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Language Abilities of Children who Qualify for Both Speech and Language Therapy and Play Therapy

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Abstract

Play is an essential role in the development of children's language and social-emotional well-being. Intervention methods with the use of play are used by both registered play therapist and speech-language pathologists. This study aims to explore if students who have met the eligibility requirements for speech-language therapy services are also eligible for child-centered play therapy services, as well as examine if students who qualify for both services have common characteristics. Findings demonstrated that students who qualified for CCPT and had individualized education plans (IEPs) for speech-language services had significantly lower poor peer social skills, as determined by teacher's rating scores, compared to students who did not have an IEP. Implications for the treatment of students who have an IEP for speech-language services and qualify for counseling services are discussed.

Introduction

Interprofessional collaboration in the educational setting is vital to a holistic approach to addressing a child's individual needs. Despite the benefits of interprofessional practices (IPP), collaboration in the educational setting can be challenging. Some challenges that impede IPP from occurring in the school setting include time constraints and scheduling conflicts; however, interprofessional practice can be an effective way to set a child up for success (Kerins, 2018). There is substantial evidence that supports the idea of collaboration within services for the well-being of a child (Choi & Pak, 2006; Ellis et al., 2005; Johnson, 2016). Counselors and speech-language pathologists often work with the same students in the educational setting. While there are often language and social-emotional goals that could be integrated into each others sessions, professionals often do not implement IPP when working with students and are often unaware of the goals and objectives being addressed for students who qualify for both types of services. Currently, there is limited evidence of collaboration occurring with child-centered play therapists and speech-language therapists. The purpose of this research inquiry is to determine if behaviors that are assessed for eligibility for counseling services are also present for students who qualify for speech-language therapy services.

Historical Perspectives of Child-Centered Play Therapy

Child-centered play therapy (CCPT) services are provided by licensed professional school or mental health counselors who are registered play therapists (RPT) and work with children of varying ages. The goal of CCPT is to establish the use of play to help students sort out psychosocial stresses and become the best version of themselves through self-expression and interpersonal connection ("Association for Play Therapy," n.d.). While there are various theoretical approaches to play therapy, the CCPT therapist allows the child to lead the session

within the safety of therapeutic limits, which are only set as needed. The purpose of this is to allow the child to build confidence and develop self-control (Landreth, 2012). This type of interactive play is critical to enhance language, social, and behavioral skills. Play therapy is normally used with younger children, ages three to twelve (Cornet, n.d.). Play within this practice is often monitored based on developmental age levels and used as a way to connect with a child. Child-centered play therapy is an evidence-based intervention practice that many professionals support as a tool that allows children to communicate with adults in a non-threatening way (Baggerly et al., 2010).

From a historical perspective, CCPT evolved from several established therapeutic practices that counselors still utilize in educational settings. Each of these subtypes have played a role in the development of CCPT.

Non-directive Therapy

Non-directive therapy, also known as client-centered therapy, is a theory based on the idea that a therapist is present to clarify the expressed feelings of an individual that are expressed by the client. Using this theoretical framework, Carl Rogers posited that therapists should be active and involved in therapy sessions (Rogers, 1951). Non-passive perspective therapy birthed child-centered play therapy (Landreth, 2012).

Relationship Play Therapy

The idea of non-directive therapy was influenced by relationship therapy (Lebo, 1955). Within this therapy practice, therapists use the technique of opting out of play until they are invited in by the child (Allen, 1934; Taft, 1933). This idea of waiting for an invitation comes from the knowledge that counselors and therapists alike need to consider the client a partner in the process (Larson & McKinley, 1985). The progression of relationship play therapy allows for an

understanding of the importance around establishing a formative relationship between the client and the therapist. Trust comes from spending time with an individual. Being invited into a client's play or life takes trust (Allen, 1934; 1942).

Release Play Therapy

Much of the idea built around the importance of building a relationship with the client and therapist came from learning from release therapy. Release play therapy puts the child in control of the sessions and allows them power over a past traumatic event. The child gets to control the outcome of the event that has already happened by using a limited number of toys (Levy, 1938, 1939). The therapist in this type of therapy can expect to learn what the child is thinking without them saying it through their expression with toys. This therapy practice has emphasized the idea that actions can speak louder than words.

Psychoanalytic Play Therapy

The psychanalytic play theory gave the first ideas on how to design therapy for children (Homeyer & DeFrance, 2005). Melanie Klein understood that, like adults, children had mental health problems, too (Klein, 1955). She combined elements of psychanalytic theory with her understanding of children's ability to express themselves through play. In this setting, play is seen as symbolism for therapists like work is for adults. Based on her observations, Klein predicted that if children could learn to identify their feelings and express themselves through play, then as adults they would have a better chance of being able to manage and express emotions. Another positive outcome of psychanalytic theory was that childhood traumas could be worked out with children while they are occurring not after the fact as adults (Klein, 1955). Psychoanalytic play therapy was the first step in establishing what CCPT is today.

Speech-Language Therapy

Speech-language pathologists (SLPs) who work with children also use play effectively within the therapeutic setting as they assess, diagnose, and treat many forms of communication difficulties. With the pediatric population, play occurs during the assessment and treatment process (American Speech-Language-Hearing Association ([ASHA]). The profession of speech-language pathology has been around since the 1920s, and there is substantial evidence that supports the benefits of speech-language therapy (Enderby & Emerson, 1996; ASHA, n.d. Early Intervention). Unlike CCPT, a large part of a speech therapists practice is therapist-directed play. Speech-language pathologists engage in strategic play with a child with goals and objectives to formulate speech sounds, enhance language skills, or facilitate appropriate social interaction while conducting therapy for the purpose of a generalization of skills.

Play and language are intricately connected when it comes to speech-language therapy for children. An SLP can look at the developmental milestones and compare them to the child as part of a comprehensive evaluation to determine if he or she is eligible for services. Age-appropriate play skills assist and facilitate the development of language skills with the implication that delays in the area of play may impact a child's language skills (Clark, n.d.).

There are three main types of play: functional play, symbolic play, and game play. Functional play is when a child starts to explore play through motor and sensory functions. Functional play typically begins to emerge before the age of two and continues on through the later stages of play. Symbolic play is when a child uses constructional and dramatic play. This type of play may include pretend scenarios, materials, and the use of creativity through self-expression. Symbolic play typically develops between the age of two and five. Game play is how a child views play in the means of sports, card games, board games, or other types of games that

require a higher level of cognitive thinking. Typically, Game play develops around school age and progresses throughout ones life span.

Carol Westby, an expert in the field of play and language, created a scale called the "Westby Play Scale" that shows where a child should be when it comes to the stages of play and their language in regard to their age of development (Westby, 2000). The scale describes ten developmental stages of symbolic play, including detailed descriptions of language associated with each stage of play. Play is an essential component during the assessment process when determining if a young child has a language delay, and speech-language pathologists routinely use play when addressing language goals in therapy.

Benefits of Play

Play is understood and practiced by everyone, but it can be hard to define because it can mean different things for different people (Reed, n.d.). The benefits of play are, but are not limited to, physical development, academics, social and emotional learning, language skills, and joy (Miller & Almon, 2009). Play is not limited to one developing stage or another, it's for everyone. It is effectively utilized by both RPTs and SLPs in different ways, but is not the main focus of either practice. It instead is a tool used to maintain attention and focus on other difficulties. The overall goal for both therapies, when it comes to the use of play, is that play could be a piece in their practices that allows them to connect with a child and helps increase the overall well-being of their patients. There have been decades of empirical research on play and its benefits, and yet it is still not fully appreciated and utilized (Else, 2014; Atkins, 2002; "Benefits of Play," n.d.).

Counseling Considerations in the Educational Setting

Counselors have backgrounds in mental health and human psychology upon entering the profession and often work with students who have behavioral problems in the school setting (Association for Play Therapy). Although most education programs require little to no training in counseling or psychology for speech-language pathologists, many SLPs work with troubled students who have difficulties in the academic setting due to limited language skills (Wolter & DiLollo, 2006; DiLollo & Neimeyer, 2002; Crowe, 1997, Webster, 1977). Research shows there is a relationship between both academics and language skills, as all activities within the school system require adequate expressive and/or receptive language skills (Aram, Ekelman, & Nation, 1984; Bishop & Adams, 1990; Catts, 1993; Wallach & Butler, 1994). The need is great for SLPs to have a skill set or background in psychology because of this relationship in the school systems. For example, Wolter & DiLolla (2006) found that speech-language pathologists often work with individuals with low self-esteem and low confidence due to their learning or speech difficulties. Additionally, DiLollo & Neimeyer (2002) reported that psychological components are often discussed with individuals who stutter within the therapeutic context. Not only are low esteem and low confidence issues common with students who are eligible for speech-language services, SLPs also provide services to students who have pragmatic and social issues that impede social relationships in the school setting. Looking at a broader view, Webster (1977) discussed the need for counseling procedures for parents with children who are seeking speech-language therapy. Due to these commonalities, counselors and speech-language pathologists may be able to strengthen the academic, as well as overall mental health of their students by working together.

Opportunities for Interprofessional Collaboration

Evidence from the literature has demonstrated various positive outcomes when collaborative efforts are effectively used. Danger (2003) found that children in kindergarten who received both play therapy and speech-language therapy showed a decrease in anxiety and improvement on receptive and expressive language skills compared to other children their age who were not participating in speech-language therapy and play therapy at the same time. Wakaba (1983) found that Japanese children who had stuttering difficulties while speaking, and also showed anxiety, and/or aggressive behavior improved if they were placed in group play therapy sessions as well as speech-therapy sessions within the same time frame. Wakaba's study showed improvements in not only stuttering, but also anxiety and aggressive behavior for the children that showed these characteristics.

Areas that are important and addressed by certified counselors and speech-language pathologists include task orientation, behavior control, assertiveness, and peer social skills. Examples of how task orientation skills might be observed in a child could be how they follow instruction, if they can work well without adult support, or if they complete schoolwork regularly. If a child struggles to follow instruction or complete work on their own they might struggle with task orientation skills. Examples of how behavior control could be observed in a child could be how a they tolerate frustration, if they are anxious or worried, and if/how they express their feelings. If a child struggles with controlling their behavior when frustration may arise, are continually anxious or worried, or have trouble expressing their feelings, then they may struggle with behavioral control. Examples of how assertiveness could be observed in a child is by examining if they would be considered a self-starter, if they are comfortable with leading, or if they defend their own views under pressure. If a child is not a self-starter, struggles with

leading, or struggles to defend their own beliefs then the child may struggle with assertiveness. Examples of how peer social skills could be observed within a child could be how they interact with peers, makes friends, or how they are viewed by their peers. If a child finds it difficult to make and maintain friendships they may struggle with peer social skills (Weber, Lotyczewski, & Montes, 2017).

Interprofessional collaboration can benefit a child's entire well-being and thus, cohesive practices that create shared common goals among professionals are essential for the success of a child (Bowers & Perryman, 2018). While both counselors and speech-language pathologists serve children from vulnerable populations within the school system, they are often unaware of which students on receiving services from both professions. There is a dearth of research on the collaboration of speech-language and child-centered play therapies, thus, we have limited knowledge on if team-based approaches are being used.

In summary, children who have delays in language may also exhibit negative social emotional skills in the classroom setting and benefit from counseling services. The purpose of this research study is to determine if students who are eligible to receive speech-language therapy services are also eligible for child-centered play therapy services. There is little research that has been done on the collaboration and correlation between speech-language therapy conducted by speech-language pathologists and child-centered play therapy conducted by licensed counselors. The goal of this project is to explore how many students who have met the eligibility requirements for speech-language therapy services also qualify for child-center play therapy and what, if any, are the similarities in characteristics of children receiving speech-language therapy services and child-centered play therapy.

Research Questions

1) How many students who have met the eligibility requirements for speech-language therapy services are also eligible for child-centered play therapy services?

2) Based on the Teacher-Child Rating Scale, what are the common characteristics (if any) of students who qualify for both child-centered play therapy services and speech-language therapy services?

Methodology

This study examined if children who are eligible for speech-language therapy services are also eligible for child-center play therapy as measured by the Teacher-Child Rating Scale 2.1 (TCRS 2.1; Rogers, 1951). An item analysis of the TCRS subtests was used to determine similarities in the data, if any, regarding children receiving speech-language therapy services and child-centered play therapy.

Participants

Seventy second grade students from one elementary school were screened using the Teacher-Child Rating Scale (TCRS 2.1) to determine students' who qualified for certified play therapy services. Additional information from students that was collected includes: IEP, attendance, race, sex, and age.

Materials

The Teacher-Child Rating Scale (TCRS 2.1) is a screening tool that is used to assess if a child is at risk for behavioral problems. It is completed by a child's teacher who is asked to evaluate positive and negative characteristics that could determine a child's ability to transition into the academic setting. The TCRS 2.1 includes 32 total items in four subtest categories (8 questions per subset): task orientation, behavior control, assertiveness, and peer social skills. Each

question allows the teacher to rate the child from 1-5 depending on if they believe the description given matches the child or not. These scores are then evaluated by certified counselors to see if certain students may qualify for services or not.

Procedures: Second grade teachers from one school completed the TCRS 2.1 on all children in the second-grade at the beginning of the year over two years. Data was merged for the two cohorts. A total of 93 children were screened using the TCRS 2.1, with 61 students qualifying for CCPT. Demographic information, including sex, race, and eligibility for speech-language services (as documented by an IEP) for the students who qualified for CCP are reported in Table 1.

Table 1. *Original and Oversampled Demographic Data.*

		Original N=61	Oversampled N=190
Sex	Male	32 (52%)	103 (54%)
	Female	29 (48%)	87 (46%)
Race	Hispanic	37 (61%)	128 (67%)
	White	7 (12%)	25 (13%)
	Black	2 (3%)	3 (2%)
	Pacific	15 (25%)	34 (18%)
IEP	Yes	8 (13%)	100 (53%)
	No	53 (87%)	90 (47%)

Data Analysis

Descriptive statistics were used to determine if students who were eligible for speech-language therapy services were also eligible for counseling services. A comprehensive qualitative analysis of the TCRS 2.1 subtest items, task orientation, behavior control, assertiveness, and peer social skills, was conducted to determine themes in the data. For statistical analysis, the Synthetic Minority Oversampling Technique (SMOTE) was then used due to the imbalance in the number of students qualifying for SLP services (see Table 2). Then, a random forest-based algorithm was used to analyze the data.

Results

Of the 93 students who were given the TCRS 2.1 screener, 66% (N=61) qualified for CCPT services. Of the nine students who had an active IEP (i.e., was in speech-language therapy) eight IEP students also qualified for play therapy services. As stated, SMOTE oversampling was used to account for the imbalance of students who qualified for CCPT services but had no IEP (N=53) and students who qualified for CCPT services and had and IEP (N=8). The oversampled data for the TCRS 2.1 is listed in Table 2.

Table 2. *Original and Oversampled TCRS 2.1 Data.*

	Original N=61			Oversampled N=190		
	Mean	Min	Max	Mean	Min	Max
Age (months)	90.56	84	103	90.75	84	103
TO_PRE	26	1	86	26	1	86
BC_PRE	34	6	77	35	6	65
ASSERT_PRE	29	3	74	27	4	74
PSS_PRE	31	1	78	29	1	77

When TCRS scores were analyzed using a conditional inference tree by IEP status, there were two big indicators for age being a determining factor within the data (see Figure 1). First, for students who identified as White or Hispanic, had poor peer social skills (below or equal to a score of 42.114), and were below or at the age of 85 months, then 0% of the students qualified for speech services. Second, if an individual identified as White or Hispanic, had poor peer social skills (below or equal to 42.114), were older than 85 months of age, had poor behavioral control scores (below or equal to 31), and were below or at the age of 95 months then around 20% would qualify for speech services. If an individual identified as White or Hispanic, had poor peer social skills (below or equal to 42.114), were older than 85 months of age, had poor behavioral control

scores (below or equal to 31), and were above the age of 95 months, then 100% of the students qualified for speech services. Overall, through the data we learned that those students who identified as White or Hispanic, had poor peer social skills and were older were more likely to qualify for speech services.

Another important demographic that emerged from the conditional inference tree was sex. The biggest indicator within the data that appears on the conditional inference tree for sex was for those who identified as Black or Pacific Islander. Those who identified as Black or Pacific Islander and were female did not qualify for speech services. Those who identified as Black or Pacific Islander and were male were about 40% likely to be in speech services. Overall, the data demonstrated that students who identified as male were more likely to qualify for speech services than those who identified as female.

Race was another important demographic indictor within the data of significance on the conditional inference tree. On the conditional inference tree race appears twice. First, those who identified as White or Hispanic were grouped together and those who identified as Black or Pacific Islander were grouped together. Individuals who identified as Black or Pacific Islander were then broken up by race, as stated above; Black or Pacific Islander Males were more likely to qualify for speech services than Black or Pacific Islander females. Second, race was an indicator for those who scored above the 31 percentile in behavioral control. Those who scored above the 31 percentile and identified as White were about 60% likely to qualify for speech services. Those who scored above the 31 percentile in behavioral control and identified as Hispanic were about 97% likely to qualify for speech services.

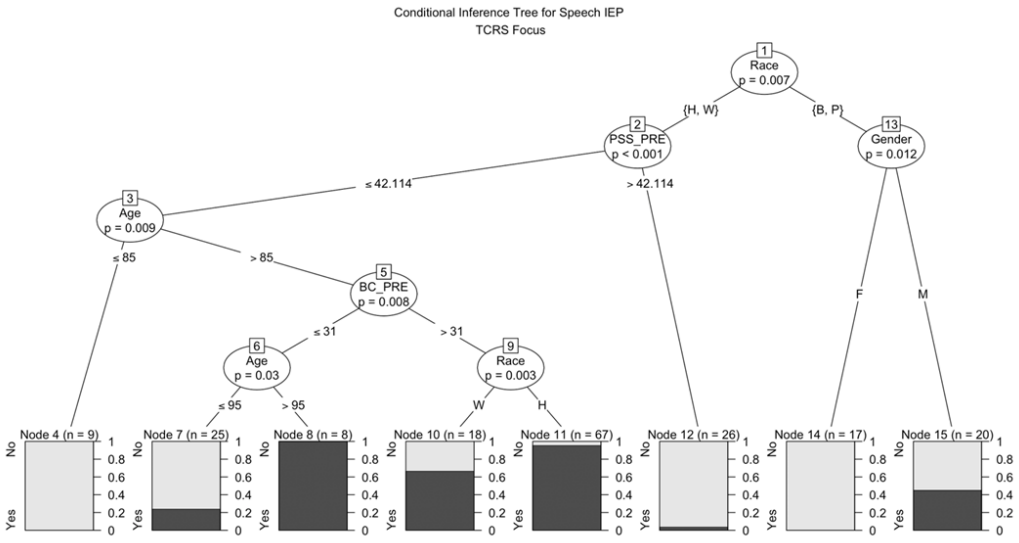

Figure 1. Conditional Inference Tree for Speech IEP with TCRS focus.

TCRS 2.1 Results

A Pearson's correlation was used from the oversampled data from the TCRS 2.1 scores of the second-grade students. A significant correlation was found within the data between group and peer social skills (need *p* value here). Students who qualified for counseling services and were eligible for speech-language services had significantly lower peer social skills compared to students who were not eligible for speech-language services.

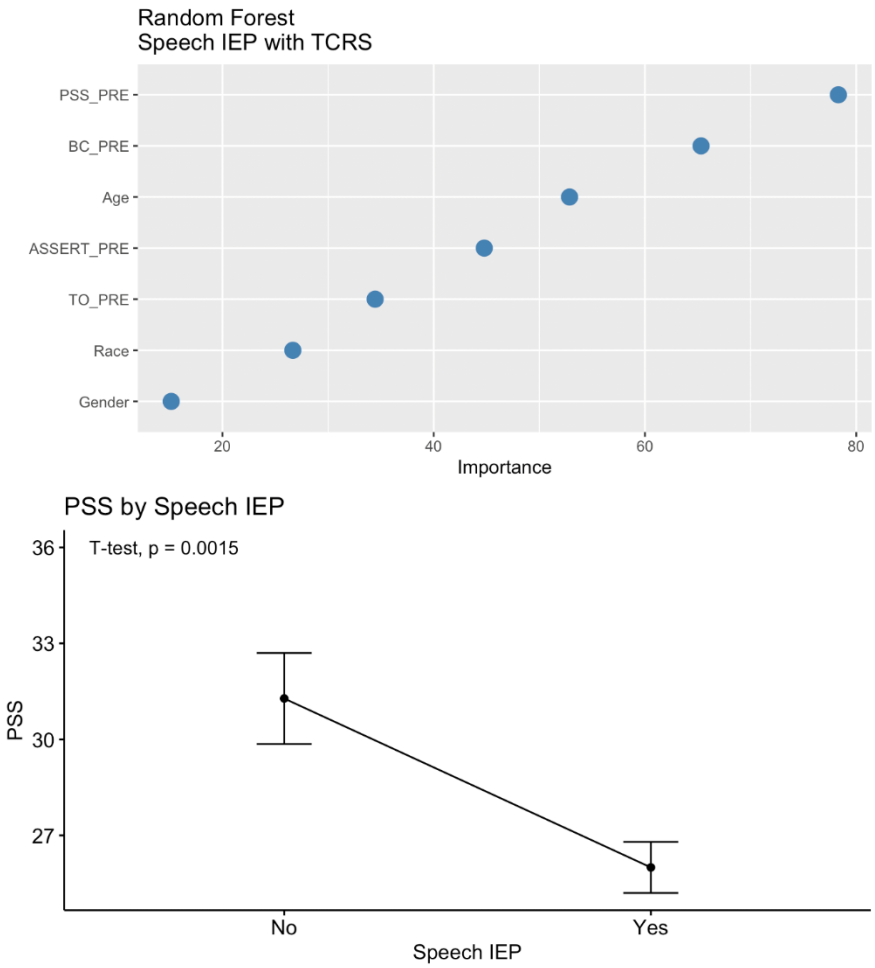

Figure 2. Random forest Speech IEP with TCRS 2.1 and Peer-Social Skills (PSS) by IEP.

Discussion

This study aimed to determine a number of individuals who met the requirements for speech-language therapy and child-centered play therapy as well as discover if there were any common characteristics among students who qualified for both services. Findings from this study demonstrated that demographics, specifically race and sex, were significant in the TCRS 2.1 scores and IEP status. Findings from this study also demonstrated an important relationship between language skills and peer/social interactions of students who qualified for CCPT services and had an active IEP. Specifically, of the cohort of second graders who qualified for counseling services, teachers perceived the peer/social skills of students who also qualified for speech-

language therapy to be significantly lower than their peers. These findings demonstrate how poor peer social skills could be an indicator for a child to qualify for both speech-language therapy services and play therapy services. Thus, coordination of efforts for RPTs and SLPs using play in CCPT and speech-language therapy may be warranted to increase positive peer social interactions within the classroom setting.

Interprofessional Collaboration

Interprofessional collaboration is essential to the benefit of the whole child (Bowers & Perryman, 2018). Both professionals, RPTs and SLPs, involve play in their work with children. Both professionals have been trained and understand the importance of play for the overall child's success. However, there has been limited opportunities for the interprofessional learning with or from the other. There is also limited evidence in the literature that RPTs and SLPs intentionally involve play to reach each other's goals. Through play, language is developed and psychological stressors are sorted out (Clark, n.d., & "Association for Play Therapy"). Through observation and communication between each other, common goals could be addressed in both services which could lead to a child functioning at their optional emotional, behavioral, and linguistic potential. This would greatly benefit both child and their therapists.

This research highlights that peer social skills are a common characteristic found in children who qualify for counseling and speech-language therapy services. If peer social and interactional goals were set between both practices a child's psychological stress and language could both benefit.

Professional Perspective

An interview was conducted with the school speech-language pathologist who was providing the services to all students in this study with an IEP. In the interview, she discussed

her work experience, including her interprofessional collaboration experiences, in the elementary school setting. This interview was conducted at the end of the year and while not a part of the original research design, it provides insight to the potential benefits of IPE.

The speech-language pathologist was various question about how she spent her time during the day and in what area of the elementary school. The SLP reported that she spent the majority of her day with students, leaving only a range of 4-10 hours per week for collaboration efforts, other meetings, and responsibilities not related to working with students directly. She reported serving students in various settings, including the general education classroom setting (25% of the time), with the remainder (75%) of the time spent in her designated therapy room/office. She reported spending as average of 2 hours, or 5% of her work week, with other specialized professionals, but did not work directly with general education teachers, even when providing services in the general education classroom.

Other information that was collected that sparked interest was the fact that the SLP had no idea what the classroom curriculum was for her students that participated in her therapy services. There seemed to be very little communication between the general education teachers and the SLP. Prior to this larger research study, the SLP also had little interaction with the school counselor. She reported that by the end of the year, the school counselor was regularly attending special education meeting that the SLP and SPED teachers held monthly. Both the SLP and school counselor commented on how they planned to continue to increase their collaborative efforts after this study was concluded.

Limitations

The results of this study should be considered in the light of some possible limitations. The imbalance in the groups (students who had and IEP and students who did not have an IEP) is

a limitation that should be considering when interpreting the results from this study. Additionally, the data was part of a larger research study that had being previously collected and there was limited access additional information (e.g., full interview with the school counselor, IEP goals and objectives). Lastly, the sample selection of students used in this study were from the same location and, therefore, could share similar characteristics that were not evaluated in the data. A larger sample could have been randomly selected between differing school systems, cities, or states.

Conclusions & Future Direction

Interprofessional collaboration in the educational setting can greatly enhance a holistic approach to a student's success. With a common factor emerging from the data set being low peer social skills for students who qualify for CCPT and SLPs services, RPTs and SLPs should work together to create goals and coordinate services that aim to increase positive peer social interactions for students. Shared professional development opportunities that leverage knowledge regarding the power of play within the therapeutic setting with SLPs and RPTs would be one way to establish IPE and IPP with these disciplines.

Interprofessional Education should include providing students receiving higher degrees of undergraduate level or higher who are planning or being prepped to work with school age children resources and real work experience of IPP in practice. Both registered play therapists and speech-language pathologist could learn from each other's practices by observation and teaching when it comes to play and language. Possessing an understanding of developmentally appropriate language skills as well as the signs of a language delay/disorder could be beneficial for registered play therapist, as well as having a deeper understanding of what an SLP’s job is. For SLPs, understanding certain ques from children and addressing psychological needs if they

arise could greatly impact their work in a beneficial way. For example, the RPT could teach the importance of waiting to be invited into a child's direction of play. Learning these skills and how to incorporate IPP in the school setting should start within undergraduate level classes and progress through graduate school advancement.

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