____ Date:_____

Adapted Child Social Skills Rating Scale (Teacher)

	NEVER	**A LITTLE** (1 time /week)	**SOMETIMES** (2 to 3 times/week)	**OFTEN** (4 to 5 times/week)	**VERY OFTEN** (6 or more times/week)
13. He/she makes friends easily. (A)	0	1	2	3	4
14. He/She starts talks with class members. (A)	0	1	2	3	4
15. He/She asks classmates to join in an activity or game. (A)	0	1	2	3	4
16. He/She tells others when he/she is upset with them. (C)	0	1	2	3	4
17. He/She listens to the teacher when a lesson is being taught. (C)	0	1	2	3	4
18. He/She follows the teacher's directions. (C)	0	1	2	3	4
19. He/She appears to feel sorry for others when bad things happen to them. (E)	0	1	2	3	4
20. He/She listens to friends when they talk about problems they are having. (E)	0	1	2	3	4
21. He/She tries to understand how friends feel when they are angry, upset, or sad. (E)	0	1	2	3	4

22. He/She controls his/her temper when people are angry with him/her. (SC)	0	1	2	3	4
23. He/She disagrees with adults without fighting or arguing. (SC)	0	1	2	3	4
24. He/She talks things over with classmates when there is a problem or an argument. (SC)	0	1	2	3	4
COLUMN TOTAL					
TOTAL SCORE		A =	C =	E =	SC =

Adapted from: Gresham, F. M., & Elliot, S. N. (1990). Social Skills Rating System, Circle Pines, MN: American Guidance Service.

Adapted Child Social Skills Rating Scale (Teacher) DIRECTIONS

Please read the statements about things that may have been displayed by the child throughout the week. You will circle either 0 (never), 1(a little; 1 time per week), 2 (sometimes; 2-3 times per week), 3(often; 4 to 5 times per week), or 4 (very often; 6-7 times per week) to tell how often you think the child displayed different behaviors this week.

For example if you read something that said "The child completes his/her schoolwork" and he/she completed schoolwork every day this week, you would circle 4 for VERY OFTEN. If the child did not complete schoolwork this week would circle 0 for NEVER. If the child completed schoolwork once this week you would circle 1 for A LITTLE. If the child completed schoolwork twice this week you would circle 2 for SOMETIMES. If the child completed schoolwork four times this week you would circle 3 for OFTEN. If you did not witness a behavior that is on the survey this week write NA in the box for 0 (NEVER).

There are no right or wrong answers, just be truthful and mark the one that sounds most like the child this week. You do not need to total the scores; the researcher will do that after you have completed the survey. Thank you for your participation!

APPENDIX C: PRACTICE SOCIAL SKILLS RATING SCALE AND SCRIPT

Adapted Child Social Skills Rating Scale (Self-Report) SCRIPT

Today, I am going to read some statements about things that may have happened to you throughout your week and about the way you think or feel about those things. There are no right or wrong answers. You will circle either 0, 1, 2, 3, or 4 to tell how often you do, think, or feel a certain way about the things that are read.

For example (while showing them the scaling on the example assessment): If I read something that said "I ride my bike" and you rode your bike every day after school this week, you would circle 4 for VERY OFTEN. If you don't have a bike, don't know how to ride a bike, or didn't ride your bike this week you would circle 0 for NEVER. If you rode your bike one day after school this week you would circle 1 for A LITTLE. If you rode your bike on two or three days this week you would circle 2 for SOMETIMES. If you rode your bike four or five times this week you would circle 3 for OFTEN. Now you are going to practice with some more examples.

Example 1: If I read something that said "I play video games" what number would you circle to describe how much you play video games? (wait for child to answer and discuss if this is accurate or not)

Example 2: If I read something that said "when I cross the street I look both ways" what number would you circle to describe how often you look both ways? (wait for child to answer and discuss if this is accurate or not)

Example3: If I read something that said "I do my homework" what number would you circle to describe how often you do your homework? (wait for child to answer and discuss if this is accurate or not)

Now I am going to read some statements and you will actually circle which one best describes you. There are no right or wrong answers.

