

## Article 7

### **Can I Play? Using Play Therapy for Children and Adolescents With Disabilities**

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Traditional modes of counseling require clients, even young children, to verbally participate within the therapeutic process. Play therapy, one of several modalities of complimentary therapies (i.e., art therapy, sand tray therapy, music therapy) allows children to utilize toys (referred hereafter as materials) to express their own story and emotions without necessarily using words to participate in the counseling process (Carmichael, 2006). Play therapy has historically been used in a myriad of interventions for children with behavioral and emotional needs. Beginning with psychoanalytic play therapy interventions, Anna Freud realized that children have emotional and behavioral needs much like their adult counter-parts and that children could be helped by modifying available psychoanalytic techniques such as free association to better meet the needs of the child (Salomon, 1983, as cited in Landreth, 2002). Complimentary therapies such as play therapy have been shown to produce outcomes that are as effective as traditional talk-therapy methodologies commonly used with adult populations (Leblanc & Ritchie, 2001). Carmichael (2006) explains play therapy as “an intervention, based on theoretical premises and recognized as a therapy” (p. 2). Needs that are often addressed through the use of play therapy include emotional and behavioral adjustment needs of children related to acting out aggressive behaviors, family and relationship issues, domestic violence, abuse, academic performance, and reduction of stress and anxiety as it is designed to provide the child with skills and experiences that assist him or her in overcoming such difficulties (Carmichael, 2006; Landreth, 2002). For these purposes, play therapy continues to be an effective means to facilitate the counseling relationship and promote positive change for children (Leblanc & Ritchie, 2001). Given the flexible conditions of play therapy and its uses, it can also be used to meet the needs of children with disabilities.

For example, child life specialists already employ play therapy techniques to allow hospitalized children to adapt to their often intimidating medical surroundings

(Landreth, 2002). Children with disabilities may face a variety of medical procedures during their young lives and may be particularly susceptible to feelings of inadequacy, low self-esteem, and incompetence (Williams & Lair, 1991) as well as feelings of anxiety, and lack of control associated with intense medical needs and demands. Given the opportunity to work with play media and a trained counselor, children with physical disabilities, communication related disabilities, and chronic medical illnesses may find solace in being able to express their emotions and tell their stories through work with play therapy materials. Particularly, children with disabilities may find strength in developing a sense of self-esteem, autonomy, and competency as well as mastering certain physical and social skills through the use of play therapy (Carmichael, 1993). Non-directive and directive approaches to play therapy procedures can allow the child with a disability to interact with his or her environment in a meaningful way, experience enhanced social interactions, develop new skills, and be fully a child. Since child-centered play therapy is the most familiar approach to play therapy a more detailed explanation is provided followed by a brief explanation of the use of directive techniques.

### **Basics of Play Therapy**

A broad set of theoretical elements help to perpetuate play therapy procedures. For example, a counselor may seek to work from their identified theoretical basis (i.e., psychoanalytic, Gestalt, Adlerian) through their practice of play therapy. Each of these theoretical components can be incorporated into three primary means of the play therapy environment. Although the most well-known is a non-directive, or child-centered approach, counselors may also use a more directive technique in selecting materials and facilitating the play therapy process, or may choose a prescribed approach that allows for counselors to select from both child-centered and directive techniques to best facilitate growth dependent upon the child's developmental, physical, and cognitive needs. For a complete description of theoretical basis of play therapy, please see Carmichael (2006).

### **Child-Centered Play Therapy**

Play is a child's natural means of communication and self-expression and can provide an opportunity for the child to work through a variety of emotions (Axline, 1947). In non-directive or child-centered play therapy, the child is given the responsibility of leading and directing the session (Axline, 1947; Landreth, 2002). Above all the relationship between the counselor and the child is paramount in the promotion of positive change (Axline, 1947). This approach can be used to allow the child to express feelings or attitudes that may be too threatening for traditional modes of counseling by allowing the child to choose his or her materials in the play therapy setting (Landreth, 2002). The counselor using child-centered play therapy remains nonjudgmental, accepting, respectful, and provides the child with unconditional positive regard, dignity, and self-worth just as the counselor would when working with an adult client from a person-centered perspective (Carmichael, 2006). The counselor attempts to understand the child's internal world in her or his expression of emotion through the use of child-selected materials. Through reflection of the child's affect, emotion, and activities the counselor is able to provide a voice for often very painful experiences for the child (Carmichael, 2006). This developmental approach is founded in the idea that the child

has a natural tendency toward growth and actualization (Landreth, 2002). Common materials the child may choose from in child-centered play therapy include nursing bottles, culturally diverse doll families, toy soldiers, toy animals, doll houses, puppets, and various art materials (Axline, 1947). For a complete description of child-centered play therapy and materials please see Axline (1947), and Landreth (2002).

