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Shining From Within: The Effect of Group Counseling on the Self-esteem of Students in Individualized Education Programs

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Shining From Within: The Effect of Group Counseling on the Self-esteem of Students in

Individualized Education Programs

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Abstract

The intent of this study was to ascertain if group counseling would be an effective intervention in raising the self-esteem levels of middle school students in Individualized Education Programs. A literature review is presented, which discusses the definition of disability as well as the accommodations and programs available to students diagnosed as having a disability. Further, the definition of self-esteem and self-concept are discussed and various self-concept domains are examined and evaluated. Relatedly, this study explores methods that have been utilized within the school environment to increase a student's self-esteem, including the employment of group counseling. Within this study, 14 students diagnosed as having a disability, volunteered to participate in a 12 week long counseling program. Group members were chosen as they were all Individualized Education Program (IEP) students participating in an existing counseling group that taught an existing group counseling curriculum as the primary intervention. The participants completed The Piers-Harris Children's Self-Concept Scale as a pre-test and post-test, which was used to quantify changes in their self-esteem levels as a result of intervention. Results are discussed, as well as the implications that this study may have on forthcoming school counselors and potential studies related to students in Individualized Education Programs and their self-esteem.

From an early age a child's self-esteem is sculpted thru a multifaceted collaboration of factors. Constantly developing and evolving, their self-esteem cultivates from the reflections they see of themselves through the eyes of those that mean the most to them. Every child's self-esteem grows with each experience they encounter; both good and bad, within the academic, social, emotional, physical and athletic domains of self-concept. The aforementioned is also accurate for students who are diagnosed as having a disability.

Research suggests that children with disabilities are at risk for having lower self-esteem and self-worth than that of their peers. These children are met with the abounding adverse and stereotypical positions of others, as well as an array of challenges that far outreach their diagnoses. According to the National Center for Learning Disabilities (2012), however, it has been advocated that if a student is able to continually enrich their self-awareness, self-esteem, significant relationships, coping skills, and life schemes within the school setting and with peers that are living comparable experiences, they are more apt to thrive. Further, students with a strong self-concept are more likely to be motivated to do well in school, have congenial relationships with friends and family, demonstrate fewer behavioral tendencies, try more intensely when confronted with difficulties, and consider themselves valuable and capable persons. As such, whether a child is diagnosed as having a cognitive, physical, emotional, or behavioral disability, the development of a fervent, affirmative self-esteem is critical to their success.

The purpose of this study was to utilize group counseling as an intervention and to determine if an existing counseling program would be an effective means of increasing the self-concept of students in Individualized Education Programs. The researcher, therefore, sought to

answer the question, “Will group counseling be effective in increasing the self-concept of students in Individualized Education Programs?”

Schools offer the perfect environment to promote a child’s positive perception of self in a safe and nurturing environment, and as such, offer a superlative atmosphere to test the research question. Specifically, a group counseling intervention within the school setting can help to optimize overall physical, social, and emotional development by promoting convenience, efficiency, rehearsal, a sense of belonging and the opportunity to learn from peers in similar situations.

For the purpose of this study, self-concept is being defined as a multidimensional construct that denotes the evaluation of self in regards to domains (Santrock, 2009), while self-esteem is described as a subdivision of self-concept and refers to the inclusive evaluations of the self (Rice & Dolgin, 2005; Santrock, 2009); both terms are used interchangeably within the research. Further, with regards to self-esteem and self-concept, the participants of whom self-esteem is being measured, are diagnosed as having a disability. According to the Americans with Disabilities Act of 1990, and the Disability Discrimination Act (1995), disability refers to a person with a physical or mental deficiency that affects day-to-day endeavors, and offers comprehensive and prolonged adverse effects.

Several limitations are identified for this research project. Much of the data is not sufficient to generalize to the overall population, as the study was limited to only middle school students in one school district. Further, the representative sample size was too small, at only 23%. Another limitation noted is that many of the participants missed several group sessions due to illness, needing to make up classwork, in-school suspensions, etc., and often, the amount of time allotted for each group session was not sufficient when variety of circumstances including

issues and mix-ups with pass distribution, students needing to check-out and obtain homework from teachers before coming to the counseling center, and/or students leaving/returning from outside medical and mental health appointments. Lastly, the researcher's lack of experience both in giving assessments and counseling practice, were limitations to the overall study.

Finally, for the purpose of this study, the researcher obtained Institutional Board Approval (ethics review committee) prior to beginning any research. The committee ensured that the researcher did not violate any considerations including, obtaining permission from the school, parents and students prior to initiating the data collection, avoiding anything that might have caused physical or emotional harm to the subjects, and keeping all findings anonymous. Further, all results were accurately represented and confidentiality of the participants was maintained.

Review of the Literature

Scholars and academics alike have acknowledged that a positive self-concept is fundamental to a student's scholastic achievement and overall personal development (Harter, 1982, 1993; James 1890). Within this context, self-concept refers to domain specific self-perceptions and evaluations, including academic, social, emotional, physical and athletic (Pajares & Schunk, 2001; Santrock, 2009). Comparably, Alexander (2001) defines self-concept as "a person's inner appreciation or assessment of him or herself. It matters because people who do not value themselves – who have low self-concept – treat themselves and others badly. Thus, low self-concept can be seen as a major factor in abuse, addiction, crime, depression, loneliness, low educational achievement, mental illness and unhappiness. People high in self-concept are often creative, joyful, fun to be with and productive" (p. 332).

For children identified as having a disability, however, a negative self-concept becomes probable as they struggle with coexisting emotional and interpersonal adversities, which stem

from their experiences within the school setting. Beyond their academic struggles and self-perceptions, these children must also face the perceptions other individuals hold of them within each of the domains. The combinations of these adversities work to enhance the probability of the child anticipating and then suffering social failures (Amerikaner & Summerlin, 1982).

In 1993, the American School Counselor Association (ASCA) published position statements on a school counselor's connection with students diagnosed as having a disability. Within the document outlined roles were suggested for working with students with disabilities: (a) advocacy, (b) transition planning, (c) behavior modification, (d) counseling parents, (e) making referrals to specialists, (f) improving self-esteem, (g) working as part of the school multidisciplinary team, (h) teaching social skills, and (i) serving as consultants to parents and school staff (ASCA, 1993). As Corey and Corey (1992) suggested, the aforementioned counseling roles assist those students that have a disability in developing personally, educationally, socially, and vocationally.

Disability Defined

Founded on the patterns of behavior and emotional indicators (Diagnostic and Statistical Manual, 2000), nearly 2.8 of 53.9 million school-aged children have been diagnosed with a disability in the United States (United States Census Bureau, 2011). The United States Department of Education (2004), however, estimates that as many as 6.5 million newborns, toddlers, children and youth have disabilities, suggesting the statistics are rising. For many of these pupils, converging academic, social, physical, behavioral, emotional and athletic aptitudes and expectations can be an overwhelming and often unproductive experience (Pajares & Schunk, 2001). The diagnosis of disability warrants distinctive approaches or other individualized accommodations to providing education (United States Census Bureau, 2011). The process of establishing these approaches has been transformed throughout contemporary times.

In 1975, Congress constituted the Education for All Handicapped Children Act, which mandated all public schools to endow equal access to education for children with physical and mental disabilities (United States Census Bureau, 2011). Subsequent to years of expansion, reauthorization and amendment, the newly termed Individuals with Disabilities Education Act (IDEA), mandates free, appropriate, public education to every student (FAPE), aged 3 to 21, that meets the benchmarks of a diagnosable disability (U.S. Department of Education, 2004; United States Census Bureau, 2011). IDEA defines disability as any child who has:

Mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbances [...], orthopedic impairments, autism, traumatic brain injury, other health impairments, or special learning disabilities; and who, by reason thereof, needs special education and related services (U.S. Department of Education, 2004, p. 401).

Comparatively, both the Americans with Disabilities Act of 1990, and the Disability Discrimination Act (1995), characterize disability as a person with a physical or mental deficiency that affects day-to-day endeavors, and offers comprehensive and prolonged adverse effects. Further, deficiency is outlined as sensory impairments, including those affecting vision or hearing; as well as impairments with fluctuating or cyclical effects such depression and epilepsy; organ specific issues, including respiratory ailments; developmental deficiencies such as autistic spectrum disorders (ASD) and dyslexia; progressive impairments including forms of dementia; learning complications; impairments shaped by damage to the body or brain; and mental health conditions and mental illnesses, such as schizophrenia and eating disorders, as well as personality disorders and self-harming behavior (Disability Discrimination Act, 1995).

Individualized Education Programs and Disability

After a disability diagnosis, parents, teachers, school administrators and related service personnel of children that portray physical and mental impairments, are often able to begin the

process of student evaluation (National Center for Learning Disabilities, 2012). A disability diagnosis, however, is not, in and of itself, sufficient for special education services. Eligibility is granted only when the educational achievement of the student are adversely affected by their diagnosis. An assessment of the student's cognitive impairments and a psychological or psychiatric evaluation, which demonstrates social and emotional impairments, are also required (Leichtentritt & Shechtman, 2010; Palombo, 2001; United States Census Bureau, 2011).

Pending eligibility, the aforementioned parties then work to develop a composed, legal, truly individualized education document, the Individualized Education Program (IEP; National Dissemination Center for Children with Disabilities, 2012; National Center for Learning Disabilities, 2012; United States Census Bureau, 2011). The IEP helps to ensure equity in education for every student with a disability by stipulating, in writing, the accommodations that the student is entitled to receive (National Center for Learning Disabilities, 2012; United States Census Bureau, 2011). The document also illustrates both noticeable and unseen adversities including, interpersonal conflict, feelings of loneliness (Lackaye & Margalit, 2006; Margalit & Al-Yagon, 2002; Pavri & Monda-Amaya, 2000), low self-esteem (Arthur, 2003), social strains (Wiener & Tardif, 2004), adverse behavior, pessimistic temperament, low self-efficacy, and (Baird, Scott, Dearing & Hamill, 2009; Lackaye & Margalit, 2006), depression and anxiety (Li & Morris, 2007; Sideridis, 2007). As such, the IEP is meant to ensure that students with disabilities obtain appropriate placement, receive help in coping with emotional and social challenges, and experience an enriched quality of life within the school setting (Leichtentritt & Shechtman, 2010; National Center for Learning Disabilities, 2012; Simon, 2006).

The IEP includes the child's strengths, parental philosophies for enriching their child's education, results of recent evaluations, and how the child has achieved on state and district-wide

tests in the past (National Dissemination Center for Children with Disabilities, 2012). Lawfully, the IEP must also include annual objectives, special education and related services required, administered accommodations, needed transition services, and measured progress (National Dissemination Center for Children with Disabilities, 2012; National Center for Learning Disabilities, 2012). Children are re-evaluated on an annual basis to modify any services rendered or accommodations provided that were not effective. Subsequent to the re-evaluation, a revised plan may be suggested (National Center for Learning Disabilities, 2012).

Accommodations for Students with Disabilities

Accommodations, or adaptations to the traditional rendering of educational services, are utilized in an attempt to support students with disabilities in the classroom and throughout mandated state and/or district assessment (National Dissemination Center for Children with Disabilities, 2012). It is projected that two-thirds of special education student's utilize accommodations in statewide assessments (Bolt & Thurlow, 2004). For students with hearing, optical, and learning disabilities, *presentation accommodations* help manage the means in which instructions and academic/social content are both delivered and received; examples include, but are not limited to, oral reading (either by an adult or a tape), enlarged print, manipulative objects, and sign language (Cortiella, 2005; National Dissemination Center for Children with Disabilities, 2012). Using a computer/typewriter or a scribe to record answers or responding directly in the test booklet rather than on an answer sheet are examples of accommodations in response. These alterations aid students with visual and hearing impairments, physical disabilities, and organizational problems to configure and examine their work (Cortiella, 2005; National Dissemination Center for Children with Disabilities, 2012). Accommodating students through a variety of settings provide classroom and testing environments that are beneficial for students that are easily distracted; testing in a separate location or with a smaller group and adjusting the

lighting are examples of *setting accommodations* (Cortiella, 2005; National Dissemination Center for Children with Disabilities, 2012). Lastly, accommodations in timing/scheduling allow flexibility in the *timing* of an assessment. Generally, this includes extended time, multiple or frequent breaks and testing over multiple days (Cortiella, 2005; National Dissemination Center for Children with Disabilities, 2012). As evidenced in the literature, students most frequently utilize extended time, alternative setting, and/or read-aloud accommodations (Bolt & Thurlow, 2004).