EXAMPLES

	NEVER	**A LITTLE** (1 time/week)	**SOMETIMES** (2 to 3 times/week)	**OFTEN** (4 to 5 times/week)	**VERY OFTEN** (6 to 7 times/week)
1. I ride my bike.	0	1	2	3	4
2. I play video games.	0	1	2	3	4
3. When I cross the street I look both ways.	0	1	2	3	4
4. I do my homework.	0	1	2	3	4

APPENDIX D: TEACHER SOCIAL VALIDITY QUESTIONNAIRE

Student ID: _____ Date: _____

CCPT Social Validity Questionnaire (Teacher Form)

Completed By: ____ Regular Classroom Teacher ____ Special Education Teacher

This questionnaire consists of 19 items. For items 1through 16, you need to indicate the extent to which you agree or disagree with each statement. Please indicate your response to each item by circling one of the five responses to the right. For items 17 through 19, please share any additional responses you might have.

	Questions	Responses				
1.	The academic, social skills, and self-concept concerns that were selected for intervention with this student are important.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
2.	Using his/her individual academic (reading and math) progress as a measure for success for this student is adequate. (weekly probes, test scores)	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
3.	The time spent in the assessment of the student's current self-concept, social skills, and academic achievement was a good investment in understanding this student.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4.	The information gathered from the assessment of the student was useful in understanding the student's current state of self-concept, social skills, and academic achievement.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5.	The curriculum-based assessment procedures that were used to measure academic achievement were appropriate and easy to implement.(weekly probes, test scores)	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
6.	Assessing the student's self-concept and using the assessment information to better understand the student and his/her academic achievement are valuable practices.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
7.	Assessing the student's social skills and using the assessment information to better understand the student and his/her academic achievement are valuable practices.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
8.	I am considering using the social skills and self-concept assessment procedures (such as the SSRS and Piers-Harris 2) to better understand my other	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

students.

9.	Assessing the student's self-concept and social skills are important aspects for understanding this student and his/her academic achievement.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
10.	The CCPT intervention program for this student was important and adequate.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
11.	I noticed meaningful increases in the student's self-concept after the implementation of the intervention.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
12.	I noticed meaningful increases in the student's academic skills after the implementation of the intervention.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
13.	I noticed meaningful improvements in the student's social skills after the implementation of the intervention.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
14.	Individual CCPT is a useful and appropriate intervention to increase this student's self-concept and social skills.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
15.	Individual CCPT is a useful and appropriate intervention to increase this student's academic achievement.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
16.	I am considering the use of CCPT with other students who have similar social skills, academic, and/or self-concept issues in my classroom.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

17. What specific changes (if any) did you observe in regards to the student's self-concept and/or social skills?

18. What improvements could be made to make CCPT sessions more available and useful? Were they disruptive to the student's/your classroom schedule? (please explain)

19. Additional comments about CCPT, the playroom, and/or the study: (please use back for additional space)

Source: Adapted from "Functional Assessments and Individualized Intervention Plans: Increasing the Behavior Adjustment of Urban Learners in General and Special Education Settings" by Y. Lo, 2003, Unpublished Dissertation, The Ohio State University, pp. 289-290.

APPENDIX E: SCHOOL COUNSELOR/ADMINSITATOR SOCIAL VALIDITY QUESTIONNAIRE

CCPT Social Validity Questionnaire (School Counselor/Administrator Form)

Completed By: _____ School Counselor _____ Administrator Date: _____

This questionnaire consists of 20 items. For items 1through 16, you need to indicate the extent to which you agree or disagree with each statement. Please indicate your response to each item by circling one of the five responses to the right. For items 17 through 20, please share any additional responses you might have.

	Questions	Responses				
1.	The academic, social skills, and self-concept concerns that were selected for intervention with these students are important.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
2.	Using individual academic (reading and math) progress as a measure for success for these students is adequate. (weekly probes, test scores)	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
3.	The time spent in the assessment of the students' current self-concept, social skills, and academic achievement was a good investment in understanding these students.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4.	The time spent in the playroom was a good investment in supporting their self-concept, social skills, and academic concerns.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5.	The curriculum-based assessment procedures that were used to measure academic achievement were appropriate and not disruptive.(weekly probes, test scores)	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
6.	Assessing these students' self-concept and using the assessment information to better understand them and their academic achievement are valuable practices.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
7.	Assessing these students' social skills and using the assessment information to better understand them and their academic achievement are valuable practices.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
8.	I would consider using the social skills and self-concept assessment procedures (such as the SSRS and Piers-Harris 2) to better understand other students in the school.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