### **Focused Play Therapy**

Depending on the child's therapeutic needs, a more directive or focused approach in play therapy may be more suitable. Directive exploration endorses the idea that self-efficacy can best be attained by either collaborative selection of materials by both the counselor and the child, or through counselor-selected activities and materials (Carmichael, 1993). Unlike child-centered play therapy, which allows for free exploration, focused approaches can also be utilized to teach alternative behaviors and new skills (Carmichael, 2006). While the relationship between the counselor and the child remains the most essential component of directive approaches to play therapy (Norton & Norton, 2006), counseling technique may incorporate theories outside of the traditional child-centered, or non-directive approach. Since child-centered play therapy is child-led, the counselor will adhere most stringently to Rogerian stylistics without directing the child. Directive approaches allow the counselor to utilize Gestalt, Adlerian, Jungian, or relationship play therapy techniques (Carmichael, 2006). Depending on the presumed basis for emotional or behavioral difficulty, counselors may assume different roles as a play therapist depending on their theoretical orientation. Common directive approaches to play therapy include cognitive behavioral play therapy, developmental play therapy, and relationship play therapy (Carmichael, 2006). Focused play therapy can be utilized as a time-limited intervention in which counseling would be limited to twelve structured sessions (May, 2006) whereas traditional child-centered play therapy is most effective when stretched over 30 to 35 sessions (Leblanc & Ritchie, 2001).

### **Prescribed Play Therapy**

Both focused and child-centered play therapy techniques can be easily adapted to meet the emotional and developmental needs of children with disabilities. Application of either technique that is best suited to the child's needs is also known as prescriptive play therapy. Counselors who use this method are knowledgeable about different approaches to play therapy and have skill in applying these strategies (Thompson, Rudolph, & Henderson, 2004). Through prescriptive play therapy the counselor is able to identify both short and long-term needs of the child and understand the world of the child through his or her play (Thompson et al., 2004). Due to the flexible nature of prescriptive play therapy, use of this approach for practice is best used to address the needs of children with disabilities as well as promote positive outcomes for the child.

### **Multicultural Considerations**

In choosing a play therapy approach for a child with a disability, it is also important for the counselor to be familiar with cultural constructs apparent within the family. Basic assumptions of play therapy include similarity of play across cultures and open expression of feelings through play. This may make it difficult for the counselor to distinguish between cultural play variants as some cultures place significant restriction on

direct expression of emotion (O'Connor, 2005). Language may also be an important component of the play therapy relationship. If a child with a disability speaks a different language at home than in the play therapy setting he or she may rely on tone of voice, facial expressions, and body movements to understand what is being said (Sue & Sue, 1990, as cited in O'Connor, 2005). Culture may also play a key role in communication variations: while some families are more directive, others may tend toward nondirective cues such as body language and nonverbal communication (O'Connor, 2005). To this end, communication is also influenced by the cultural perspective of spontaneous exchange of ideas and statements about difficulties within the family as some may believe that problems should be handled within the home and some families may be less likely to spontaneously present this information unless directly questioned about it (O'Connor, 2005). Counselors seeking to use play therapy must also understand that families may feel some shame in regards to having “failed to address their child’s difficulties” (O'Connor, 2005, p. 567).

### **Modifications for Children with Disabilities**

Children with disabilities may be faced with a multitude of different experiences that are unique to having specific disabilities including exposure to medical procedures, feelings of loss of autonomy and inadequacy that may lead to low self-esteem and decreased independence. Children with communication disabilities may also experience behavioral difficulties if they are unable to effectively communicate with peers and caregivers. Addressing these concerns in play therapy the child can express him or herself without the need for verbal explanations. Having materials available that relate to the child’s world is essential for children with and without a disability as it allows them to express their concerns, fears, and emotions using commonalities from their world as they see it. To allow for this expression it may be necessary to modify procedures used in play therapy and/or materials utilized in the play therapy setting.

### **Procedure Modifications**

Procedural modifications are the first step in addressing the needs of a child with a disability in the play therapy setting. Inclusion of an interdisciplinary team as well as appropriate family members will enable the counselor provide suitable accommodations within the counseling environment both through implementation of play therapy practice and use of any needed adaptive materials.

The child is the most important consideration when choosing the optimal approach to play therapy. The first recommended modification to procedural practices in play therapy is the inclusion of a treatment team (Carmichael, 1994). An interdisciplinary team should consist of those individuals currently providing services to the child (Carmichael, 1994). Members of this team could be medical specialists, occupational and physical therapists, and other personnel involved in the care of a child with a disability. Inclusion of the interdisciplinary team in procedural constructs with a child with a disability will aid the counselor in setting up appropriate accommodations while also allowing them to become familiar with realistic expectations for the goals of the family and a child with a disability (Carmichael, 1994). These members may also be able to

provide the counselor with feedback regarding the effectiveness of play therapy as it relates to behavioral, emotional, and social needs across settings (Carmichael, 1993).

Inclusion of a treatment team can bring up some ethical concerns related to confidentiality of the child with a disability and of the family. For the counselor it is essential to work with both the child and the family to ensure that having a treatment team in place adequately meets the needs of the child with a disability. Given the sensitive nature of sharing information with individuals outside of the play therapy environment the counselor should obtain all appropriate consent forms at the onset of counseling and regularly meet with the family to discuss any concerns prior to meeting with the treatment team. As always the counselor should seek to disclose only information necessary to the ongoing benefit of the child with a disability. The family should also be advised of their right to not have information shared with the treatment team.

A secondary component for procedural modifications for play therapy for a child with a disability includes the incorporation of parents and caregivers in the therapeutic process (Carmichael, 1993, 1994; Cogher, 1999; Guerney, 1991). Although this is useful in working with children without disabilities in treatment planning, it may be more beneficial to counselors working with a child with a disability as it will allow them to have further insight into the child's immediate needs and how to best address them within the play therapy setting. Parental involvement can be implemented in several ways depending on the specific needs of the child. Filial play therapy, or child relationship enhancement family therapy (CREFT), allows the counselor to train parents to provide play therapy sessions while they are away from the counseling setting (Carmichael, 2006). The counselor may also choose to incorporate the use of homework assignments for the parents to complete with the child. These can include setting a date with the child, structured play activities, and the use of notes, cards and phone calls to let the child know that they are being thought about (Mcguire & Mcguire, 2001). Parents should also be invited to attend a weekly 15-minute parent meeting arranged either at the beginning or the very end of the play therapy session (Mcguire & Mcguire, 2001). This meeting would allow parents to share weekly highlights and information about the week's homework assignments, and it would allow the counselor to share session themes and to make new homework assignments (Mcguire & Mcguire, 2001). This collaborative work between the parents or caregivers in play therapy and the counselor may assist in linking individual play therapy with parental empowerment practices to transference of positive change into other arenas outside the counseling office (Thompson et al., 2004). Parental training will introduce parents to methods of play therapy and encourage a collaborative working alliance between the counselor and the family.

### **Material Modifications**

To provide an appropriate play therapy environment for a child with a disability the following factors must be taken into consideration: specific disability, physical accommodation, material modifications or adaptive toys, developmental level, and experiences that may be unique to a child with a disability. Ability to modify play therapy techniques and materials to suit both the child and the child's support system will yield more successful therapeutic outcomes (O'Connor, 2005). The play therapy environment provides a child with a disability with freedom, acceptance, and permissiveness (Jones,

2001) characteristics that may have been limited in nature in their young lives given the fact that many children with a disability may have experienced a broad range of medical situations (Kunkle-Miller, 1990). Children with a disability may have experienced a loss of control, loss of freedom, and loss of choice (Jones, 2001). For this reason the first suggested material modification is the inclusion of both real and pretend medical equipment (Kunkle-Miller, 1990). Incorporation of materials found in the child's environment will allow the child with a disability to "work through feelings about being hurt and powerless and having a disability that cannot be 'fixed'" (Kunkle-Miller, 1990, p. 5). Counselors may also wish to include items that would be disability-specific for dolls such as wheelchairs, braces, crutches, and hearing aids.