Accommodations, however, are not always effective in enhancing academic performance. Although scores usually improve with the implementation of testing modifications, a decline in scores was reported in some research (Elliot, Kratochwill, & McKevitt, 2001; Koenig & Bachman, 2004; Schulte, Elliott, & Kratochwill, 2001). Lower scores were concurrent with student accommodations being insufficiently coordinated. The researchers further surmised that low scores were a result of student's not having adequate opportunities to become acquainted with the setting prior to the testing situation (Elliot, et al., 2001; Koenig & Bachman, 2004; Schulte, et al., 2001). Stemming from these findings, it can be inferred that much diligence must be paid to the essential resources required for student achievement.

Self-Esteem

In the late 19th century, William James, a founding father of Western Psychology, first defined the "self" as how an individual feels about themselves based on their interaction with others; either positive or negative (Turner, 1998). According to James (1890), self-esteem was a ratio of an individual's accomplishments in relation to their potential. He believed that self-esteem was the byproduct of perceived competency in domains that held significance for the individual; that is to say, self-esteem stemmed from the belief that if an individual was proficient

within a specific domain that held great importance for them, they were more likely to view themselves positively (James, 1890; Neff, 2011).

Like James, Robert White and Charles Horton Cooley, saw self-esteem as a developmental phenomenon, in which self-esteem was gradually cultivated and was affected by behavior and experience (Mruk, 1995). Cooley (1902) propositioned that an individual's self-esteem developed exclusively from how they perceived being seen by others. White, however, hypothesized that both external sources, including the affirmations and judgments from others, and internal sources, formed the foundation for an individual's self-esteem (Mruk, 1995).

Similarly, Morris Rosenberg (1965; 1989) described self-esteem as a construct of an individual's thoughts and feelings about his or herself self, in relation to his or her unwavering sense of personal worthiness. As the leading scholar in the analysis of early self-esteem, Rosenberg postulated that receiving and acknowledging another individual's perspectives was an important factor in human communication. Within the communication process, however, individuals became awakened to the notion that they were the recipients of the evaluations and perceptions of others. Consequently, they began to see themselves through the lens of others (Rosenberg, 1965). In the review of these various perspectives and definitions, it can be denoted that self-esteem is not a static construct, but rather a dynamic concept that continues to be manipulated by an individual's expectations, accomplishments and/or perceptions (Mruk, 1995).

Self-concept

When conveying or deliberating the characterizations of both self-esteem and self-concept, researchers often use the expressions interchangeably within the context of the research literature (Santrock, 2009). Elbaum and Vaughn (2001) obscured the issue by stating that the terms self-esteem, self-concept, self-worth, self-perception, self-image, self-evaluation and self-regard were used interchangeably within the context of their study. Self-esteem, however, is a

subcategory of self-concept that refers to the global evaluations of the self and allows an individual to develop self-worth (Rice & Dolgin, 2005; Santrock, 2009). Self-concept is defined as a multidimensional construct that denotes the evaluation of self in regards to domains (Santrock, 2009). As children grow and mature, their self-concept becomes more conceptual and less distinct (Montemayor & Eisen, 1977; Rice & Dolgin, 2005). Whereas adolescents describe themselves in highly subjective and theoretical categories including personal philosophies, relational and motivational features, mood states, ideological beliefs and values, children view themselves in terms of objective and exclusive categories such as gender, age, likes, physical appearance and possessions (Montemayor & Eisen, 1977). Self-concept, therefore, undertakes a progressive transformation, and generates an image of the individual that is well-defined and unique (Montemayor & Eisen, 1977; Rice & Dolgin, 2005). Deduced from these studies, overall self-concept manages to remain fairly constant throughout an individual's life (Montemayor & Eisen, 1977; Shavelson & Bolus, 1982). Domain specific self-concept, however, has proven vulnerable to evaluations, societal judgments, experiences and personal interpretations (Rice & Dolgin, 2005; Shavelson & Bolus, 1982).

Self-esteem and Self-concept and Achievement

It is suggested that if a student is able to continually cultivate self-awareness, self-esteem, consequential relationships, coping skills, and life schemes within the school setting and with peers that are living comparable experiences, they are more apt to thrive (National Center for Learning Disabilities, 2012). Students with disabilities are also likely to thrive under the same aforesaid circumstances. Self-concept can be considered an overall snapshot of an individual's thoughts and feelings, as well as their perception of attributes and the way they are regarded by others (Rice & Dolgin, 2005; Rosenberg, 1989). Self-concept refers to domain specific self-

perceptions and evaluations with domains, including academic, social, emotional, physical and athletic (Pajares & Schunk, 2001; Santrock, 2009). Domains can be further subdivided to include specific academic subjects. A subdivision of academic self-concept, therefore, may include math, science, social studies and English. As such, perceptions of ability within these subject specific domains, influences the overall sense of academic self-concept. The academic self-concept, then pairs with all other domains to construct the global self-concept (Pajares & Schunk, 2001; Santrock, 2009).

Students with a strong self-concept are more likely to be motivated to do well in school, have congenial relationships with friends and family, demonstrate fewer behavioral tendencies, try more intensely when confronted with difficulties, and consider themselves valuable and capable persons (Eccles, Wigfield & Schiefele, 1998; Garaigordobil, Pérez & Mozaz, 2008). In contrast, children with a low self-concept are more likely to view themselves as having difficulty in academic subjects, evaluate their academic skills negatively in comparison to their peers, regard themselves as ostracized, feel inadequate in regards to athletics, are displeased with their physical attributes and demonstrate behavioral issues (Kloomok & Cosden, 1994).

Academic self-concept and disability

Students diagnosed as having a disability often experience feelings of inferiority, bullying, embarrassment, rejection and failure, which foster and protract negative self-beliefs, low self-worth, feelings of vulnerability, and low self-concept (Hughes & Baker, 1990; Whelan, Haywood & Galloway, 2007). Continued exposure to negative experiences associated with having a disability, and the corresponding emotions, can have a profound negative effect on the academic self-concept (Hughes & Baker, 1990; Marsh, 1989).

The enhancement of a student's self-concept has become a fundamental objective within the education system and is often viewed as a conduit used to address social imbalances experienced by disadvantaged students (Marsh & Craven, 2006). In their model of effectual schools, Brookover and Lezotte (1979) stressed that amplifying academic self-concept and academic achievement should be the foremost objective of schooling. It is noted that self-concepts play a significant role in determining a student's strength in scholastic accomplishment and their satisfaction and interest in school overall (Ackerman, 2003). As professionals and researchers agree that underachievement in schools and a low academic self-concept are classic attributes of students with disabilities, working to enhance their self-concept is of the utmost importance (Kavale & Forness, 2000).

Employing the Self-Perception Profile for Adolescents, Harter, Whitesell & Junkin (1998) learned that students with disabilities reported feeling inferior with regards to intellectual ability than did students without a disability diagnosis. Comparably, students that participated in the Piers-Harris Self Concept Scale generally perceived themselves as having less proficiencies and inadequate academic skills when compared with their general education peers (Gans, Kenny, & Ghany, 2003). An analysis of 28 studies surveying the divergence between the academic self-concept of students with disabilities and their average and high achieving peers was conducted. The researchers found that 89% of studies reviewed revealed that students with learning disabilities embrace a more damaging self-concept than their average-achieving peers. In contrast, only 7% of the studies suggested no significant difference between the two groups (Zelege, 2004).

Two studies that assessed the self-concept of students with disabilities found that these individuals consistently hold positive images of the self, but demonstrate deficient self-assurance

with regards to scholastic competence (Kloomok & Cosden, 1994; Montgomery, 1994).

Kloomok and Cosden (1994) used Harter's model to explore the association between global self-concept and various self-concept domains. They studied 72 elementary school students diagnosed with a disability and found that 67% of the children exhibited a positive global self-concept. When considering the academic self-concept of the same children, however, feelings of inadequacy were communicated by 85% of the participants implying that they felt inadequate academically, but good about themselves overall. As predicted, findings differed for students exhibiting both a low self-concept and a low academic self-concept, as these individuals held the lowest perceptions of their academic ability (Kloomok & Cosden, 1994). Kloomok and Cosden (1994) also found evidence that students with disabilities place high significance on academics in spite of their level of competence within the academic domain. In other words, the students did not disregard the value of scholastic competence in an attempt to improve their self-esteem, overall.

Relatedly, Montgomery (1994) used the Multidimensional Self-Concept Scale to assess the self-concept of 135, sixth, seventh and eighth graders. While Montgomery found that students with a disability reported lower academic self-concept than their peers without disability, there was not a significant difference reported in any other domain. Whelan, Haywood and Galloway (2007), provided similar findings, disclosing that students diagnosed as having a disability did not reveal substantial divergence in the social, family, affect or physical self-concept domains, indicating no generalization from one domain to another.

Social Self-Concept and Disability

The exploration of social self-concept, beginning as early as the 1970s, has demonstrated that children with disabilities are at a heightened risk for social skill deficits when compared to

students without a disability (Gresham & Elliott, 1989; Kavale & Forness, 1996). The deficit, however, is not acknowledged until age seven. Prior to age seven, children with a disability are not likely to utilize social comparisons as a means of self-evaluation (Ruble, 1983). According to Erik Erikson, these children are becoming self-sufficient in their widening social world and are focused on facing new challenges (Santrock, 2009). Between the ages of seven and nine, however, and traditionally during the transition to the middle school environment, social comparison begins to develop and alter social self-concept (Ruble, 1983; Santrock, 2009). The industry vs. inferiority developmental stage transpires as children begin grasping information and advancing their academic skills, although it can also be the stage when children experience feelings of incompetence and inadequacy (Santrock, 2009).

An overview of the literature suggests that children with disabilities, who demonstrate an inferior self-concept and feelings of inadequacy, are much less likely to be accepted by peers without a disability; these students typically feel the need to retract from their peer groups which often leads to segregation and considerable loneliness in a larger social context (Diagnostic and Statistical Manual, 2000; Pijl & Frostad, 2010; Whelan, Haywood & Galloway, 2007). When looking at domain specific self-concept, studies on social self-concept revealed inconsistent findings. In an analysis of 29 studies on the social self-concept of students with a learning disability, only 6 of the 29 studies reported a lower social self-concept in students with learning disabilities when compared to students without disabilities (Zelege, 2004). Within the findings, however, it is also noted that 21 of the 29 studies found no significant difference between the two groups. Most surprising, and expressing further discrepancy, two of the studies indicated a slightly higher self-concept for schoolchildren with a learning disability as compared to their peers without diagnosed disabilities (Zelege, 2004). As Whelan, Haywood & Galloway (2007)

suggested, students with moderate to severe disabilities are less likely to develop a low self-concept because they cannot completely comprehend their level of acceptance from peers

Unlike academic self-concept, which was infrequently conjoined with any other domain, social self-concept was linked in various areas. Students with disabilities are often negatively criticized and judged by their general education counterparts. The judgment, however, is repeatedly based on the externalized negative behavior exhibited by students, rather than the disability itself (Bakker, Denessen, Bosman, Krijger, & Bouts, 2007). Negative behaviors include impulsiveness (Wu, 2002), aggression towards peers and adults (Kanne, 2011; McNamara, 2010), delinquent behavior at home or in the community (McNamara, 2010), clowning around and inappropriate joking within the classroom, breaking school rules and referrals for discipline, magnetism toward other underachievers (Cihak, 2009), impaired social skills, strained relationships (Gresham, 2002), and behavior problems at home (Hubert, 2011).

Subsequent to the maturation associated with age, general education classmates begin to include academic performance to their judgments in addition to the negative behavior; this is likely due to their personal strengthening cognitive functioning (Bakker, et al., 2007). As evidenced in Bakker, et al. (2007), the sociometric status within special education was appraised by judgments on performance level as opposed to diagnostic label or overall popularity. According to the study, to be categorized as popular, within the sphere of special education, a female student must demonstrate an elevated scholastic performance level. In direct correlation, a subpar academic presentation will likely result in perceived social rejection and judgment (Bakker, et al., 2007). Intriguingly, self-perception of popularity did not always correlate with actual acceptance, likely indicating that the stigma associated with having a disability held more weight than academic performance.

Emotional Self-Concept and Disability

Due to their often poor scholastic performance and difficulties with self-concept, motivation, temperament and loneliness, it is not surprising that previous analyses have linked children with disabilities to the predisposition of social and emotional impediments (Gallegos, Langley & Villegas, 2012; Manassis & Young, 2004; Margalit & Al-Yagon, 2002). Specifically, students with special needs have been closely linked to an increased risk of depression and anxiety (Gallegos, et al., 2012). Studies have shown that the onset of these emotional disorders can be attributed to the intricacy of social information processing as well as their difficulties interpreting complex emotions (Margalit, 2004). Due to their lacking social skills, the victimization of students with disabilities often fosters feelings of depression and anxiety. Adjustment problems, rejection from peers, school frustration and limited flexibility and adaptability also contribute to the increased risk for anxiety and depression (Gallegos, et al., 2012).

Depression. An overview of the literature by Maag and Reid (2006) suggested that students with disabilities experience depressive symptoms. Here, depression is defined as a psychological disorder that is distinguished by symptoms of internal distress including melancholy, depleted self-concept and feelings of worthlessness. Often, these symptoms go undetected unless a student is able to actively self-report their experiences and feelings (Kazdin & Marciano, 1998; Kendall, Cantwell, & Kazdin, 1989). DeSocio and Hootman (2004) stated, “depressed children and adolescents attract less notice from teachers and school officials than do their disruptive classmates, but their academic performance can be severely compromised by symptoms of poor concentration, distractibility, insomnia and daytime sleepiness, irritability and low self-esteem” (p. 192). As such, self-reports have been described as the most important

source used to ascertain suppressed psychological problems (Seeley, Rohde, Lewinsohn & Clarke, 2002). Self-reports indicated that 32% of children with disabilities also are at risk for depression (Gallegos, et al., 2012).

Anxiety. Anxiety is a particular form of emotional stress that affects roughly 22.3% of children with disabilities (Gallegos, et al., 2012; Nelson, 2011) and can be correlated with deviant behavior, substance abuse, depression and an interference with academic, domestic and social functioning. Students usually express their anxieties with symptoms including crying, avoidant behaviors, nervousness and somatic distress; these manifestations have been likened to academics (Gallegos, et al., 2012). A meta-analysis of 58 studies revealed that because academic achievement is a principal endeavor and major developmental task during childhood, students that struggle to master scholastic skills develop anxiety in anticipation of failure (Nelson & Harwood, 2011). Overall, academic achievement produced that most anxiety for students with disabilities.

Physical Self-Concept and Disability

Physical self-concept, which can also be identified as body self-concept, is often defined by an individual's perceptions of themselves, designed by their experience with, and analyses of, the physical domain (Mayer & Eisenberg, 1982; Shavelson, Hubner, & Stanton, 1976). Research has suggested that physical self-concept correlates directly with body image dissatisfaction which can be explained as the discrepancy between the perceived image of the ideal body, and the image of an individual's current body (Wood, Becker, & Thompson, 1996). Body image is the dynamic view of one's physique which is influenced by perception, feelings, and physical impressions (Stanford & McCabe, 2002). Research has found that body image is not stagnant, but rather that it can change in relation to attitude, physical experience, and surroundings

(Banfield & McCabe, 2002). Adolescents are prone to experiencing highly active and altering perceptions of body image, because they experience substantial physical transformations during puberty (Santrock, 2009). Furthermore, scholars have discovered that an individual's self-perceptions, self-evaluations, and self-concept alike, are heavily influenced by their body image, even more so than by the evaluations of others. Cultural messages and social criterions of attractiveness and appearance, on the other hand, were founded to effectively persuade physical self-concept (Croll, 2012).

A perception of physical attractiveness is intimately linked with social acceptance and self-concept, and is shaped in part, by the messages sent by media outlets. Researchers have concluded that individuals deemed physically attractive by the media, peers, adults, etc., are more likely to have a higher physical self-concept, be perceived as socially practiced and amiable, be more likely to marry, hold a higher likelihood of obtaining a prestigious job, and be preferred as friends and significant others when compared to individuals considered unattractive (Berscheid & Walster, 1973; Dion, Berscheid, & Walster, 1972; Harter, 1993; Maner, Gailliot, Rouby, & Miller, 2007; Snyder, Tanke, & Berscheid, 1977). As such, the achievements of an individual who is perceived as physically attractive, highlights the valued social and personal aspects of today's society (Graham & Perry, 1976).

Unlike studies comparing academic self-concept or social self-concept, research on the physical domain has been predominantly focused on students without disability, and as such, has resulted in minimal documentation about the physical domain for students with disabilities. Specifically, the self-perceptions of physical appearance and its effect on the self-concept of individuals with disabilities have been infrequently examined (Heath & Wiener, 1996). A positive self-image, as evidenced in the research, has been associated with good health and

enhanced behavior in children (Dalgas-Pelish, 2006; Paradise & Kerr, 2002). Comparatively, a negative self-image has been linked to an increase in risk-taking and self-injurious behaviors, the onset of eating disorders and suicidal tendencies (Rhodes & Wood, 1992). Emler (2001) speculates that when an individual treats themselves inadequately as a response to their negative self-image, they also summon others to treat them negatively. Zigler and Bennett-Gates (1999) suggested that the aforementioned is equally applicable to adolescents with disabilities; however, the research remains limited.

As Berscheid (1981) suggested, what is evident is that attractiveness functions as a cue utilized to generate social evaluations of an individual; that is to say if an adult's perception of a child's appearance affects the manner in which he or she interacts with that child, it can be assumed that the child's perception of himself or herself will also be affected (Searcy, 1988). As such, a child with a disability that others perceive as attractive will be viewed positively as compared to an unattractive child and will therefore, develop a more positive physical self-concept (Berscheid 1981; Searcy, 1988).

Athletic Self-Concept and Disability

It is argued that participation in sports and exercise fosters a physically and psychologically healthy conduit for students (Daniels, Sirinda, & Campbell, 2005). Many scholars have documented sport participation's impact on student's self-perceptions (President's Council on Physical Fitness and Sports, 1997). The research, however, is just starting to move beyond a focus on simple associations, to address a more comprehensive impact of sport participation on domain specific aspects of the self (Brettschneider & Heim, 1997). Here, the focus is on athletic identity.

When viewed in combination with other aspects of an individual's self-concept, athletic identity plays a substantial role in understanding physical, social, psychological and moral development (Horton & Mack, 2000; Sallis & McKenzie, 1991). In this context, athletic identity is defined as a social construct that measures the degree to which an individual identifies with an athletic role (Brewer, Van Raatle, & Linder, 1993). Although the definition is concrete, the way in which individuals intellectualize the role of an athlete can waver. Some individuals identify an athlete as a person that partakes in a sport. Others trust that an athlete encompasses those that are skilled at a sport. Still others define athlete as one that is being physically active and fit by participating in a sport (Anderson, 2004). Although the athletic construct can be conceptualized differently, there is consensus that the term commonly refers to an individual's view of self, relative to physical activity and involvement in sport (Groff & Zabriskie, 2006). Students with a sound athletic identity view statements such as "I consider myself an athlete" and "sport is the only important thing in my life" as highly representative of themselves overall (Brewer, Van Raatle, & Linder, 1993).

The possession of a strong athletic identity in students without disabilities has been supplementary to improved athletic execution, a swelled social system, positive experiences in training, and commitment to sport (Horton & Mack, 2000). Heavily influenced by the opinion of friends, family and coaches, students often look to others for the validation of the role (Brewer, Van Raatle, & Linder, 1993). Research has indicated that this is also true for students with disabilities. Williams (1994) argues that for persons with a disability, the importance of sport as a context for identity formation rests in its ability to argue existing disability definitions and prove the definitions unfitting (Groff & Zabriskie, 2006).

In a qualitative study of 11 youth diagnosed with a disability, Groff and Kleiber (2001) discovered that participation in physical sports appeared to impact both personal and social identity when compared to previous research of children without a disability. The researchers discovered that involvement served as an outlet for expression and strong determinant of self-perception development (Groff & Kleiber, 2001). The students in the study also indicated that the social interaction that occurred during their participation in sports, helped facilitate a sense of connectedness with peers living similar experiences. Furthermore, by partaking in athletics, students experienced a subsided awareness of their disability and expressed themselves in new ways. Therefore, it is likely that sport plays an identifiable role in facilitating the social and personal identity of athletes with disabilities both within the specific domain of sport and perhaps, beyond (Groff & Kleiber, 2001).

Research has also found that regular participation in exercise and physical activity holds many benefits for those with and without a disability. Increases in immune function, flexibility and strength, along with decreases in depression, anxiety and weight gain have suggested that athletic activity should be adapted as a vital lifelong behavior (Bouchard, Shephard, & Stephens, 1994; Petruzzello & Landers, 1994). Similarly, a lack of exercise is correlated with many negative health outcomes (Powell, Thompson, Casperson, & Kendrick, 1987). Unfortunately, population-based surveys have revealed that persons with disabilities are less likely to be physically active, overall when compared to their peers without disabilities.

A study by Kang, Zhu, Ragan, & Frogley (2007) examined perceived barriers to exercise and physical activity held by children with disabilities. Barriers included an overall lack of motivation, a deficiency of time to participate in sport, physical condition of certain disabilities, pain or discomfort associated with their disability, an absence of a setting to exercise with peers,

and a perceived misconception of the person's physical condition or ability. Similarly, Tappe, Duda and Ehrnwald (1989) identified time, unsuitable weather, time constrictions, a lack of interest or desire, and school and schoolwork as barriers to exercise and sport participation.

Closely linked with desire, interest and motivation, an important factor in a student's participation in athletic activity is perceived competence. According to Harter (1982), the concept of perceived competence refers to a student's beliefs regarding their capability in an achievement domain, such as athletic activity or sports. Perceived competence is directly linked to motivational markers, such as choosing to partake in a sport or continuing to hold interest in an athletic activity (Weiss & Horn; 1990). Specifically, students that perceive themselves as being able to manage the requirements of an athletic activity environment are more likely to continue their participation, while students that perceive themselves as having lower competence are more likely to retreat or preclude initial participation (Ebbeck, 1990; Klint & Weiss, 1987); this, in turn, lowers their self-concept.

Intervention Options

Indirect and direct interventions are incorporated within schools, and can be used to address self-concept issues, and ultimately the self-esteem of students with disabilities. Mishna and Muskat (2004) stated that indirect interventions are incorporated within schools, and can be used to augment and enhance the effectiveness of direct interventions.

Indirect Options. A new vision of school counseling summons counselors to act as advocates and leaders for all students, by removing systemic barriers that impede overall success. Through their implementation of counseling, and the effective use of leadership, collaboration, and advocacy, a school counselor is able to reduce barriers allowing all students the opportunity to achieve in school. As such, by using these methods, students with and without

disabilities are provided access to a quality curriculum and appropriate coursework, which in turn, aids their development of a strong self-concept (House & Hayes, 2002).

Collectively, community agencies and school systems trust that indirect interventions, including collaboration, education and consultation must be paired with the implementation of direct services to best reach students diagnosed with a disability (Meyers, et al., 1990).

According to Allen (1994) collaboration is defined as the process by which two individuals or groups work together for a common purpose, a desired outcome or a shared benefit. A review of literature on this subject indicates that carefully nurtured associations among administrators, teachers, counselors, community agencies and businesses will help to aid school counseling programs and promote the success of students diagnosed as having a disability (Herr, 2001; Stone & Clark, 2001). As Allen (1994) further suggests, participants in the collaborative process must share a common vision for their students, and agree on a common mission. Relatedly, in order for the collaborative efforts among involved parties to be successful, trust, respect, openness, active listening, clear communication, and risk taking are required.

Collaboration. Stone and Dahir (2006) discuss the CASTT school counseling program that includes the community, administrators, students, teachers and technology as the acronym suggests. Due to the continued diversity and growing immensity of needs students with disabilities may have, other and often outside resources are now sharing the responsibility of educating and working with school counselors in the best interest of the students. CASTT suggests that counselors collaborate with the community, parents, human service agencies, neighborhood associations and groups, businesses, post-secondary institutions, alumni, administrators, other students, teachers, other staff members and technology to best aid the

academic, personal/social and career development of students with disabilities (Stone & Dahir, 2006).

The ASCA National Model (2005) closely connects consultation with collaboration specifying that "Counselors consult with parents or guardians, teachers, other educators, and community agencies regarding strategies to help students and families" (p. 42). Collaboration to aid students diagnosed with a disability involves counselors and other collaborative parties mutually seeking ways to understand and resolve challenges (Baker, Robichaud, Dietrich, Wells, & Schreck, 2009). The process of consultation includes outlining the problem, identifying potential solutions, evaluating the advantages and disadvantages of the potential solutions, pursuing further information as needed, selecting the best perceived solution, implementing that solution, evaluating the outcomes, and concluding whether the implementation is effective or if alternative solutions must be identified (Baker, et al., 2009). As an indirect intervention, school counselors as consultants are better able to make a major impact on a student's self-concept and on the academic, personal/social and career development of students with disabilities by working with adults in the student's life (Fitch and Marshall, 2004; Kahn, 2000).

Leadership. School counselors are effectively moving into leadership roles within schools (House & Hayes, 2002). The standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001) stated that school counselors, as leaders already possess knowledge and skills in "understanding of community, environmental, and institutional opportunities that enhance, as well as create barriers that impede student academic, career, and personal/social success" (p. 92). By working as educational leaders who advocate for all students, school counselors can promote student achievement by articulating a well-developed program that pays attention to equity, access, and support services (House & Hayes, 2002).