9.	Schools should gather self-concept and social skills information from students in general, as they are important aspects for understanding students and their academic achievement.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
10.	The CCPT intervention program for these students was important and adequate.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
11.	Individual CCPT is a useful and appropriate intervention to increase social skills of these students	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
12.	Individual CCPT is a useful and appropriate intervention to increase academic achievement of these students.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
13.	Individual CCPT is a useful and appropriate intervention to increase self-concept of these students.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
14.	I would encourage other schools to implement CCPT services in their schools to address academic concerns.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
15.	I would encourage other schools to implement CCPT services in their schools to address social skills and self-concept concerns.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
16.	I am considering the use of CCPT with other students who have similar social skills, academic, and/or self-concept issues in my school.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

17. What specific changes (if any) did you observe in regards to the student's self-concept and/or social skills?

18. What improvements could be made to make CCPT sessions more available and useful?

19. What feedback (if any) did you hear from teachers (or other staff) about having the playroom and/or CCPT at your school?

20. Additional comments about CPT, the playroom, and/or the study: (please use back for additional space)

Source: Adapted from "Functional Assessments and Individualized Intervention Plans: Increasing the Behavior Adjustment of Urban Learners in General and Special Education Settings" by Y. Lo, 2003, Unpublished Dissertation, The Ohio State University, pp. 289-290.

APPENDIX F: PARENT/GUARDIAN SOCIAL VALIDITY QUESTIONNAIRE

Student ID: _____ Date: _____

CCPT Social Validity Questionnaire (Parent/Guardian Form)

Completed by: _____ mother _____ father _____ other: _____

INSTRUCTIONS: This questionnaire consists of 12 items. For items 1 through 9, you need to indicate the extent to which you agree or disagree with each statement. Please indicate your response to each item by circling one of the five responses to the right. For items 10 through 12, please share any additional responses you might have.

	Questions	Responses				
1.	At the beginning of the school year, I felt that my child needed some emotional support to be more successful at school.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
2.	At the beginning of the school year, I felt that my child needed some academic support to be more successful at school.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
3.	I feel that CCPT sessions are useful and appropriate ways to improve my child's academic achievement.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4.	I feel that CCPT sessions helped to improve my child's self-concept and social skills.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5.	The CCPT program was appropriate and beneficial for my child to participate in at school.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
6.	I would recommend to other parents that their children with similar issues be involved in the CCPT program at school.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
7.	My child talked about the CCPT program at home in a positive way.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
8.	I am glad my child participated in the CCPT program.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
9.	I would like for my child to continue participating in CCPT sessions if possible.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

(continued)

10. What specific changes in self-concept, social skills, and/or academic achievement did you see on your child for the past few months?

11. What changes would you suggest to improve the use and availability of CCPT sessions in the school? Do you feel the school should continue to offer CCPT in the school?

12. Additional comments:

Source: Adapted from "Functional Assessments and Individualized Intervention Plans: Increasing the Behavior Adjustment of Urban Learners in General and Special Education Settings" by Y. Lo, 2003, Unpublished Dissertation, The Ohio State University, pp. 289-290.

APPENDIX G: STUDENT SOCIAL VALIDITY INTERVIEW

Child ID: _____ Date:_____

CCPT Social Validity Interview (Student Form)

"I have some questions to ask you. I just want to know how you feel about participating in our special play time together. There are no right or wrong answers, just relax and tell me how you feel."

Questions

1.	I liked going to the play room and playing with my counselor.	Yes	Maybe	No
2.	The play time helped me to feel better about myself.	Yes	Maybe	No
3.	The play time helped me to get along better with my classmates.	Yes	Maybe	No
4.	The play time helped me do better in reading and math.	Yes	Maybe	No
5.	I would go to the playroom again if I am able to.	Yes	Maybe	No
6.	I would tell my friends to go to the playroom if they needed to feel better about themselves or do better in school.	Yes	Maybe	No

7. What did you learn from going to the playroom?

8. What did you like best?

9. What did you not like?

10. If you were in charge, what would you have changed?

11. Is there anything else you want to say about the playroom or your special play time?

APPENDIX H: INFORMED CONSENT (PARENT/STUDENT)

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

INFORMED CONSENT (PARENT/STUDENT)

Your child is being invited to participate in a research study based on his or her selection by the school counselor and special education teacher at North Rowan Elementary School. This study is titled Effects of Child-Centered Play Therapy on Social Skills, Academic Achievement, and Self-Concept of Children with Learning Disabilities: A Single-Case Design. It is important that you read and understand the following explanation before agreeing to participate in this research study. You may ask questions at any time.