Secondary material selection may be made based on specific disability needs. This can include the adaptation of play therapy materials already available or the addition of other materials that allow for a child with a disability to easily manipulate the item. It is also necessary for the counselor to determine whether to use a child-centered approach or a focused approach for play therapy. This determination will dictate whether or not the child with a disability is able to choose from the entire toy library or from a few selected materials. This decision should depend on the developmental level of the children, and whether they have the requisite skills needed to explore their environment (Bradley, 1970, as cited in Carmichael, 1993). If a focused approach is decided upon the counselor must choose which materials and for what reason they would like for the child to begin working with.

Depending upon the goals for play therapy, inclusion of materials that allow a child with a disability to master physical skills, such as finger dexterity, may be appropriate (Carmichael, 1993). Items like homemade play dough and activities such as macramé, mosaic tiles projects, string art, and sculpturing may also provide physical benefits to a child with a disability along with the emotional and behavioral benefits of play therapy (Carmichael, 1993). Modifications to current materials already in the toy library may be needed for specific needs. For example, traditional art supplies such as crayons, paint brushes, and pencils can be easily adapted by slipping the foam cushion from hair rollers over them to allow for easier manipulation by a child with a disability (Musselwhite, 1986, as cited in Carmichael, 1993). For dramatic play, costume items like purses, hats, and scarves may prove simpler for a child with a physical disability to manipulate and utilize in their play (Salomon, 1983, as cited in Carmichael, 1993). Children who have a hearing disability and use sign language for communication may find that having puppets placed on jars will allow them to continue to communicate while still manipulating the puppet (Kunkle-Miller, 1990). For some children a glove that is fashioned with Velcro or magnetic strips may allow them to handle metal or textured items easily (Carmichael, 1994).

Items that can be added to the play therapy library include activity boards, pegboards with yarn, and large beads with yarn for stringing (Musselwhite, 1986, as cited in Carmichael, 1993). Other adaptive toys that have been used successfully with children with disabilities include sliding panels, bells, wheels, and lights; a rummage box with toys of varying textures, sizes, and shapes; sand trays, and musical instruments (Darbyshire, 1980, as cited in Carmichael, 1994). Providing small bean bags in different shapes and sizes is an alternative to balls that roll away or that may be difficult to grasp (Salomon, 1983, as cited in Carmichael, 1993). Some materials traditionally used for play

therapy may need to be altered to effectively make the play therapy environment “user friendly” (Carmichael, 1994, p. 53). For example, Kunkle-Miller (1990) suggests using plasticine instead of ceramic clay because the slip from ceramic play impairs the ability to sign and the alternative leaves hands free to communicate. Adaptive play materials such as roundheads and roundkids (poseable foam figurines that are easily manipulated and hold their shape), tactile discs, and adaptive art materials are nice additions to the play therapy library and are available at [www.ableplay.org](http://www.ableplay.org). Counselors may also find adaptive materials at [www.abilitations.com](http://www.abilitations.com) and can search several adaptive toy vendors through [disability-resource.com/toys.html](http://disability-resource.com/toys.html).

### **Setting Modifications**

Modifying the play therapy setting is the third component of providing services to children with disabilities. Depending upon the specific needs of a child with a disability several things can be done to adapt the environment to facilitate productive play therapy. For instance, for children who have a disability that inhibits their mobility the use of wedge pillows, and bean bags placed in different places throughout the room encourages different positions and independence (Carmichael, 1994). Large stuffed animals may also be an effective support for a child with a disability (Carmichael, 1994). For children who have a limited range of motion, c-clamps can be used to stabilize a dollhouse on a table and items can be arranged on an elevated tray (Carmichael, 1994). Other considerations must be taken in regards to the lighting and the general arrangements of the room. Particularly with children who have a hearing impairment and use sign language to communicate, appropriate lighting is essential to understand what the child is saying (Kunkle-Miller, 1990). Arrangement of the play therapy room in such a way that allows the counselor to see the work of the child with a disability may also enable communication. Another aspect is to ensure that children with a physical disability that inhibits mobility have enough room to maneuver their wheelchair throughout the space, and that children who are able to stand with assistance have plenty of places throughout the room to lean and brace themselves. Appropriate modification of materials and the play therapy environment can encourage children with a disability to achieve independence and competence not always available elsewhere (Carmichael, 1994).

### **Implications for Counselors and Counselor Educators**

Counselors utilizing play therapy for children with disabilities must be prepared to implement appropriate modifications in technique, material selection, and setting. Unlike other treatment modules in traditional play therapy the inclusion of an interdisciplinary treatment team as well as concurrent involvement with the parents or caregivers in the therapeutic process is essential to promote positive change for a child with a disability. By creating a safe environment for the child with a disability the counselor can encourage the expression of positive and negative emotions and help the child to develop refined coping and social skills as well as assist them in attaining a level of autonomy and competency. Prior to exploring work with a child with a disability the counselor should also become aware of any dual diagnosis the child may have that would indicate the need for further accommodations in play therapy. For example, a child with spina bifida may have a physical disability as well as a cognitive disability. Parental input

for this reason is essential at facilitating play therapy and can provide counselors with needed information to supply needed accommodations for a child with a disability. Cultural expectations should also be addressed at this level as it may effect the parents' expectations of treatment as well as their level of involvement.

Counselor educators should be acutely aware of the specific needs that children with disabilities may bring to play therapy. Counselors in training are best served by a variety of field experiences that allow them to work with children with disabilities. Coursework should also incorporate different theoretical approaches to play therapy so that future counselors may be able to draw from a prescribed method of play therapy that is best suited for both the child and the family. Multicultural implications should also be addressed throughout the coursework, and fieldwork. Since most masters level counseling programs do not include coursework or fieldwork in play therapy, counselor educators should continue to encourage counselors-in-training to seek out continuing education through appropriate avenues prior to practicing play therapy with children with a disability. Counselors seeking additional training for play therapy can consult the Association for Play Therapy (APT) online at [www.a4pt.org](http://www.a4pt.org) for continuing education, readings, and conference information. Ethical considerations regarding the limits of confidentiality in play therapy as discussed earlier particularly as it applies to the involvement of an interdisciplinary team and the inclusion of filial play therapy should also be considered.

### **Conclusion**

Play therapy provides holistic counseling and is an effective means of working with children with a disability. Systemic approaches that identify the child's family, community, and society allow the child to interact with play therapy materials in a meaningful way. Choosing the appropriate medium of intervention aids children with a disability in free expression and helps them to establish some control over their environment. While a brief outline of modifications to play therapy techniques, materials, and settings is provided here, future research could look at the efficacy of needed modifications for specific disabilities. For example, addressing accommodations needed for cognitive based, physical based, communication based, and sensorimotor based disabilities may allow counselors to employ different modifications to best serve the children they work with.

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## Handout 1

### Can I Play? Useful Information for Counselors

#### *Procedural Modifications*

- Greater collaboration with parents/caregivers
- Collaboration with interdisciplinary team members
- Weekly meetings with the family
- Use of homework assignments outside of session

#### *Playroom Modifications*

- Physical accessibility of the room
- Use of c-clamps to stabilize large objects like doll houses
- Accessibility of facilities (e.g., parking, entrances, restrooms)
- Use of bolster pillow/bean bags for floor work
- Appropriate lighting
- Open room arrangement for varied forms of communication

#### *Material Modifications/Additions*

- Materials of various textures
- Puppets on canning jars for hands to communicate
- String art
- Sculpting
- Use of foam cushion roller on crayons, paint brushes and pencils for easier manipulation
- Costume items like scarves, hats, and purses
- Activity boards
- Pegboards with yarn
- Large beads with yarn
- Musical instruments
- Plasticine instead of ceramic play for easier sign communication
- Roundheads or Roundkids
- Tactile discs
- Adaptive art materials
- Medical materials-play and real

#### *Resources*

- Adaptive play materials:
  - [www.ableplay.org](http://www.ableplay.org)
  - [www.abilations.com](http://www.abilations.com)
  - [www.disability-resource.com/toys.html](http://www.disability-resource.com/toys.html)
- Children's Disability Information:
  - [www.childrensdisabilities.info](http://www.childrensdisabilities.info)
  - [www.nichcy.org/](http://www.nichcy.org/)
  - <http://mentalhealth.samhsa.gov/child/childhealth.asp>

- Play Therapy Resources:
  - [www.a4pt.org](http://www.a4pt.org)
  - [www.playtherapy.org](http://www.playtherapy.org)
  - [www.play-therapy.com](http://www.play-therapy.com)