Relatedly, the ASCA's ethical standards (2010) for school counselors states that as leaders, school counselors must promote and advocate for respect and dignified treatment of all students from diverse populations including, ethnic and racial identity, economic status, age, abilities/disabilities, language, immigration status, gender, sexual orientation, family type, religious identity and appearance. School counselors also support that students with disabilities receive the information and support needed to move toward self-direction, self-development and correspondingly, a positive self-concept (ASCA, 2010).

Advocacy. As a caregiver within the school system, counselors are ideally situated to serve as advocates for all students (House & Hayes, 2002). Lewis, Lewis, Daniels and D'Andrea (1998) define advocacy in counseling as the process of identifying individuals who would likely benefit from increasing their own strength. The authors further characterize these individuals as being adversely stratified by policy, practices and procedures. Namely, students with disabilities would fit into this categorization as school counselors often help these students identify barriers that impede their success (Stone & Dahir, 2006). For school counselors, the advocacy role is currently supported by professional counseling organizations which identify advocating for students as a necessary and critical component of success in schools (House & Hayes, 2002).

Direct Interventions

While indirect services are imperative to student success, school counselors spend the majority of their time in direct service to and contact with students (American School Counseling Association, 2005). As ASCA suggests, a school counselors' duties include implementing the school counseling core curriculum, providing individual student planning, offering responsive services as well as offering individual and/or group counseling. The responsibilities of a school

counselor are integrated to provide academic, personal/social, and career development for all students, including those with a disability (2005).

Individual student planning. Cohen (2001) in conjunction with the American School Counseling Association (2005), identified that the individual student planning component of a comprehensive counseling program works to provide all students with ongoing systemic activities designed to assist students in monitoring and managing their personal-social, academic, and career development. The activities that school counselors integrate, aid students in focusing on their current and future goals (Cohen, 2001). Gysbers (2009) identified curriculum activities to include self-concept development, personal awareness, and interpersonal development, the acquisition of learning skills, decision making skills, and exploration of educational and occupational possibilities. Students with disabilities benefit from these offered activities as they learn to assess their differences, abilities and skills and use the self-appraised information to plan for and realize their life goals. By expecting and understanding this information, students further work to establish a positive self-concept (Gysbers, 2009).

Classroom interventions. Developmental classroom educational lessons are described under the school guidance curriculum component of the ASCA National Model (American School Counselor Association, 2008). Gysbers and Henderson (2000) illustrated the importance of education interventions through the use of obtained data. Accordingly, 35-45% of a school counselor's time should be devoted to educational curriculum at the elementary school level, 25-35% at the middle school level, and 15-25% at the high school level. Myrick (2002) and Schmidt (2008) further suggested that developmental classroom lessons are an efficient and effective means for school counselors to meet the mounting needs of a rising number of students diagnosed with disability. Often, counselors will assume the responsibility for developing,

organizing and leading lessons that address important topics related to the academic, personal/social and career development of students with disabilities (Goodnough, Perusse, & Erford, 2007; Myrick, 2002; Schmidt, 2008).

Recently, Fennick (2001) used classroom interventions to teach students with and without disabilities the skills required for their post-secondary lives. Students learned how to write resumes, seek jobs, interview, budget their money, and prepare meals. The findings of this research insinuated that students benefit from working together on these activities and are also able to demonstrate gains in academic, personal/social and career development, knowledge, skill and self-concept. Similarly, in a study conducted by Ciechalski and Schmidt (1995) it was found that school counselors, who incorporated role plays into their classroom interventions, found the approach to be an effective method for allowing students with disabilities to observe and implement social skills. Students with and without disabilities were able to better interact with others and feel confident about their interactions after participating in these cooperative learning activities, which in turn, benefited their overall self-concept. As such, the practice and repetition of these classroom interventions helped students with disability become self-assured, resilient and capable individuals despite their diagnosis (Ciechalski & Schmidt, 1995).

Individual counseling. According to the American School Counselor Association (2008), school counselors fulfill many responsibilities. As part of ASCA's National Framework (2005), the responsibilities of a school counselor includes the facilitation of services which are intended to assist all children in academic, personal/social and career development by way of differed counseling approaches. Further, school counselors collaborate with stakeholders including teachers, parents, other school personnel, community members, and mental health professionals to provide developmentally appropriate prevention and intervention programs;

promote equitable access to educational opportunities for all students; and use obtainable data to evaluate outcomes of school counseling services (ASCA, 2008; DeKruyf, 2011). Here, close attention is paid to the individual counseling approach.

In meta-analyses of the literature, both Lipsey and Wilson (1993) and Smith, Glass and Miller (1980) found individual counseling to have a positive effect on individuals as compared to the placebo effect threshold, indicating that this approach to counseling proved effective for the overall population. Individual counseling, however, has also been suggested as a beneficial option when working with student's with disability. Specifically, Lapan, Gysbers, and Sun (1997) found that individual counseling decreases the prevalence of classroom disturbances most typically displayed by students with a disability. Relatedly, the individual counseling services, paired with the collaboration and consultation amongst the school counselor and classroom teachers enabled teachers to provide quality instruction designed to assist all students in achievement. The American School Counseling Association (2005) added that individual counseling helped students with disabilities develop self-knowledge, foster a more positive self-concept, make effective decisions, improve overall responsibility, develop a positive attitude, analyze the relationship between interests and abilities, explore careers, improve test-taking skills, resolve conflicts, and recognize and utilize strengths. Additionally, the ASCA (2005) identified advantages of individual counseling to include un-divided attention between counselor and client, a tailored treatment specific to the student's needs which is accurately identified in a timelier manner, and an increased haste in goal development. As research has demonstrated students' with disability develop low self-concepts closely related to their academic achievement, social interactions and behavior; therefore, individual counseling can be an

effective tool, for students with disabilities, in overcoming the barriers of their development (National Dissemination Center for Children with Disabilities, 2012).

Group counseling. For children and adolescence diagnosed with a disability, the importance of peer relations make group counseling a natural and effectual intervention (Berkovitz & Sugar, 1986). The Association for Specialists in Group Work (ASGW) defines group counseling as a comprehensive professional practice that incorporates group theories and process to facilitate a group of individuals in reaching mutually agreed upon goals and objectives (2012). Similarly, the American School Counseling Associate (ASCA) outlines group counseling as a means of adjusting to a rapidly transforming culture in an effective and efficient manner. The group process makes it possible to identify multiple students' developmental and situational needs in an effort to attain healthier scholastic and personal adjustments. ASCA also considers group work as an integral part of a comprehensive school counseling program (2012). According to Corey and Corey (1992) group counseling assists students with a disability in developing personally, educationally, socially, and vocationally. Comparably, Berkovitz (1989) argues that the role of group counseling within schools signifies one of the most essential, preventative mental health measures, for children and adolescence.

Convenience. Johnson and Johnson (2005) along with Whiston and Quinby (2009) argued that group counseling is markedly effective within the school environment, and should be implemented more often. As schools are the primary setting for academic, personal/social, and career development, school based interventions conveniently reach students with disabilities, who may not otherwise obtain services (Berkovitz, 1989; Meyer, Parsons, & Martin, 1990). Likewise, because students spend such an exorbitant amount of time within the school environment, it is not surprising that the professional literature suggests that this setting provides

the idyllic location for prevention and intervention services (ASCA, 2008; Frydenberg & Lewis, et al, 2004; Whiston & Quinby, 2009). Through counseling groups, students accomplish goals and associate with others in an inventive, supportive and constructive way (McClure, 1990)

Efficiency. The benefits of integrating groups into schools are numerous. Stemming from his work regarding group counseling, Corey (2008) stated that, “Although there is still a place in a community agency for individual counseling, limiting the delivery of services to this model is no longer practical, especially in these tight financial times. Not only do groups let practitioners’ work with more clients, the group process also has unique learning advantages” (p. 3). Counselors' have the ability to meet the needs of a larger number of students in a significantly shorter amount of time than individual counseling would allow which is, in and of itself, a valid reason for incorporating a group counseling approach (Cook & Weldon, 2006). Stewart and McKay (1995) reflected that a recent rising trend in observed aggressive behaviors as well as an increased need for social skills training makes it difficult, if not impossible to address the needs of so many students individually. By using groups, school counselors can efficiently help a larger population of students.

Learning from one another. Livneh, Wilson, and Pullo (2004) further highlighted some of the advantages of using groups to support children with disabilities. According to the research, counseling groups provide a forum for students to learn from one another and provides a backdrop for generating solutions. As Santrock (2009) stated, children look to one another for advice, support and the acquisition of knowledge, during this developmental stage. Through discussion and the sharing of experiences, personal concerns, thoughts, and feelings, children ascertain that they are not alone in their experiences; this is also known as the experience of commonality or universality (Jacobs, Masson & Harvill, 2008; Stephens, Jain, & Kim, 2010;

Yalom, 2005). Whatever the term used to characterize this experience, the realization that situations are not always unique, can help to diminish anxiety and lessen fears students with a disability may have, especially in social situations. With that sense of mutual understanding, the group offers students a safe place for emotional release and the expression of emotions and attitudes including confrontation, rigidity, fear, anger, doubt, worry, and jealousy (Jacobs, et al., 2008; Stephens, et al., 2010).

Rehearsal. The literature suggests that groups are the most effectual place for children with disabilities to put into practice and rehearse what they are learning in counseling (Court & Givon, 2003; Milsom, 2007; Stephens, et al., 2010; Stewart and McKay, 1995). Further, Milsom (2007) suggested that, by bringing children with a disability out of a stigmatizing environment, and into an accepting space within the school, they are able to create a benign place for practicing social skills. Group counseling, consequently, helps children foster a social network by incorporating the therapeutic factors of support, catharsis, altruism, cohesion, interpersonal learning and self-disclosure (Leichtentritt, & Shechtman, 2010; Stephens, et al., 2010).

Belonging. The influence of the counseling group can help nurture positive growth, interactions a sense of belonging and development for students with disability (Gladding, 2008; Greenberg, 2003). Writers in counseling and psychology have identified and communicated the human need for belonging (Adler, 1927; Berne, 1964; Jacobs, et al., 2008; Maslow, 1962). As a microcosm of society, the group setting encourages an environment conducive to associations and friendships, which helps satisfy the need to belong (Gladding, 2008; Greenberg, 2003; Kottler, 1994; Trotzer, 2006; Yalom, 2005). Students learn about relationships through experience rather than training (Stephens, et al., 2010). Johnson and Johnson (2004) also

explained that within the group setting, children can learn to manage the symptoms associated with their disabilities and learn to cope with the limitations that stem from the diagnosis.

Summary

The literature suggests that students diagnosed with a disability often experience coexisting emotional and interpersonal adversities including issues of depression, inferiority, bullying, rejection, isolation, a low self-concept and failure. The issues that arise are often related to a student's self-perceptions of their academic, social, emotional, physical and athletic self-concept and capabilities. As a student's self-concept has become a fundamental objective within the education system, school counselors now play an even more significant role in addressing and implementing self-esteem developing and social skill building strategies for school personnel, administration and parents, as well as students.

School counselors must utilize a blend of direct and indirect interventions, including, but not limited to, the implementation of group counseling as a time convenient resource used to support students in Individualized Education Programs. By working to increase the self-concept of students with disabilities, school counselors can help reduce the likelihood of students in Individualized Education Programs experiencing anxiety, depression, academic inadequacies, social disparities, loneliness and delinquent behavior. Furthermore, by increasing a student's self-concept through the use of group counseling, a healthier scholastic and personal development will be attained. School counselors can play a critical role in encouraging consultation, collaboration, and advocacy while also developing strategies to foster academic, personal/social and career development for students with disabilities.

Research Question

The purpose of this study was to utilize group counseling as an intervention and to determine if the counseling program would be an effective means of increasing the self-concept of students in Individualized Education Programs. As such, the researcher sought to answer the question, “Will group counseling be effective in increasing the self-concept of students in Individualized Education Programs?”

Method

Self-Esteem is considered a critical component to academic success, as low self-esteem is associated with a variety of behaviors that impede academic success. This study followed a quantitative, quasi-experimental research design, with a one group, pretest – posttest method. Descriptive statistics were used to summarize the collected data and answer the research question.

Setting

The study was conducted in an urban-suburban middle school setting with students enrolled in the fifth, sixth, seventh and eighth grades. According to data obtained from the U.S. Department of Education (2010-2011), the middle school served a total of 542 students in grades six through eight. The aforementioned figure, however, was outdated by two years’ time and therefore, did not account for the transition of the fifth grade class to the middle school setting during the 2012-2013 school year. The population of fifth graders during this study was 184 students. Demographics for grades six through eight offered that, 77% of the school population was White, 12% were Black, 4% were Hispanic or Latino, 6% were Multiracial, and 2% were Asian or Native Hawaiian/Other Pacific Islander. Student stability was calculated at 87%.

Additionally, 41% the equivalent of 220 students were eligible for free lunch, while 9% were eligible for reduced-price lunch.

Participants

Participants were selected on the basis that they were students with Individualized Education Programs (IEP) and were participating in an existing counseling group. There were 14 participants in the study; seven females and seven males. Each of the 14 participants ranged in age from 10-14 years at the time the study was conducted, with one student being in fifth grade, four students being in sixth grade, six students being in seventh grade and three students being in eighth grade. Of the 14 participants, nine identified themselves as Caucasian, two as Hispanic and three as African American. Nine of the students were classified as having Attention Deficit Hyperactivity Disorder, while six of the aforementioned nine concurrently were diagnosed with epilepsy, Pervasive Developmental Disorder, Sickle Cell Anemia, Bipolar Disorder, emotional disturbance, asthma or Oppositional Defiant Disorder. Additionally, the five remaining students were diagnosed as having either an anxiety disorder, issues related to hearing, multiple disabilities, or behavioral difficulties. Despite the diversity and purposive selection of the sample, a power and precision analysis determined that the sample size was not sufficient for generalizability to the greater population.

Intervention and Materials

For the purpose of this study, the independent variable was the group counseling sessions being offered to students. The dependent variable, or what was being measured, was the self-esteem of students in Individualized Education Programs.

Instrumentation

The Piers-Harris Children's Self-Concept Scale (Piers & Harris, 1969), also known as "The Way I feel About Myself," was designed and implemented as an 80-item, self-report, utilized for the assessment of self-concept in children and adolescents between the ages of eight and 18. For the purposes of this research, the authors define self-concept as, "a relatively stable set of self-attitudes reflecting both a description and an evaluation of one's own behavior and attributes" (Piers & Harris, 1996, p.1). This study utilized the Piers-Harris Children's Self-Concept Scale to measure the effectiveness of the Individualized Education Program counseling groups.

The Piers-Harris questionnaire presented 80 items as descriptive statements, and was scored categorically with students answering in a yes or no manner. The directions were altered from requiring students to answer every question, to reminding them that it was 'ok to not answer every question.' Additionally, question #35 was changed to 'I follow directions at home.'

Responses to specific questions were indicative of six cluster scales which included:

Behavioral adjustment- a subscale of 14 items measuring admission or denial of problematic behaviors

Intellectual and school status- a subscale of 16 items reflecting the child's assessment of his/her abilities with respect to intellectual and academic tasks; general satisfaction with school, and perceptions of future achievements

Physical appearance and attributes- a subscale of 11 items about perceptions of physical appearance and other attributes such as leadership and ability to express ideas

Freedom from Anxiety- a subscale of 14 items exploring a variety of feelings including fear, unhappiness, nervousness, shyness and feeling left out of things

Popularity- a subscale of 12 items exploring the child's evaluation of his or her social functioning

Happiness and satisfaction- a subscale of 10 items reflecting feelings of happiness and satisfaction with life (Piers-Harris, 1996).

The aforementioned scales were scored so that a higher score indicated a more positive self-evaluation in the domain being measured (Piers & Harris, 1996).

The Piers-Harris questionnaire was administered in paper and pencil format. Furthermore, it was designed to be dispensed individually or within a group setting and reported a 15-20 minute administration time. For the purpose of this study, students took the pretest and posttest individually, and classroom testing accommodations for all students participating in the study applied. The questionnaire was written at a third grade level and required an answer of either “yes” or “no.” Test takers were instructed to choose a response that best fit how they felt about themselves the majority of time. Following completion of the Piers-Harris, the test was then hand or computer scored depending on the version administered. Assessments of both general (total score) and specific self-concept (cluster score) were identified. An inclusive assessment of self-concept was reflected in the total raw score, as well as conversions to normalized T-scores (Piers & Harris, 1996).

Reliability. According to Piers and Harris (1996), test-retest reliability can be defined as, “the extent to which scores for a single individual are consistent over time and across settings” (p. 55). Numerous studies have examined and recorded the test-retest permanence with regards to both normal and special samples, and have demonstrated that the subscales have validated strong reliability (Piers & Harris, 1996; Simola & Holden, 1992). For this study, students in Individualized Education Plans fall under the category of special samples as they tend to exhibit an unstable self-concept (Piers & Harris, 1969). The initial version of the Piers-Harris Scale (1969), which incorporated 95 descriptive statements rather than the currently used 80 question scale, and was administered to grades 3, 6 and 10, reported resulting coefficients of .72, .71, and .72, with a retest time of 4 months. More recent studies have founded that within the revised 80-

item scale, reliability coefficients ranged from .71 to .81 with an average retest time of five months (Harter, 1985; McLaughlin, 1970; Simola & Holden, 1992; Shavelson and Bolus, 1982). Few studies have examined reliability coefficients for children diagnosed as having a disability.

Internal consistency. To judge the homogeneity of the questionnaire, internal consistency was measured. According to Piers and Harris (1969), internal consistency is defined as, “a measure of the average correlation among the items within a test” (p. 55). Evidenced in the literature, several studies have conducted and investigated the internal consistency coefficients of the Piers-Harris, including the Kuder-Richardson, Formula 21, which was employed with resulting coefficients ranging from .78 to .93 and was reflective of the size of the standard deviation (Piers & Harris, 1969).

Validity. Piers and Harris (1996) noted four significant factors, which affect the validity of the instrument. These four areas include: faking, which is the test takers attempt to distort his or her answers in order to produce positively or negatively skewed results; acquiescence and negative response set, which is summarized as either the tendency to say “yes” to all or almost all of the test items or to disagree with the items regardless of their content; random responding, which occurs results are logically inconsistent; and special populations and moderator variables, which may include, for example, children who differ in ethnicity or socioeconomic background from the normative sample (Piers & Harris, 1996). Concurrent validities and rating correspondences between children’s self-report were measured by both Piers (1965) and Cox (1966).

Procedure

The participants involved in this study were recruited due to their classification as students with Individualized Education Programs. All IEP students were actively participating in an

existing counseling group that was teaching an existing group counseling curriculum during the enlistment process. The researcher infiltrated the existing counseling groups to facilitate a brief educational presentation on self-esteem. Subsequent to administrative approval, all students (approximately 60) with an IEP classification between the ages of nine and 19, grades 5-12 were invited to participate in the study. During this presentation, the researcher also explained the study and passed out a recruitment packet that contained an informed parent consent form as well as a child assent form. Students were instructed to take the forms home, review them with a parent or legal guardian, and return them to the researcher. As incentive for returning the forms, students were immediately rewarded with coupons used to purchase an additional snack during lunches. The coupons were worth \$0.50 and could be used to purchase a cookie or bag of chips during lunch periods. Once coupons were redeemed, they became void and were thrown out. Succeeding the return of the consent and assent forms to the researcher, students were administered the Piers-Harris Children's Self-Concept Scale, as a pretest, within one week's time. Those students that did not return the consent and assent forms joined a different counseling group for the week and were not administered the pretest. The following academic week, those students returned to the original groups to receive group counseling as stipulated in their Individualized Education Plans.

The 14 participants remained in their respective counseling groups to assume an identity within their six counseling groups for a total of 12 weeks. Each group met once per week, for 40 minute group sessions. All groups utilized a curriculum based on their academic level, age and IEP goals. The group curriculums contained a series of psychoeducational and discussion based lessons, activities and games aimed at aiding students in the development of assertiveness skills, the identification and expression of emotions, the recognition and utilization of a support system,

the significance of team work, and the practice of role plays. The topic for each of the group sessions is listed in Table 1.

Table 1

Group Counseling Weekly Session Activities

Session	Activities
Session One	Administer Pre-test Questionnaire Group Share Discussion/definition of Self-esteem One Positive Thing
Session Two	Sharing Review of Circles Program Relation to Self-esteem One Positive Thing
Session Three	Sharing Disability Project Identification/Definition/Symptoms One Positive Thing
Session Four	Sharing Disability Project Cont. Treatment/Accommodations/ How it affects me One Positive Thing
Session Five	Sharing Present Disability Projects One Positive Thing
Session Six	Sharing Begin Coping Mechanisms/ Things Enjoyed Collage One Positive Thing
Session Seven	Sharing Continued Collage One Positive Thing
Session Eight	Sharing Continued Collage One Positive Thing
Session Nine	Sharing Optimistic vs. Pessimistic Lesson One Positive Thing

Session Ten	Youth Conference
Session Eleven	Sharing Friendship Wreath One Positive Thing
Session Twelve	Closing Activities Administer post-test questionnaire

Session one.

At the start of session one, the researcher administered the pre-test assessment (Piers-Harris Self-Concept Scale) to the 14 participants, within their counseling group time slot. The group members without consent were scheduled to arrive separately from participating students for this week. Students contributing to the study were reminded that their participation was voluntary and that their answers on the assessments would remain confidential. Further, students were encouraged to answer all 80 questions honestly and to the best of their ability. As needed all individual IEP accommodations were applied. The researcher provided aid, when requested, and ensured that the participants had completed the questionnaire correctly.

The confidentiality of participants and their responses was maintained. All results were collected and identified by participant number. A master list matching participants' names and numbers was locked in the researcher's file, and only used to keep track of the changes that occurred during the interventions.

Following the completion of the assessment, students not participating in the study joined their peers to partake in the weekly sharing portion of the counseling session. During this time, each member was encouraged to share something about their week. Student's often shared what they did the evening before, or what they planned to do during the upcoming weekend.

Generally, this was also a good time to review group norms and expectations as all members

were encouraged to “be respectful,” “be good listeners,” and “be accepting” of all their group members.

Next, group members were asked to share and discuss how they defined self-esteem. The researcher later provided a formal definition. Lastly, group members were asked to state one positive thing about themselves.

Session two.

Session Two began with a sharing portion during which all group members were encouraged to share something going on in their life. Following this activity, all students reviewed the CIRCLES Program; the basis for all IEP counseling lessons determined by individual goals. For the purpose of this study, the CIRCLES Program included Special Educational Techniques used to teach functionally challenged students the social sexual concepts of personal space, levels of intimacy, social distance, and social/sexual concepts using six, color coded concentric circles (Friedman, 1991). Starting from the epicenter, which was the self, each consecutive colored circle represented behaviors, actions and feelings appropriate to the distance from the self.

All group members reviewed each of the six circles during the second session. The centermost “purple private circle,” reminds students that they are the most important person in their world. As an empowerment tool, this circle postulates and conveys the specialness and autonomy of the student and affords a point of view for all other relationships. In addition, it helps students to understand that the choices they make regarding their relationships can be based on self-value and self-knowledge (Friedman, 1991).

The concentric “blue hug circle,” included those closest to the student in both a physical and emotional sense. Students were asked to identify their support system when discussing this circle and typically included mother/father, boyfriend/girlfriend and siblings. Next, the “green

far away hug circle,” reminded students that they should have less physical contact with these individuals; typically identified as friends. During the discussion of this circle, students were also reminded that the formation and maintenance of relationships was based largely on the social norms of our day and age. Reviewing this with participants helped emphasize their personal responsibility in their friendships and helped them to appreciate diversity. Students were also reminded that physical contact included aggressive actions taken against others within this circle (Friedman, 1991).

Following the green circle, students reviewed the “yellow handshake circle,” which suggested no emotional attachment and limited physical contact, characteristically exhibited towards acquaintances. As a part of this circle, students were further able to develop healthy socialization skills, identifying appropriate and inappropriate things to say to those in this circle. The “orange wave circle,” was the next concentric circle which encompassed no physical or emotional contact and was demonstrated with children and other distant acquaintances. Lastly, the “red stranger space,” included two categories, the community helper and strangers. Students identified the difference between the two categories and expressed appropriate behaviors to be exhibited (Friedman, 1991).

Once the CIRCLES Program was reviewed, students were asked to relate the information to self-esteem. Student’s acknowledged that they had great power in determining who to have relationships with. Following the discussion, students again shared one positive thing about themselves.

Sessions three - five.

Sessions three through five all began with the sharing segment and concluded with students stating one positive thing about themselves. Following the sharing statements by every member

of the group, students were asked to think about their disability. Once all students were able to identify and vocalize their disability they began to construct a presentation about themselves. During session three, students defined their disability and listed both common symptoms and symptoms they experienced personally. In the subsequent session, the students were asked to share any treatments they received to help combat their disability, including the use of medications. Next, all members recorded accommodations received. As a final piece, the IEP students had to express how their disability affected them and their experiences. Students were encouraged to include how they felt about themselves with regards to having a disability.

During session five, students presented their work to all building counselors, a handful of teachers and the director of special education for the district. All students claimed to enjoy the presentations and expressed feeling extremely proud.

Sessions six – eight.

Sessions six through eight all began with the sharing segment and concluded with students stating one positive thing about themselves. Intermediately, students began working on either a “stress coping mechanisms” collage or a “things enjoyed” collage depending on their individual counseling goals and in relation to the purple circle. Students were provided a laptop and were encouraged to search and select pictures, words, phrases or quotes that either helped them calm down or occupied their time and excitement. Simultaneous to their searching, the group discussed making healthy choices in all facets of their lives and reviewed the benefits of coping and/or living effectively, including the benefit of increased self-esteem. The activity also helped students to understand and reflect back upon the factors, events, and life situations that determined their view of the world around them while providing the self-knowledge to change

any negatives they expressed. The subsequent two sessions allowed further work on their collages with the final session culminating in a supportive share of the projects.

Session nine.

Following sharing, group members were asked to discuss the difference between the terms optimistic and pessimistic. Each member contributed to the discussion. The researcher then provided the group with concrete definitions of the terms. Students were instructed to then make a power point listing three optimistic things about themselves or their experiences in three different categories which included home/community, personal/social and school. Students were encouraged to add pictures and designs to their power points and were also encouraged to review and alter their lists throughout the school year. After students shared the projects with one another, they each identified one additional positive thing about themselves.

Session ten.

Session ten varied drastically from all other session as students attended a day long youth conference, which was considered a counseling session, due to the message that was relayed. The conference started with a guest speaker who spent the first 15-20 minutes of the assembly using magic tricks and comedy to capture attention. The speaker then made it clear that his magic tricks were just an illusion and related it to life, and how we have all believe at least one illusion. For example; like believing that bullying and disrespecting others is fun or that girls must look like the magazine cover or they are not pretty enough. Students were asked to repeat the phrase "I am perfect, just the way I am," numerous time, resulting in them walking away from the assembly having more self-worth, wanting to respect others, make wiser choices, stand up against bullying and see their life with a new purpose.

Following the speaker, students transitioned to three different, 55 minute workshops that discussed a variety of topics including: introduction to zumba, sports smart-injury prevention, career choices, yoga, teen education and awareness, dodge ball, K-9 dog, nutritional jeopardy, media literacy/body image and peaceful conflict resolution.

Session eleven.

Session eleven commenced with group sharing. Subsequent to the discussion and in connection with the green circle from the CIRCLES program, group members were instructed to finish the sentence "I like friends who... " Students were reminded that having a strong support systems and people they could count on within the school setting would help attribute to positive self-esteem. The discussion was intended to begin a dialogue of qualities students should search for in friendship. Next, students paired up and were told to trace the other person's hands on a piece of construction paper with a pencil. Group members then proceeded to cut out the handprints. Afterwards the students printed their name on each of their handprints and were instructed to draw a picture or print a sentence about friendship on each of their handprints. As a collective group, students worked together to glue the handprints in a circle (to make a friendship wreath). The wreath was hung in the counseling room as a reminder of advantageous friendship qualities. The group concluded with members sharing one positive thing about themselves.

Session twelve.

Session twelve began with sharing, as usual, although it was explained to the participants that sharing would also include one thing they each discovered in the twelve weeks. Each group member was instructed to respond as quickly and briefly as possible. Next, the researcher asked members to share any recurring themes they noticed in lessons or as everyone shared about what was learned through this group experience. In closing, members were once again distributed the

Piers-Harris Children's Self-Concept Scale as a post-test questionnaire. Again, the confidentiality of participants and their responses was maintained. All results were collected and identified by participant number. A master list matching participants' names and numbers was locked in the researcher's file, and only used to keep track of the changes that occurred during the interventions.

Results

Evidenced within the aforementioned literature, self-esteem is related to self-concept. Students' self-concepts are largely influenced by their thoughts and feelings, as well as their perception of attributes, attitudes and behaviors, and the way they are regarded by others (Rice & Dolgin, 2005; Rosenberg, 1989). To this regard, The Piers-Harris Children's Self Concept Scale was utilized to determine a preparatory position for each student's self-concept. The pretest was administered during each participant's initial group session. Relatedly, the posttest was administered twelve weeks later, and was applied to measure the effectiveness of counseling groups on improving an IEP student's self-concept. Each student's total score was calculated for both the pre-test and post-test, with scores averaging between 40T and 60T; participants' scores varied from one standard deviation above the mean and one standard deviation below the mean, respectively. Higher scores reflect a more positive self-concept. Complete self-concept scores of 29T or below were considered an exceptionally low measure of self-concept. Scores between 30T and 39T were considered typical of a student with a low self-concept, while those ranging between 40T and 44T were deemed slightly below average. Correspondingly, scores calculated that diverged between 45T and 55T were indicative of an average self-concept, with scores of 56T to 60T, being used to describe students with a slightly above average measure of self-concept. T scores of 61T-65T were considered above average, 66T to 70T were regarded much

above average, and scores greater than 70T were considered significantly above average and suggestive of exceedingly superior self-concept.

Pre-test

As illustrated in the chart below, students three and 14 scored in the below average total self-concept range and as such, reported an exceptionally low level of self-concept following the completion of the pre-test. Students 12 and 13 scored in the low average range, indicating a low self-concept. Students 2, 9, and 10 scored in the average total self-concept range, suggesting a level of general self-esteem (positive and negative aspects of self). During the pre-test, the majority of students; 4, 5, 7, 8 and 11, revealed scores in the above average range, signifying a strong positive self-appraisal of self-concept. Piers-Harris (1996), argued that students in the higher ranges are typically confident in their abilities across many domains, are accustomed to success and tend to be highly motivated. Students in the higher ranges also view themselves as likeable and valued by others. Student 1 reported a score of 62T, indicative of a much above average self-concept while student 6 reported the highest score of 77T, noting exceedingly superior self-concept.

Cluster scores were obtained by use of a five-tiered model to describe the general level of self-esteem in each area. The clusters were defined as Behavior (BEH), Intellectual/School Status (INT), Physical Appearance/Attributes (PHY), Anxiety (ANX), Popularity (POP) and Happiness/Satisfaction (HAP). With regard to measuring the self-concept of students by cluster, T score ranges included 65T or more, indicating the highest self-concept, 56T-65T, 45T-55T, 35T-44T, and less than 35T, indicative of the lowest self-concept. The ranges were consistent across all six scales.

With regards to the Behavior (BEH) cluster, a student scoring in the average range would consider themselves well behaved, but would also acknowledge adversities in their conduct. Only one student fell within this range. A few students ($n = 2$) were below the mean, while the majority of students, ($n = 10$) scored in the above average range. Piers-Harris (1996), postulated that students in the above average range would likely hold positive feelings regarding their behaviors in a variety of settings as well as their interpersonal relationships and skills.

The Intellectual/School Status (INT) category questioned whether students felt equal, inadequate or superior to their peers on intellectual and academic tasks within the school setting. Students ($n = 4$) scored below average in the INT category. One student scored within the average range, while the remaining students ($n = 5$) scored in the above average range.

Within the Physical Appearance and Attributes (PHY) cluster, some students ($n = 4$) scored below average, indicating that they felt negatively about their physical appearance. A few students ($n = 4$) scored in the average range while the majority of students ($n = 6$) scored in the above average range. Piers-Harris (1996), argued that the higher the score in this category, the more positive the self-perceptions in regards to physical appearance, the expression of ideas and leadership ability.

Scoring was more widespread within the Anxiety (ANX) scale as a vast array of emotions including worry, nervousness, shyness, fear, and isolation were assessed and reflected in the score. Students ($n = 5$) scored below average, students ($n = 3$) scored in the average range, and students ($n = 6$) scored in the above average range. A below average score suggested that students may experience some emotional disturbances, while scores in the above average range suggested feelings of content. It is important to note that scores above the average may be

reflective of a student's desire to conceal or deny feelings. The aforementioned was especially relevant for one of the students', who was diagnosed as having an emotional disturbance.

In the Popularity (POP) scale students ($n = 6$) scored below average. Students indicating low self-concept in this area tend to be shy, lack interpersonal skills and often feel isolated. One student fell within the average range. Students ($n = 5$) scored in the above average range indicating that they felt included in peer activities and experienced positive peer relations.

In the Happiness and Satisfaction (HAP) scale two students scored below average. Low scores on this scale are associated with general dissatisfaction, feelings of negative self-worth, and a longing for things to be different. One student scored within the average range, with the vast majority of students ($n = 9$) scored in the above average range. These student's responses suggested that they generally felt satisfied with themselves as people, viewed themselves as cheerful and easy to get along with, and did not feel any strong desire to change.

Post-test

As indicated in the diagram below, total self-concept scores for all 14 students participating in the study, did show some divergence from original pre-test scores.

Table 2

Pretest and Posttest Self-Concept Scores

Student #	Diagnosis	Pretest Score	Posttest Score	Change in Score
1	-Attention Deficit Disorder	62T	52T	-10
2	-Attention Deficit Hyperactivity Disorder -Asthma	43T	46T	+3
3	-Attention Deficit Hyperactivity Disorder	25T	32T	+7

4	-Attention Deficit Hyperactivity Disorder	50T	56T	+6
5	-Attention Deficit Hyperactivity Disorder -Oppositional Defiance Disorder -Separation Anxiety -Adjustment Disorder	53T	56T	+3
6	-Attention Deficit Hyperactivity Disorder -Asthma	77T	77T	0
7	-Attention Deficit Hyperactivity Disorder	55T	50T	-5
8	-Attention Deficit Hyperactivity Disorder -Sickle Cell Trait	54T	59T	+5
9	-Behavioral Concerns	43T	33T	-10
10	-Pervasive Developmental Disorder	42T	41T	-1
11	-Attention Deficit Hyperactivity Disorder -Bipolar	50T	56T	+6
12	-Attention Deficit Hyperactivity Disorder -Oppositional Defiance Disorder	30T	35T	+5
13	-Learning Disability -Post Traumatic Stress Disorder	35T	39T	+4
14	-Anxiety -Emotional Disturbance	25T	21T	-4

Student 1 was diagnosed with ADD and recorded pretest scores that decreased significantly on the posttest evaluation. The total score worsened by 10T, though the student's INT, PHY and HAP subscales increased. Student 2 was diagnosed with ADHD and Asthma. The student's overall self-concept score increased by 3T, with concurrent increases being found within the INT, ANX and POP clusters. Decreases were documented in both BEH and HAP with PHY remaining constant.

Student 3 was also diagnosed with ADHD and noted an increase in overall self-concept; from 25T to 32T. Increases were also evident in subscales BEH, INT, and ANX with PHY and POP remaining the same. A decrease of 1T was also logged for HAP. The student's scores indicated a generally positive effect on overall self-esteem and an overall improvement in nearly all subscales.

Student 4 also was diagnosed with ADHD and recorded pretest scores that increased on the posttest evaluation. The total score improved by 6T, with no decrease in any subscale. An increase of 4T was chronicled in PHY, an increase of 5T was founded in ANX, an increase of 2T was noted in POP and finally an increase of 3T was verified in HAP. Both BEH and INT remained the same. The scores reflected an elevated appraisal in all areas of self-esteem and signified a positive group experience.

As noted on the IEP, student 5 was diagnosed with ADHD, ODD, Separation Anxiety and Adjustment Disorder. The student offered a total score increase of 3T taking the score from a 50T to a 53T, which falls in the average range. The student's most significant increase was found in the ANX subscale, with the score increasing by 6T. Increases were also shown in PHY, POP and HAP with INT remaining the same for both the pre and post-test. The increase in ANX self-concept speaks volumes for the effectiveness of the group in working with the student's disability.

Student 6 was diagnosed with ADHD and Asthma. Marking the highest self-concept recorded with a total score of 77T, the score remained constant throughout the group as evidenced by the post-test. All subscales also remained the unchanged. Although no improvement was shown it should be noted that the group did not appear to negatively affect the students self-reports.

Student 7 was diagnosed with ADHD. The student's overall self-concept score decreased from 55T to 53T, although PHY, ANX and HAP increased by 1T, 2T and 1T respectively. The student's INT remained constant, while the BEH and POP scores decreased. The overall score remained within the average range though it is possible that the group had a negative impact of two of the clusters.

Student 8 was diagnosed with a Sickle Cell Trait and ADHD. The student recorded pretest scores that increased on the posttest evaluation. The total score progressed by 5T, though the only subscale to increase was BEH (5T). Subscales INT, ANX and POP remained unbothered, while PHY and HAP decreased by 2T and 1T. These results suggested that the group may not have positively influenced this student in all measured areas of self-concept, though overall self-concept was improved.

As noted on the IEP, student 9 struggles with behavioral concerns. The student's total score and several other scores decreased. The BEH remained static and below average at 6T. Both ANX and POP scores decreased significantly from 12T to 7T and 8T to 3T. INT, PHY and HAP score also decreased. Results revealed that the group may have negatively impacted the student's overall self-esteem as well as self-concept within clusters. The student, however, was also dealing with significant home issues that had not surfaced during the pre-test.

According to the IEP, student 10 was diagnosed with PDD. The student marked a 1T decrease in total self-concept as well as a decrease of 2T in ANX and 3T in HAP. Scores remained stagnant for both INT and PHY, while both BEH and POP scores increased. Although the overall score decreased, the group experience appeared to benefit the student in the areas of behavior and popularity, allowing the student the experience of connecting with new peers and establishing friendships within the group.

As evidenced in the IEP, student 11 was diagnosed with ADHD and as Bipolar. The student recorded pretest scores that increased on the posttest evaluation. The total score progressed by 6T, though the only 2 subscales increased. INT increased by 2T and HAP increased by 3T. Both subscales PHY and ANX decreased by 1T, while BEH and POP remained fixed. These results suggested that the group may not have positively influenced this student in all measured areas of self-concept, though overall self-concept was improved.

Student 12 was diagnosed with ADHD and ODD. The student's overall self-concept score increased by 5T from 30T to 35T, with both HAP and ANX increasing as well. BEH and INT decreased whereas PHY and POP remained the same at 4T and 1T, respectively. The scores indicated a below average range with regards to overall self-concept. The scores, however also revealed that the group had a positive impact in several cluster areas for this particular student.

Student 13 was evaluated as having a learning disability and was also struggling with some severe trauma while taking the Piers-Harris as a post-test. Overall self-concept increased by 4T for this student, while ANX and HAP remained static. Decreases were noticed in subscale cluster BEH. The remaining scores, INT, PHY and POP increased by 3T, 1T and 1T. As subscale BEH only decreased by 1T, the group proved highly successful for student 13, especially in regards to the improved feelings of intellect.

Lastly, student 14 was diagnosed with anxiety and emotional disturbance. The student recorded pretest scores that decreased on the posttest evaluation. The total score deteriorated by 4T, though the student's BEH subscale increased. Both PHY and ANX also decreased by 1T each. An equal number of subscales (INT, POP and HAP) remained unaffected. These results suggested that the group may not have positively influenced this student in all measured areas of self-concept.

A comparison of each student's pre-test and post-test was calculated by the difference between scores. A range of change was noted (-10 to +7).

Following a Paired Samples T-test, $t(12) = 0.6109$, the degree of freedom was recorded at 12 and the standard error of difference was 1.637. Moreover, the two-tailed P value was documented at $p = 0.5527$, indicating that results of the research were not statistically significant by conventional criteria. The mean, standard deviation and Standard Error of Measure are noted in the table below.

Table 3

Pretest and Posttest Descriptive Statistics

	Pre-Test	Post-Test
Mean	46.00	48.62
SD	14.51	12.76
SEM	3.88	3.54

Relatedly, following a Paired Samples T-test used to measure changes in scores between the pre-test and the post-test for the seven males, the two-tailed P value was calculated at $p = 0.9012$. By conventional criteria, the aforementioned calculation is considered to be not statistically significant; however the intervention did prove more beneficial for females when compared to males as the two-tailed P value for the seven females was equal to $p = 0.5405$. When scores amongst grade levels were compared, all findings were founded to be insignificant as well.

Discussion

The purpose of this study was to utilize group counseling as an intervention and to determine if the counseling program would be an effective means of increasing the self-concept of students in Individualized Education Programs. The group counseling curriculum consisted of a variety of discussion-based topics, psychoeducational activities, assertiveness skill building, games, role playing activities, etc. Data was collected via pre-test and post-test both before and after twelve consecutive weeks of group counseling lessons and activities in an attempt to answer and address the research question, “Will group counseling be effective in increasing the self-concept of students in Individualized Education Programs?”

Findings developed from the comparison between the pre-test and post-test scores illustrate an improved or unchanged general self-concept for nine of the 14 participants. General self-concept diminished for five of the 14 participants at the culmination of the study. More specifically, a change in subscale scores for each student was calculated. To this regard, it was founded that 31 of 84 collective subscale cluster scores improved, with the greatest improvements being shown in the Intellectual and School Status (INT) and Popularity (POP) subscales. The said results indicate that students diagnosed as having a disability, who participate in a counseling group for a minimum of 12 weeks, will demonstrate an improved self-concept in both the academic and social domains as compared to other domains. The INT subscale was the most effected cluster, with 12 out of a possible 14 students exhibiting a self-concept that developed or remained stagnant. The aforementioned finding suggests that a student diagnosed as having a disability can change their self-perception of their own academic ability via a group counseling process. As professionals and researchers agree that underachievement in schools and a low academic self-concept are classic attributes of students

with disabilities, the above said realization stresses the notion that academic self-concept and academic achievement should be the foremost objective of group counseling within the school setting (Brookover & Lezotte, 1979; Kavale & Forness, 2000).

Relatedly, the POP subscale showed improved or static self-concept for 11 out of the 14 participants and demonstrated a possible link between the perceived intellectual/school status and the perceived social (popularity) status of students diagnosed as having a disability; that is to say students who feel better about their academic ability, will be more likely to perceive themselves as socially sound and accepted by others. Further, the literature also conjoins social self-concept with exhibited behaviors and suggests that a student who feels confident in the appropriateness of their conduct will also be likely to develop increased confidence in their social skills, relationships and overall magnetism. The hypothesis was shown to be accurate based on the results of the change in cluster scores. Eight out of a possible 14 students demonstrated an increase in their behavioral self-concept.

Also linked closely with social self-concept, the subscale of Physical Appearance (PHY) was used to measure the participant's body image perceptions and in accordance, physical self-concept. The PHY cluster recorded a significant increase in scores with 10 out of 14 participants indicating a physical self-concept score that improved or remained stationary. The aforementioned outcome proposes that a student diagnosed as having a disability, including those within the middle school setting, can change their self-perception of their own physical appearance via a group counseling process.

Lastly, improvements were found in the Anxiety (ANX) and Happiness and Satisfaction (HAP) subscales. The said results indicate that students diagnosed as having a disability, who participate in a counseling group, will demonstrate an improved self-concept in the emotional

self-concept domain. Both the ANX and the HAP subscale reported that nine out of a possible 14 students exhibited an emotional self-concept that developed or remained stagnant during the 12 week counseling sessions. As the literature suggests that academic achievement produced the most anxiety for students diagnosed as having a disability, it is not surprising that a general increase of self-concept within the anxiety subscale coincided with the general increase of the overall academic self-concept. To supplement the abovementioned correlation, the rise in self-concept for the first five subscales of the Piers-Harris Children's Self-Concept Scale was likely indicative of the increase of self-concept within the HAP cluster.

Although the literature links athletic self-concept with physical, social and emotional self-concept, little evidence is provided, within the study, to connect these domains. It is believed that participation in sports and/or exercise, concurrent with the counseling groups, worked to foster a physically and psychologically healthy conduit for students (Daniels, Sirinda, & Campbell, 2005). Still, a more comprehensive impact of sport participation on domain specific aspects of the self, were not measured within the Piers-Harris Self-Concept Scale (Brettschneider & Heim, 1997).

While a majority of students within each subscale reported an increase in self-concept, it is important to note that 28 of 84 collective subscale cluster scores remained static and 25 of 84 declined.

By working to increase the self-concept of students with disabilities, and as minimally evidenced here, school counselors can help reduce the likelihood of students in Individualized Education Programs experiencing anxiety, depression, academic inadequacies, social disparities, loneliness and delinquent behavior. Furthermore, by increasing a student's self-concept through

the use of group counseling, a healthier scholastic and personal development is more likely attained.

Limitations

Several limitations were identified for this research project. First, with only 14 IEP students participating in the study, out of an approximate 60, the sample size (23%) was not sufficient to generalize to the overall population. Furthermore, the study was limited to middle school students in one school district. A larger sample that includes more students from varied grade levels and schools would allow for a broader examination of how the self-esteem of IEP students is impacted by group counseling. There is potential that students of mixed grades and various schools would respond differently to group counseling sessions than the students in this study responded.

Another limitation noted is that many of the participants missed several group sessions due to illness, needing to make up classwork, in-school suspensions, etc. Although some of the group members attended each and every scheduled group sessions, there were a few members who missed one or more groups, which reduced the effectiveness of the counseling group.

Correspondingly, another limitation was the amount of time allotted for each group session. Counseling groups were slated in 40 minute increments, but were often lessened by a variety of circumstances including issues and mix-ups with pass distribution, students needing to check-out and obtain homework from teachers before coming to the counseling center, and/or students leaving/returning from outside medical and mental health appointments. As such, some activities and lessons were modified and adjusted in reaction to these issues.

Lastly, the researcher's lack of experience is suggested as a limitation of the study, in two regards. Firstly, although the Piers-Harris Children's Self-Concept Scale is straightforward and

test administration does not require extensive training, the authors of the scale do caution that only an individual with psychological assessment training should guide the interpretation and use of scores. For the purpose of this study, the scale was not administered by an individual with psychological assessment training, and thus interpretation and use of scores may differ from the analyses of other professionals in the field. Further, the researcher lacked experience in the domain of counseling, as evidenced by only a year of practice working as a counselor within the school setting.

Suggestions for future study

It is suggested that future researchers use the more recent, up-to-date form of the Piers-Harris Self-Concept Scale 2nd Edition. The newest questionnaire offers reduced length (only 60 questions compared to 80), an expanded age range, improved informational instructions; a more sizeable and diversified standardization sample, and updated computer assessment tools. Further, as counseling is mandated for all IEP students, and as further research continues to suggest that counseling groups are effective in reducing the likelihood of experiencing anxiety, depression, academic inadequacies, social disparities, loneliness and delinquent behavior it would be advantageous to govern a yearlong counseling group.

Another suggestion is that groups be formed based on teacher recommendation and/or counselor observation, as for this study, the groups were already in existence, and for many of the groups, had existed for years prior. Groups had been originally picked based on both student compatibility with one another/similar IEP counseling goals, as well as the limited open slots available due to the counselor's schedule. By forming new groups based on need, counselors could more specifically address areas in which individual students are struggling. Additionally,

rather than using predetermined lessons and activities, school counselors could distribute the pre-test, evaluate the results and then structure their lessons around student need in the moment.

Lastly, although the scale was deemed appropriate for students with disabilities and was reviewed by an institutional review board, some terminology proved too confusing for students. The aforementioned includes the word “pep” from question #55 and the context of question #31, “in school I am a dreamer.” It is suggested that this wording be changed if future researchers plan to use The Piers-Harris Children’s Self-Concept Scale rather than the 2nd edition of the questionnaire.

Conclusion

Research has suggested that if a student is able to continually cultivate self-awareness, self-esteem, consequential relationships, coping skills, and life schemes within the school setting and with peers that are living comparable experiences, they are more apt to thrive; the aforementioned is also true for students diagnosed as having a disability. Without the development of curriculums aimed at providing psychoeducational, discussion based lessons and activities that focus on the development of assertiveness skills, the identification and expression of emotions, the recognition and utilization of a support system, the significance of team work, and the practice of role plays, students diagnosed with a disability are more likely to depreciate. Although this research study was not statistically significant by conventional criteria, the research was shown to be minimally effective in increasing the self-esteem levels of students in Individualized Education Programs. Pending supplementary and slightly augmented research, it is favorable that school counselors will be profoundly employed to lead group counseling sessions aimed at increasing the self-esteem of students with disability.

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The College at
BROCKPORT
STATE UNIVERSITY OF NEW YORK

Grants Development Director

Date: November 9, 2012
To: Lindsay Rollo
From: Colleen Donaldson
Institutional Review Board Director
Re: IRB Project # 2012-22

Project Title: Shining from Within: The Effect of Group Counseling on the Self-esteem of Students in Individualized Education Program

Your proposal, "Shining from Within: The Effect of Group Counseling on the Self-esteem of Students in Individualized Education Program" has been approved as of 11/8/12.

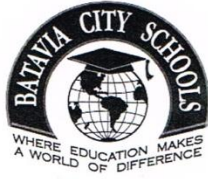
You must use only the approved consent form or informational letter and any applicable surveys or interview questions that have been approved by the IRB in conducting your project. If you desire to make any changes in these documents or the procedures that were approved by the IRB you must obtain approval from the IRB prior to implementing any changes.

If you wish to continue this project beyond one year, federal guidelines require IRB approval before the project can be approved for an additional year. A reminder continuation letter will be send to you in eleven months with the specific information that you will need to submit for continued approval of your project. Please note also that if the project initially required a full meeting of the IRB (Category III proposal) for the first review, then continuation of the project after one year will again require full IRB review.

Please contact Colleen Donaldson, IRB Administrator, Office of Academic Affairs, at (585) 395-5118 or cdonalds@brockport.edu, **immediately** if:

- the project changes substantially,
- a subject is injured,
- the level of risk increases
- changes are needed in your consent document, survey or interview questions or other related materials.

Best wishes in conducting your research.



39 Washington Avenue, P.O. Box 677, Batavia, NY 14021
PHONE: 585/343-2480 FAX: 585/344-8204

BATAVIA CITY SCHOOLS

Margaret Puzio, Superintendent of Schools
Christopher J. Dailey, Deputy Superintendent of Schools

Sandra C. Griffin, Principal 585/343-2480 x3000
Julia M. Rogers, 5/6 House Administrator 585/343-2480 x3002
Tim M. McArdle, 7/8 Assistant Principal 585/343-2480 x3001
FAX 585/344-8626
Batavia Middle School
96 Ross Street

September 25, 2012

To: Institutional Review Board
The College at Brockport, SUNY

I have read and approve the research study entitled, "Shining from Within: The Effect of Group Counseling on the Self-esteem of Students in Individualized Education Programs", by Lindsay Rollo, and give consent for the study to be conducted at Batavia Middle School, as long as parental permission is obtained.

Sandra C. Griffin, Principal

Signature and Professional Title

9-26-12

Date

NOV 08 2012

STATEMENT OF INFORMED CONSENT FOR PARENTS

As you know, your child participates in a group counseling program that teaches the "Circles" and/or "PeopleSmart" curriculum. The purpose of this research is to investigate the effectiveness of the preexisting group counseling curriculums on your child's self-esteem. The person conducting the research is a graduate student in the Counselor Education Department at The College at Brockport, SUNY. If you agree to have your child participate in this study, s/he will be asked to complete a pretest and posttest titled "The Piers-Harris Children's Self-Concept Scale."

Your child's participation in this study is completely voluntary. Joining in the study or refusing to participate, will not affect your child's grades or class standing or group counseling participation. S/he is free to change her/his mind or stop being in the study at any time.

As incentive for returning the forms, students will be immediately rewarded with coupons that they may use to purchase an additional snack during lunches. The coupons are worth \$0.50 and may be used to purchase a cookie or bag of chips during lunch periods. There are no other anticipated benefits as a result of completing the Piers-Harris Children's Self-Concept Scale as a pretest and posttest.

One risk is the time that the child will spend completing the pretest and posttest. Another risk is that the time spent completing the pretest and posttest could possibly result in fatigue. Lastly, a minor risk is that the child will miss one counseling session to complete the pretest and posttest.

I understand that:

1. My child's participation is voluntary and s/he has the right to refuse to answer any questions. S/he will have a chance to discuss any questions s/he has about the study with the researcher after completing the questionnaire.
2. My child's confidentiality is protected. Her/his name will not be written on the survey. All results will be collected and identified by a participant number only. There will be no way to connect my child to the written survey. When the research is published, my child will not be identified by name. Results will be given confidentially and in group-form only, so that neither the participants nor their schools can be identified. Participation will have no effect on grades status.
3. There are no benefits as a result of completing the pretest and posttest. One anticipated risk is the time that the child will spend completing the pretest and posttest. Another risk is that the time spent completing the pretest and posttest could possibly result in fatigue. Lastly, a minor risk is that the child will miss one counseling session to complete the pretest and posttest.
4. My child's participation involves reading a written survey of 80 questions and answering those questions by circling yes or no. It is estimated that it will take 15-

20 minutes to complete the survey. Your child's classroom testing accommodations will be applied.

5. Approximately 60 students will be invited to take part in this study. The results will be used for the completion of a research project by the primary researcher.
6. Data and consent forms will be kept separately in a locked filing cabinet by the researcher and will be destroyed by shredding when the research has been completed.

You are being asked whether or not you will permit your child to participate in this study. If you wish to give permission to participate, and you agree with the statement below, please sign in the space provided. Remember, you may change your mind at any point and withdraw from the study. Your child can refuse to participate even if you have given permission for her/him to participate.

I understand the information provided in this form and agree to allow my child to participate as a participant in this project. I am 18 years of age or older. I have read and understand the above statements. All my questions about my child's participation in this study have been answered to my satisfaction.

If you have any questions you may contact:

<u>Primary researcher</u>	<u>Faculty Advisor</u>
Name: Lindsay Rollo Counseling Intern	Name: Dr. Summer Reiner Assistant Professor
Phone Number: [REDACTED]	Counselor Education Department (585) 395-5497
Email address: [REDACTED]	Email address: sreiner@brockport.edu

Signature of Parent /Date _____

Child's name _____

NOV 08 2012

STATEMENT OF INFORMED ASSENT FOR MINORS

As you know, you are a member of a counseling group that works on the “Circles” and/or “PeopleSmart” curriculum. The goal of this research is to study how your self-esteem changes because of your participation in group counseling. The person conducting this research is a graduate student in the Counselor Education Department at The College at Brockport, SUNY. If you agree to take part in this study, you will be asked to complete a survey titled “The Piers-Harris Children’s Self-Concept Scale.”

Your participation in this study is completely up to you. Taking the survey, or deciding not to take it, will not affect your grades, class standing or group counseling participation. You are allowed to change your mind or stop being in the study at any time.

If you return the forms, you will receive a coupon that you may use to purchase an additional snack during lunches. The coupon is worth \$0.50 and may be used to purchase a cookie or bag of chips during lunch periods. There are no other benefits for taking the survey.

One risk is that you will spend time completing the pretest and posttest. Another risk is that the pretest and posttest could make you tired. Also, you will miss one counseling session to complete the survey.

I understand that:

1. I decide if I want to participate in the study, and I have the right to refuse to answer any questions. I will have a chance to talk about any questions I have about the study with the researcher after finishing the survey.
2. My privacy is protected. My name will not be written on the survey. There will be no way to connect me to the written survey. When the research is published, my name will not be on it.
3. I will have to read a written survey of 80 questions and answer those questions by circling yes or no. It will take me 15-20 minutes to complete the survey. My classroom testing accommodations will be applied.
4. Approximately 60 people will be invited to take part in this study. The results will be used to finish a research project by the primary researcher.
5. Your signed forms will be kept in a locked filing cabinet by the researcher and will be destroyed when the study is done.

You are being asked whether or not you want to participate in this study. If you wish to participate, and you agree with the statement below, please sign in the space provided. Remember, you can change your mind at any point and not be a part of the study. You can decide to not participate even if your parent/guardian says that you can.

If you have any questions you may contact:

<u>Primary researcher</u>	<u>Faculty Advisor</u>
Name: Lindsay Rollo Counseling Intern	Name: Dr. Summer Reiner Assistant Professor
Phone Number: [REDACTED]	Counselor Education Department (585) 395-5497
Email address: [REDACTED]	Email address: sreiner@brockport.edu

I understand the information provided in this form and agree to participate in this project.

Signature of participant /Date

Birth date of participant

Signature of a witness 18 years of age or older /Date

THE PIERS - HARRIS CHILDREN'S SELF CONCEPT SCALE

(The Way I Feel About Myself)

by

ELLEN V. PIERS, Ph.D.

and

DALE B. HARRIS, Ph.D.

Published by

Counselor Recordings and Tests

BOX 6184 ACKLEN STATION

NASHVILLE, TENNESSEE 37212

Here are a set of statements. Some of them are true of you and so you will circle the yes. Some are not true of you and so you will circle the no.

It is OK to not answer every question, but do *not* circle both *yes* and *no*. Remember, circle the yes if the statement is generally like you, or circle the no if the statement is generally not like you. There are no right or wrong answers. Only you can tell us how you feel about yourself, so we hope you will mark the way you really feel inside.

1. My classmates make fun of me..... yes no
2. I am a happy person..... yes no
3. It is hard for me to make friends..... yes no
4. I am often sad..... yes no
5. I am smart..... yes no
6. I am shy..... yes no
7. I get nervous when the teacher calls on me..... yes no
8. My looks bother me..... yes no
9. When I grow up, I will be an important person..... yes no
10. I get worried when we have tests in school..... yes no
11. I am unpopular..... yes no
12. I am well behaved in school..... yes no
13. It is usually my fault when something goes wrong..... yes no
14. I cause trouble to my family..... yes no
15. I am strong..... yes no
16. I have good ideas..... yes no
17. I am an important member of my family..... yes no
18. I usually want my own way..... yes no
19. I am good at making things with my hands..... yes no
20. I give up easily..... yes no

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21. I am good in my school work yes no
22. I do many bad things yes no
23. I can draw well yes no
24. I am good in music yes no
25. I behave badly at home yes no
26. I am slow in finishing my school work..... yes no
27. I am an important member of my class yes no
28. I am nervous..... yes no
29. I have pretty eyes yes no
30. I can give a good report in front of the class yes no
31. In school I am a dreamer..... yes no
32. I pick on my brother(s) and sister(s) yes no
33. My friends like my ideas yes no
34. I often get into trouble..... yes no
35. I follow directions at home yes no
36. I am lucky yes no
37. I worry a lot..... yes no
38. My parents expect too much of me yes no
39. I like being the way I am yes no
40. I feel left out of things yes no

41. I have nice hair..... yes no
42. I often volunteer in school yes no
43. I wish I were different yes no
44. I sleep well at night..... yes no
45. I hate school..... yes no
46. I am among the last to be chosen for games..... yes no
47. I am sick a lot yes no
48. I am often mean to other people..... yes no
49. My classmates in school think I have good ideas yes no
50. I am unhappy yes no
51. I have many friends yes no
52. I am cheerful yes no
53. I am dumb about most things yes no
54. I am good looking yes no
55. I have lots of pep..... yes no
56. I get into a lot of fights..... yes no
57. I am popular with boys..... yes no
58. People pick on me yes no
59. My family is disappointed in me yes no
60. I have a pleasant face yes no

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61. When I try to make something, everything seems to go wrong. yes no
62. I am picked on at home yes no
63. I am a leader in games and sports yes no
64. I am clumsy..... yes no
65. In games and sports, I watch instead of play yes no
66. I forget what I learn..... yes no
67. I am easy to get along with..... yes no
68. I lose my temper easily yes no
69. I am popular with girls yes no
70. I am a good reader yes no
71. I would rather work alone than with a group yes no
72. I like my brother (sister) yes no
73. I have a good figure yes no
74. I am often afraid..... yes no
75. I am always dropping or breaking things yes no
76. I can be trusted yes no
77. I am different from other people..... yes no
78. I think bad thoughts yes no
79. I cry easily..... yes no
80. I am a good person..... yes no
-

Friendship Wreath

Make one big friendship wreath for the bulletin board or break up into groups of 5 or 6 to make smaller take home wreaths.

Materials:

- construction paper
- scissors
- pencils
- markers
- crayons
- glue



Instructions:

You might want to take 5 minutes of circle time before starting the craft to talk about friendship. Let the kids finish the sentence "I like friends who..." to give them inspiration for their handprints. At the end of the craft you can have circle time again to talk about what the children decided they liked in a friend. Talk about the importance of having those qualities -- ex: if you like friends who smile lots then you should try to smile lots too.

Group Wreath:

Have the children pair up and trace each other's hand on a piece of construction paper (let them pick their favorite color) with a pencil

Cut out the handprints (may require adult assistance).

Have the children print their name on each of their handprints and draw a picture or print a sentence about friendship on each of their handprints. Have the children take their finished handprint to the leader

Glue the handprints together in a circle (to make a wreath) -- the leader can do this or you can let the children attach theirs to the wreath

Middle school students learn about social issues and explore new skills at youth conference

Submitted by Howard Owens on March 14, 2013 - 10:43pm



Press release:

The Genesee County Youth Conference Coalition sponsored its 25th Annual Youth Conference at Genesee Community College this week. This conference is offered on an annual basis to local students in an effort to address pertinent social issues of interest to youngsters of middle-school age. This year we also invited a select group of students from Orleans County. There were approximately 500 students in attendance.

This year's theme of the conference was "Illusions ... To Lead or to be Mis-Led." The keynote speaker, nationally known Illusionist Tom Coverly, addressed the kids in the areas of bullying, respect and positive decision-making.

After the keynote, students attended two morning workshops, were provided lunch and then attended an interactive afternoon workshop. Professionals from the community volunteered their time to provide information to the students in their respective fields of expertise. Workshops were provided in the areas of...Communication, Yoga, Nutrition, Careers, Pet Therapy, Zumba, Triple D-Dodgeball (Drug and Alcohol Awareness Game), Conflict Resolution, Dance, Getting Active with GPS, Creating Artist Trading Cards, Assuring a Positive Future and many others.

Members of the Youth Conference Committee are extremely grateful to the workshop presenters who volunteered their time to educate our area seventh and eighth graders. We are also grateful to the following businesses/organizations that provided discounts or donations for the conference...Genesee County Stop DWI Program, Upstate Milk and Subway. The Genesee County Youth Conference Committee is comprised of representatives from the following agencies: Batavia Youth Bureau, Genesee County Youth Bureau, Genesee Community College, GCASA and YMCA (The Batavian. N.p., n.d. Web. 02 May 2013).