Your decision to allow your child to participate is entirely voluntary. You/your child may choose to withdraw from the study at any point without penalty. Your decision to allow your child to participate or not participate in this study, as well as any decision to withdraw, will have no effect on the services your child is receiving at XXX Elementary School.

Purpose of the study:
The purpose of this study is to investigate the effectiveness of Child Centered Play Therapy (CCPT) with children who are labeled with LD. The focus of this study is to see if there is an impact on their social skills, self-concept, and academic achievement.

CCPT:
CCPT is a therapeutic intervention used with children, typically ages 3-10 years old. CCPT was developed by Landreth, (2012) and is defined as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development". Research in the field of play therapy has demonstrated that CCPT is effective in addressing many different issues with many different populations of children.

Duration of the study:
Your child's participation in the study will vary depending upon the application of the intervention but is expected to last approximately 8 weeks. During this time (s)he will participate in 30-minute play sessions two times per week with a doctoral student trained in CCPT (the researcher).

Description of the study and procedures:
Individual Play Sessions: If you choose to have your child to participate, your child will receive one-on-one play sessions for 30 minutes at least two times per week. These play sessions will take place with the researcher at XXX Elementary School during the school day. It is expected that your child will enjoy these sessions.

Video-recordings: As part of the research study, all CCPT sessions will be recorded. Recordings will be used to assess the researcher's adherence to the CCPT model. Only the researcher or trained research assistant(s) will review these recordings. Recordings will be kept in locked file cabinets and password protected. After the completion of the study, these recordings will be destroyed.

Assessments: Throughout the course of the study, measurements will be administered to assess the effectiveness of the CCPT intervention. Information collected will include: the child's perception of his/her self-concept and social skills as well as his/her academic achievement, as measured by the special education progress monitoring assessments. The researcher will administer the self-concept and social skills assessments in the school counselor's office and will follow any adaptations for testing outlined in your child's IEP. The data collected will be stored in a locked file cabinet and will be destroyed following the entry of the data electronically. All data will be assigned an ID code number and therefore will not include your child's name. All assessments and documentation will be kept in locked filing cabinets and destroyed after being converted to de-identified electronic data. Electronic data will be password protected.

Additionally, the researcher will also be collecting information from you and your child about the CCPT sessions when they have ended. You will be asked to complete a questionnaire to provide feedback about the sessions and your child's participation. Your child will also be asked to provide feedback about the sessions by participating in a questionnaire/interview done by the researcher.

Description of risks or discomfort:
There are no expected significant risks associated with this study. However, you can decide to withdraw your child's participation at any time.

Description of participant or others' benefits:
Research suggests that CCPT sessions conducted with your child may result in improvements in a variety of areas. Areas that may be positively impacted include: coping skills, expression of feelings, self-control, and self-confidence.

Confidentiality:
All information about you and your child's participation will be kept confidential. Neither your identity nor that of your child will be disclosed. Your child will be assigned an ID code number that will be used in place of names on all assessment data. The master list matching codes to child names will be stored only in the researcher's password protected file. All electronic data will be encrypted and password protected. Play sessions will be video recorded. It is possible that your child's name may be said in these recordings. Thus, it is not possible to keep your child's identity completely confidential. However, only the researcher and trained research assistant(s) will review video recordings of play sessions or video/audio recordings. These individuals are all obligated to protect confidentiality. All video/audio recordings will be stored in a locked cabinet at XXX Elementary School or at the University of North Carolina at Charlotte, will be password protected, and will be deleted after the completion of the research. The only exceptions to confidentiality are: 1) a child discloses abuse, neglect, or exploitation, 2) the child is a danger to him or herself or to someone else, 3) a court orders disclosure of information, or 4) the parent or legal guardian requests release of information.

Investigator and review information:
The researcher in this study is Jennifer Geddes Hall, MA, LPC a doctoral student at UNC Charlotte (jgeddes@uncc.edu). She has over 11 years of experience as a child therapist and is a former school counselor and special education teacher. The responsible faculty member is Dr. Phyllis Post, LPC, RPT, Professor and director of the UNC Charlotte Multicultural Play Therapy Center (ppost@uncc.edu). If you have any questions about this study please contact Jennifer Geddes Hall (XXX-XXX-XXXX or at her email address provided above) or Dr. Phyllis Post (704-687-8961 or at her email address provided above).

UNCC's Institutional Review Board has approved this research protocol and form for one year beginning on 1-10-2014. UNC Charlotte wants to make sure you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-1871; uncc-irb@uncc.edu) if you have any questions about how you are treated as study participant.

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age. I agree to allow my child to participate in this research project and I agree to provide feedback at the conclusion of the sessions. I understand that I will receive a copy of this form after it has been signed by me and the researcher of this study. I understand my rights and voluntarily consent to have my child participate in this research. I understand that I can withdraw that consent at any time.

_____

Child's name (PLEASE PRINT)

_____

Parent/guardian's name (PLEASE PRINT)

_____

Parent/guardian's signature and date

_____

Researcher's signature and date

APPENDIX I: INFORMED CONSENT
(TEACHER/ADMINISTRATOR/COUNSELOR)

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

INFORMED CONSENT (TEACHER/ADMINISTRATOR/COUNSELOR)

You are being invited to participate in a research study that will be conducted at North Rowan Elementary School. This study is titled Effects of Child-Centered Play Therapy on Social Skills, Academic Achievement, and Self-Concept of Children with Learning Disabilities: A Single-Case Design. It is important that you read and understand the following explanation before agreeing to participate in this research study. You may ask questions at any time.

Your decision to participate is entirely voluntary. You may choose to withdraw from the study at any point without penalty. Your decision to participate or not participate in this study, as well as any decision to withdraw, will have no effect on your employment at XXX Elementary School.

Purpose of the study:
The purpose of this study is to investigate the effectiveness of Child Centered Play Therapy (CCPT) with children who are labeled with LD. The focus of this study is to see if there is an impact on their social skills, self-concept, and academic achievement.

CCPT:
CCPT is a therapeutic intervention used with children, typically ages 3-10 years old. CCPT was developed by Landreth, (2012) and is defined as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development". Research in the field of play therapy has demonstrated that CCPT is effective in addressing many different issues with many different populations of children.

Duration of the study:
Children's participation in the study will vary depending upon the application of the intervention but is expected to last approximately 8 weeks. During this time (s)he will participate in 30-minute play sessions two times per week with a doctoral student trained in CCPT (the researcher).

Description of the study and procedures:
Individual Play Sessions: Children will receive one-on-one play sessions for 30 minutes at least two times per week. These play sessions will take place with the researcher at XXX Elementary School during the school day. It is expected that the children will enjoy these sessions.

Video-recordings: As part of the research study, all CCPT sessions will be recorded. Recordings will be used to assess the researcher's adherence to the CCPT model. Only the researcher and the trained research assistant(s) will review these recordings. Recordings will be kept in locked file cabinets and password protected. After the completion of the study, these recordings will be destroyed.

Assessments: Throughout the course of the study, measurements will be administered to assess the effectiveness of the CCPT intervention. Information collected will include: the child's perception of his/her self-concept and social skills as well as his/her academic achievement, as measured by the special education progress monitoring assessments. The researcher will administer the self-concept and social skills assessments in the school counselor's office and will follow any adaptations for testing outlined in the child's IEP. The data collected will be stored in a locked file cabinet and will be destroyed following the entry of the data electronically. All data will be assigned an ID code number and therefore will not include the child's name. All assessments and documentation will be kept in locked filing cabinets and destroyed after being converted to de-identified electronic data. Electronic data will be encrypted and password protected.

Additionally, the researcher will also be collecting information from you, the children, and their parents about the CCPT sessions when they have ended. You will be asked to complete a questionnaire to provide feedback about the sessions and the children's participation. The children will also be asked to provide feedback about the sessions by participating in a questionnaire/interview done by the researcher.

Description of risks or discomfort:
There are no expected significant risks associated with this study. However, you can decide to withdraw your participation at any time.

Description of participant or others' benefits:
Research suggests that CCPT sessions conducted with the children may result in improvements in a variety of areas. Areas that may be positively impacted include: coping skills, expression of feelings, self-control, and self-confidence.

Confidentiality:
All information about your participation will be kept confidential. Neither your identity nor that of the children will be disclosed. You and the children will be assigned an ID code number that will be used in place of names on all assessment data. The master list matching codes to names will be stored only in the researcher's password protected file. All electronic data will also be encrypted and password protected. The only exceptions to confidentiality are: 1) a child discloses abuse, neglect, or exploitation, 2) the child is a danger to him or herself or to someone else, 3) a court orders disclosure of information, or 4) the parent or legal guardian requests release of information.

Investigator and review information:
The researcher in this study is Jennifer Geddes Hall, MA, LPC a doctoral student at UNC Charlotte (jgeddes@uncc.edu). She has over 11 years of experience as a child therapist and is a former school counselor and special education teacher. The responsible faculty member is Dr. Phyllis Post, LPC, RPT, Professor and director of the UNC Charlotte Multicultural Play Therapy Center (ppost@uncc.edu). If you have any questions about this study please contact Jennifer Geddes Hall (XXX-XXX-XXXX or at her email address provided above) or Dr. Phyllis Post (704-687-8961 or at her email address provided above).

UNCC's Institutional Review Board has approved this research protocol and form for one year beginning on 1-10 -2014. UNC Charlotte wants to make sure you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-1871; uncc-irb@uncc.edu) if you have any questions about how you are treated as study participant.

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age. I agree to participate in this research project and provide feedback at the conclusion of the sessions. I understand that I will receive a copy of this form after it has been signed by me and the researcher of this study. I understand my rights and voluntarily consent to participate in this research. I understand that I can withdraw that consent at any time.

_____
Participant's name (PLEASE PRINT)

_____
Participant's signature and date

_____
Researcher's signature and date

APPENDIX J: CHILD ASSENT

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

CHILD ASSENT

You are being asked to meet with me (a student at UNC Charlotte) two times per week in a special playroom at your school. We hope to see if coming to meet with me will help you with your math and reading, getting along with others, and how you feel about yourself.

If you want to participate, you will have playtimes with me at least two times per week. During those playtimes, you can play with the toys and materials in a lot of the ways you would like to. The playtimes will be recorded, but people who are not working with me at school will not see them. But, if you tell me that someone has hurt you or is hurting you or that you might hurt yourself or someone else I will need to tell someone. Also, a judge or parent/guardian can ask me about these types of things. Anything else that you do or say during our special playtime will be kept between you and me.

Before we begin our playtimes and each time after our special playtimes, I will ask you to answer some questions about yourself and others. There are no right or wrong answers to the questions and all answers to these questions will not be seen by anyone else but me, the school counselor, and people helping me at my school. You will miss as little class time as possible and will most likely come to see me during independent study time or when the teacher assistant is doing an enhancement activity.

I think that you will have fun during the playtimes. If you have any questions, you can ask them any time. Do you have any questions right now?

If you would like to meet with me and understand what I have said to you today, please write your name below.

_____

Participant's signature and date

_____

Investigator's signature and date

APPENDIX K: PLAY THERAPY SKILLS CHECKLIST (PTSC)

PLAY THERAPY SKILLS CHECKLIST (PTSC)

Therapist: _____ Student Code: _____
Observer: _____ Session # & Time: _____

Therapist Non-Verbal Communication		Too Much	Appro-priate	Need More	None	Therapist Responses/ Examples	Supervision Comments
Lean Forward/Open							
Appeared Interested							
Relaxed Comfortable							
Tone/ Expression Congruent with Child's Affect							
Succinct/ Interactive							
Rate of Responses							
Therapist Responses:	# of Responses	Too Much	Appro-priate	Need More	None	Therapist Responses/ Examples	Other Possible Responses
Tracking Behavior							
Reflecting Content							
Reflecting Feelings							
Facilitating Decision Making/ Responsibility							
Facilitating Creativity/ Spontaneity							

Esteem Building/ Encouraging							
Facilitating Relationship							
Limit-Setting							
Non-CCPT Responses							

Child Made Contact/Connectedness: Yes No Examples:
Identified Themes:
Therapist's Strengths:
Areas for Growth: