Play Therapy Issues and Applications Pertaining Deaf Children:

Analysis and Recommendations

by

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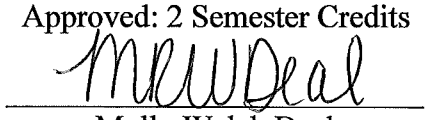
A Research Paper
Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
in

Guidance & Counseling

Approved: 2 Semester Credits



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July, 2009

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Title: ***Play Therapy Issues and Applications Pertaining Deaf Children: Analysis and Recommendations***

Graduate Degree/ Major: MS Guidance & Counseling

Research Adviser: **Molly Welch Deal**

Month/Year: **July, 2009**

Number of Pages: **48**

Style Manual Used: **American Psychological Association, 5th edition**

ABSTRACT

Play is crucial toward understanding the child since his natural instinct is to play. Though studies have been conducted by various counselors and therapists on the application of their theories and techniques of play therapy, there are limited studies in the effectiveness of play therapy with deaf individuals. The lack of direct communication and the low number of students who are deaf and hard of hearing within the school systems contribute to the high incidences of emotional difficulties among students. The purpose of this study is to fill a gap in research and establish effective play techniques to use with deaf children. This study also aims at critically analyzing the current research to provide recommendations for play therapists, the use of play therapy, and implications for future research.

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Acknowledgments

Kristin this is for you. For all the times I came home and needed to work on this paper to get it completed and you allowed me to do just that. Through all the wedding planning and all the times you came home just wanting to sit and chat you allowed me the time to get this done I love you pinky. To my sister Becky when you came to help us pack and still found the time to be an editor. Thanks Kiddo you are the greatest sister a guy could ever ask for. To the staff at UW-Stout who continuously let me know that the end would be in sight. It was worth all the knowledge you have given me and here it is presented in its completed form from all of my hard work through the years in the program.

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Chapter I: Introduction

Children are a unique set of humans and for many years they have been looked upon as "miniature adults" (Landreth, 2002). Landreth (2002) states "children must be approached and understood from a developmental perspective…Unlike adults, whose natural medium of communication is verbalization, the natural medium of communication for children is play and activity" (p. 9). Play is crucial toward understanding the child since a his natural instinct is to play; there is no better communication method children have to express what they feel, what they are thinking, and what their intentions are.

Despite the best intentions of the psychoanalytic therapists of the early 1900's, there is still a struggle to conceptualize and understand children in a therapeutic sense. Since the days of Melanie Klein and Anna Freud approaches and techniques of play therapy have been documented, tested and adapted by several therapists. Today, play therapy is more widespread. Yet research is still evolving in terms of validating play therapy as a productive and effective medium in working with children through emotional, behavioral, or cognitive concerns that impair their development.

Garry Landreth, Terry Kottman, and Virgina Axline are some of the leaders in play therapy research. Though studies have been conducted by various counselors and therapists on the application of their theories and techniques of play therapy, there are limited studies in the effectiveness of play therapy with deaf individuals. Harris, VanZandt, and Rees (cited in Smith & Landreth, 2004) stated that since the beginning of time deafness and limited hearing in human beings has existed. They noted that in the United States alone, as long as public education has been around, professionals have been seeking a way to implement effective methods toward educating, socializing, and meeting the emotional needs of children who are deaf and hard of hearing. "Whether deaf and

hard of hearing students are educated in special education classes within the mainstream public education system, in public or private schools designed for deaf and hard of hearing students only, or in residential schools for deaf and hard of hearing students, research confirms that these students experience higher incidences of behavioral and emotional difficulties within the school environment (Mantanini-Manfredi, 1993)" (Cited in Smith & Landreth, p. 14). The lack of direct communication and the low number of students who are deaf and hard of hearing within the school systems contribute to the high incidences of emotional difficulties among these students. Deaf individuals are typically raised in hearing dominated families with minimal or no communication between the family members. However, minimal or no communication can not be considered the only contributing factor that leads to the high incidences of emotional difficulties among deaf children. Hoemann (1991) points out, "Likely possibilities include the lack of incentives to perform well, insufficient experience or practice on the relevant tasks, incomplete understanding of the task requirements, and poor rapport with the examiner" (p. 229). All of these are valid considerations as to why a deaf child would not have a complete understanding toward expressing emotional, social and behavioral abilities appropriately.

It is clear that deafness alone can not be considered the only culprit for a deaf child's development. Hoemann (1991) states "Deafness does not preclude normal development of adaptive behaviors for which there is a biological basis in human development, whether they are cognitive behaviors such as thinking, remembering, and perceiving or whether they are linguistic behaviors, such as speaking, listening, understanding and communicating" (238). With this statement, Hoemann is noting that deafness should not disqualify normal development of adaptive behaviors in an

individual. Therapists need to keep in mind that simply providing a deaf child with services will not resolve the underlying issue of emotional distress.

A hearing child has the capacity to play; a deaf child has the capacity to play. At first glance there would not seem to be any difference in the contexts of play between a hearing and deaf child. Consider two distinct family groups, a deaf child growing up in a family that has deaf caregivers, and a deaf child growing up in a family with hearing caregivers. Typically deaf caregivers have a much more positive affect toward the deaf child than a hearing parent who has been presented with a deaf child. Deaf children in hearing families make up 90% of the population of deaf individuals. It has been shown in most reports that the deaf child being raised by hearing parents experiences a tendency for significantly delayed language development, and has a lack of mutual responsiveness during mother-child interactions (Marschark & Clark, 1993). Due to amplified technology this mutual responsiveness between a deaf child and the hearing caregiver is constantly under debate. However, the general consensus among researchers is that there is a difference between the deaf individual and his/her hearing counterparts in terms of both the cognitive and social aspects of play.

Darbyshire (1977) reported that the play of 45 deaf children, ranging in age from 3 to 8 years, included less "make believe" play and fewer substitutions than was the case for hearing children's play. Higginbotham and Baker reported that the deaf children differed from hearing children in social aspects of play, spending significantly less time in cooperative play and significantly more time in solitary play…Deaf children engaged in more constructive play than dramatic play, whereas hearing children spent similar amounts of time in constructive and dramatic play (Marshark & Clark, 1993). Studies on the difference between cognitive and social aspects of play have shown differences in the play of a deaf child versus a hearing child. Literature shows that something about

vary based on the intended focus of the study. In a study completed by Patricia Spencer and David Deyo at Gallaudet University, using dyads of hearing children and deaf children along with their caregivers in symbolic play, there were varying degrees to which the deaf child interacted with the hearing parents through play. The study concluded that it is not merely a lack of hearing that negatively affects the child. Delays in language development and disruptions in social interaction patterns experienced by many deaf children may also interfere with their acquisition and demonstration of symbolic play (Marshark & Clark, 1993).

Many factors such as home life, social life, and academics cause behavioral or emotional difficulties to arise. To address these issues in a way that allows the child to express themselves without boundaries or communication barriers, play therapy presents itself as a useful tool in working with a deaf child. Since research on the effectiveness of play therapy supports the notion that play is the natural communication method of a child regardless of whether the child is deaf or hearing, play therapy is essentially a way for a child to test out and examine the various tasks that are presented to him in a safe manner without the fear of correction or discouragement. As the author became interested in the techniques of play therapy and was considering doing a case study with a deaf child to test out a specific theory, it dawned on him that he had no basis as to how to approach play therapy with a deaf child. As research continues to validate play therapy within the general population, play therapy techniques and approaches specifically focused on use with deaf children are still surfacing. Much of the research that exists in relation to deaf children is academically driven, focusing on performance, increasing academic abilities, and emerging developmental issues. What is missing from this puzzle is how to work with deaf children in therapeutic settings, and what techniques are effective in working

with the deaf child specifically in relation to the unique techniques used by play therapists.

Statement of the Problem

Deaf children whether mainstreamed, or placed in residential settings with other deaf students, have shown to have a higher incidence of emotional and behavioral difficulties (Mantanini-Manfredi, 1993). Deaf children are already limited in their communication methods with their families due to the majority of deaf children being born into families that are dominantly hearing. Since play therapy has been proven to be a multi-faceted approach in communicating with children with limited verbal ability, research which would establish a cohesive blueprint of play therapy techniques that work with deaf children in particular is a necessity.

Purpose of the study

The purpose of this study is to fill a gap in existing search with regard to effective techniques used to address incidences of social, emotional and behavior difficulties with deaf children in the play room. This will be achieved through the following: (a) examination of developmental issues unique to the deaf child, (b) examination of play therapy approaches, (c) examination of literature based on play therapy implemented with deaf children, and (d) through interviews of current play therapists whose main clients are deaf children.

Definition of Terms

Concept: Merriam-Webster online dictionary states the definition of concept as "an abstract or generic idea generalized from particular instances" (Concepts, 2009).

Concrete Play: The child's play is largely imitative and objects being used in the play session tend to have an exact meaning such as a dog is a dog, a cat is a cat and so forth. It can also mean the child has difficulty differentiating between reality and fantasy.

Directive play therapy: A form of therapy in which the child is able to lead the session some of the time and other times the therapist will establish the direction of the play.

Facilitative Responses: Responses that are used in the play process which allows the child to know they are capable coming to a resolution to their questions or comments. It is a way for the therapist to be on the child's level of communicating instead of questioning or correcting the child.

Non Directive play therapy: A form of therapy in which the child leads within the session and the therapist tracks behaviors and restates content being said.

Percept: Merriam Webster online dictionary states the definition of percepts as "an impression of an object obtained by use of the senses" (Percept, 2009).

Restating: A technique that utilizes skilled responses to restate content and convey meaning of what a child has just expressed.

Tracking: A skill in which the therapist states what the child is currently doing either with a toy or behaviors being exhibited within the play room. This is used to let the child know the therapist is paying attention to the child's play.

Symbolic Play: Landreth, 2002 gives the best representation of symbolic play, "A major function of play is the changing of what may be unmanageable in reality to manageable situations through symbolic representation, which provides children with opportunities for learning to cope by engaging in self-directed exploration (12)."

Limitations

A limitation to this study is the lack of research applying play therapy to the deaf population. Much research has been completed on deaf children primarily focusing on the linguistic acquisition delays due to their deafness or best practices for academic enrichment. This study used research conducted more than 10 years ago, and had a

limited selection of licensed therapists that use play therapy as a main tool in the therapeutic process.

Chapter 2: Literature Review

This chapter will thoroughly review information related to establishing play therapy as a technique that can be effective in working with deaf children. Four main sections will be addressed; developmental issues, types of play therapy, play therapy research specifically focused on deaf children, and actual techniques/issues currently used/addressed by play therapists in the field derived from interviews.

Developmental Issues

Play therapy is generally thought to be most effective for children ages four to 12. In looking at the developmental issues that impact deaf children within this category, it is important to put the perspectives within a theoretical framework. For this section the theories set forth by Erik Erikson and Jean Piaget will be used to assist in understanding developmental issues that impact deaf children. The average deaf child is born into a family that is hearing dominated. Although this is not the primary cause of developmental delays in deaf children it is a major contributing factor. Humans depend on language to navigate the world and understand those around them. According to Spencer quoting research by Moores et. al, "The majority of deaf children (>90%) are born to hearing parents, most of whom have little knowledge about deafness before their children's diagnosis…Not surprisingly, deaf children with hearing parents (dH) have high rates of language delays and deficiencies (Moores, 1987; Rodda & Grove, 1987)" (p. 868). It is important to understand that these deficiencies arise due to dismissiveness and communication barriers. Many parents who find out their child is deaf experience denial or depression over the issue and stray from helping the child learn language, instead anguishing over whether to use speech or sign with the child. This results in a delay of language acquisition. It should be noted that research pertaining to deaf children born to

deaf parents typically does not show a delay in language acquisition since the natural method of signed communication is present at birth.

Clearly language acquisition is an important factor in the development of any child, deaf or hearing. According to Hoemann "A central aspect of Piaget's theory is the process of equilibration (Piaget, 1975). Equilibration refers to the coordination that takes place when an individual assimilates some aspect of the environment and at the same time accommodates to its specific features" (p. 236). Basically what Hoemann is stating in relation to Piaget is that there is a natural balance between the child's ability to understand her environment versus the child's actual intellectual ability. Hoemann goes on to state "If deafness has any affect on deaf children's understanding of the world around them, it is because the world includes events that can only be assimilated by means of hearing" (p. 237). For instance, if a deaf child is outside playing and suddenly sees her mother cringe in fear due to the sound of two cars crashing, and suddenly begins to cry as a result of the experience, the child is unable to assimilate the environment and the emotion related to the situation due to the fact that the child was unable to hear the crash that just took place. This scenario has the potential to be misinterpreted by the child. He may believe that he has done something to cause his mother to react in such a manner. A potential consequence of this is that the child withdraws from play activity or stops altogether. This hypothetical situation has the potential to be concerning in terms of continuous development of a deaf child, since situations like these occur daily in a variety of misinterpreted emotional situations. Athey, 1984 brings up the topic of discontinuity within the stage theories. Discontinuity has to do with breaks between developmental stages versus continuous development of the life span. Discontinuity is something that hinders the normal development of the individual. Athey makes an excellent point regarding the impact of discontinuity on deaf students:

> In the case of the deaf person, the history of discontinuity begins in early childhood. If the child is not born deaf, development will probably proceed on a normal course during the first critical years. The child will learn about object constancies and the rhythms and regularities of daily events. He will establish a basis of trust in his interpersonal relations. He may also acquire a fair degree of language through which he can communicate with others. With the onset of deafness, every thing changes. The parents have a hard time assimilating this traumatic event, and their behavior toward the child undergoes drastic modifications. It may become rejecting or oversolicitous. Meanwhile, the child is trying to cope with the discontinuities in his perceptual world. He can no longer hear the sounds he previously heard. When he tries to communicate, he cannot hear the responses to his questions and comments. Gradually, through lack of auditory feedback, his own verbal ability begins to decline, and he becomes less comprehensible to others, thus increasing his frustration. If the child is born deaf, it may appear as though some of these discontinuities will be avoided, and this may be the case. However, In many cases a long period elapses before the parents become aware that their child is deaf, and when they do realize this unpleasant fact, the same pattern of rejection and disbelief or overprotection may ensue. (p. 86)

It should be noted that much of this pertains to deaf children born into hearing families. Delayed language acquisition and the impact of parental issues can arise as factors in the discontinuity of a deaf child's development. Deaf children often do not have the proper outlet for expressing and communicating their emotions, resulting in misidentified situations.

Portner (1977) references a study in her article that was conducted by Hans G. Furth stating the following "Furth points out that deaf children can learn symbolic thinking, but the symbols in this process are related to percepts, not concepts, concepts must be heard to be learned; they cannot be seen" (p. 56). Percepts are basic components in the formation of concepts. A good example of this would be the inkblot test during which an individual makes a mental impression of what they see and then transforms this into a concept. What this means for a deaf child's development is that she needs more visual stimulation in order to engage in symbolic representation. This can be difficult for a deaf child since much of her development is delayed due to the lack of language acquisition as the parent tries to decide the best course of action for the child's development. Often parents research the best course of action while the child lags in development and connectedness to the world around him since he is not getting the stimulation needed to spark the age appropriate development. Clearly, language is a critical component for a child's development. Play therapy, which relies on the child's own manipulation of her environment, and is not dependent upon verbal or visual communication, is a natural medium that can be used in therapy to bring about more normalized development while services and decisions are being made in regards to the child.

Dr. Laurel Wills and Dr. Karen Wills (2008) gave a presentation titled "Mental Health Needs of Deaf and Hard of Hearing Children and Youth" that illustrates more developmental issues deaf children encounter. The presentation illustrates an ABC approach when considering the factors that impact deaf children and adolescent's mental health. "A" relates to audiology, "B" relates to biology and brain, and "C" pertains to the culture, caregiving and communication. The author is more interested in the category related to culture, caregiving and communication. Within this category Wills & Wills

believe that the following things need to be considered: (a) communication skills (open or close doors), (b) attitudes (peer/teacher relations, inclusion, loneliness, stress, support), (c) socioeconomic stress and resources (affect staff ratio, quality assurance, programming), and (d) Staff knowledge (finding and using resources, client advocacy, self advocacy) 2008.

Wills & Wills perspective on deaf children's development falls in line with Erik Erikson's eight ages of man. Erikson's eight ages and generally accepted age frames are as follows: Trust vs. Mistrust (birth to about 18 months), Autonomy vs. Doubt (18 months to about three years of age), Initiative vs. Guilt (age three to about the age of five), Industry vs. Inferiority (age six to about age 12), Identity vs. Role Confusion (age 12 to about age 18), Intimacy vs. Isolation (age 18 to about age 35), Generativity vs. Self Absorption (age 35 to about age 55 or 65), Integrity vs. Despair (age 55 or 65 to time of death). For the sake of this research ages four to approximately age 12 will be focused on in terms of the generally accepted ages for play therapy effectiveness.

The issues that Wills and Wills presented fell into four categories: (a) self, (b) family, (c) school, and (d) "village." They presented three areas: the age and what children tend to do at that age frame, the age frame and what the presenting problems that seems to arise, and finally an acceptable treatment focus which could be used to address the presenting problems. Two areas of particular interest to the author were the two tables that present information grouped into the four to six age ranges, and the six to 11 age ranges.

Table 1

Age	Self	Family	School	"Village"
4-6	Explore; Master	Siblings "Roots"	Basic Concepts	Preschool Playing
4-6 Problem	Withdrawn Hyper Defiant	Rivalry Preference Infantilize	Lack of Progress in Foundations	Withdrawn Aggressive Self-Absorbed
4-6 RX?	Play Tx	Parent coaching; Help Sibs; Marital	Modify and intensify teaching	Center-based preschool social skills

Table 2

Age	Self	Family	School	"Village"
6-11	Compare; Compete	Chores Traditions	"Learning to read"	Friends and Sharing
6-11 Problem	Self-critical Shutdown Sad/angry Frustrated	Overprotect Leave out Underrate	English-based learning problems	Isolated Neglected Rejected Aggressing
6-11 RX?	Play Tx Talk Tx Behavioral	Family Tx Parenting	Visual phonics, Cued speech?	Friendship groups; Antibullying; Peer Tx

Between the ages of four and six years a deaf child begins to explore and master her environment and often she is doing so without stimulation from the environment around her. As one can note under the "Self" category in Table 1, the child becomes withdrawn, hyper, and even defiant. As the caregivers attempt to understand the deaf child and assist her through this stage of development, the child becomes frustrated, unable to understand what is going on within her environment due to a language barrier with her caregiver. These behaviors can have an adverse effect on the deaf child and she could become withdrawn and frustrated. This could lead to fewer attempts to explore

tasks and understand her environment. This in turn, causes the child to attach a meaning to an object or situation regardless of whether it is the correct interpretation or not. The child then grows up believing this interpretation and is often corrected or dismissed when it arises at a later age creating a gap in the developmental progress of the child even though cognitive development is normal. When this is considered in relation to Erikson's eight ages of man it falls into the stage of Initiative vs. Guilt. The deaf child is often told "no" in relation to play activity, not due to any fault of the child but in relation to the communication barrier that exist between the caregiver and the child. According to Erikson this leads to a sense of guilt, keeping the child from developing self initiative, often leading to dependency. Best (1973) interprets Erikson's stage as follows "The impact of deafness: Deaf children are exuberant only in their actions. They are inhibited by numerous safety regulations" (p. 17). This can be true to a limited extent as deaf children are always sheltered due to their lack of auditory stimulation at being aware of the environment and the dangers it may present them. This can also be considered to some extent a factor that leads to dependency within the child's developmental progress.

As noted in Table 2 between the ages six to 11 years, the presenting problem of the child is that he becomes self-critical, shutdowns, becomes frustrated, and generally appears sad or angry. The child who has already attached meaning to objects and situations in the exploration/mastering stage is now being corrected or dismissed, leading to an increase in behavioral issues arising, which may be viewed as an emotional behavior disorder. When put into the Erikson perspective, this would fall within the Industry vs. Inferiority stage. A child in this stage should be developing an understanding of how things work and should be praised and encouraged for their exploration and building of objects, and their sense of symbolic and fantasy play. The deaf child who is already language-delayed has a need to be caught up with his/her peers and, thus, is often

put into special education classrooms and taught to focus on language acquisition and developing communication. This can create a sense of inferiority in academic progress and can impact the child throughout his educational career. As a result, the deaf child is discouraged from exploring the world around him. The deaf child begins to engage in concrete play to learn what objects are since the child may not have the vocabulary to identify the true objects presented to him. Keep in mind the deaf child in most cases is not cognitively delayed but appears to be as a result of the delayed language. In relation to cognitive development of deaf children Hoemann, 1991 states: "There is one thing that Piaget's theory can do, however, that no other presently available theoretical perspective can do, and that is to explain how cognitive development can proceed normally in deaf children, even when their language development is severely constrained by circumstances" (p. 242). Deaf children can have normal cognitive development, with the exception of other mental disabilities; their development is delayed due to a lack of language. This impacts social, behavioral and emotional abilities because the child is unable to absorb what is going on around her due to a lack of acoustics and direct communication. A deaf child who is already closed off to the environment around her due to communication barriers will experience a delay in learning social, behavioral and emotional abilities.

Deafness is a major factor that hinders a deaf child's ability to communicate needs, and learn without communicative barriers. This can have a lasting impact on the deaf child's development of her identity as an individual. Ahrbeck (1995) sums up communication in relation to a deaf individual developing identity, "From a sociological view point, deaf people can only develop an identity when they are able to communicate without limitations, including extensive opportunities of personal expression and

understanding" (p. 6). In this case play therapy has been established in research to be an effective method for working with children in a barrier free communication environment.

Play Therapy

According to Landreth (2002) "Children must be approached and understood from a developmental perspective…Unlike adults, whose natural medium of communication is verbalization, the natural medium of communication for children is play and activity" (p. 9). Landreth sets the tone for looking at play therapy and its techniques nicely. This section will look at four types of play therapy: Child-Centered play therapy, which is a non-directive approach; Adlerian play therapy, which is a mixture of directive and non directive techniques; Filial Therapy, which incorporates caregivers into the play process, and Sandtray therapy, which is another non-directive technique.

Child Centered therapy is a unique form of therapy in which the child has control over the play room and of what types of play he engages in with minimal limitations. Landreth (2002) states " The child-centered philosophy is an encompassing philosophy for living one's life in relationships with children-not a cloak of techniques to put on upon entering the playroom, but a way of being based on a deep commitment to certain beliefs about children and their innate capacity to strive toward growth and maturity" (p. 59). Child-Centered approaches put a premium on the child and allow her to guide the relationship through play. The therapist follows the child's play using specific techniques to bring about therapeutic effects during the play process without taking charge or leading the play sessions. The Child-Centered approach is built on three key constructs, which include; the person, the phenomenal field and the self. These are derived from Carl Rogers' theory. The person relates everything the child is. According to Landreth (2002) this includes the child's thoughts, behaviors, feelings and the physical being. It is a

construct that is considered to be all inclusive which means it includes the external as well as the internal experiences of the child as she is engaged in play. The child will work toward a goal to satisfy, in essence, a personal need. The phenomenal field as Landreth states encompasses "everything the child experiences, whether or not at a conscious level, internal as well as external" (p. 61). This means that during the child's play, whatever he thinks is happening at the moment is considered reality. It is critical at this juncture to understand reality from the child's perspective rather than from the therapist's perspective. The third construct that encompasses Child-Centered play therapy is the Self. Self is everything tied together through the relationships with other individuals within the environment of the child. The self is critical for the child to develop awareness about her own wellbeing and her behaviors. It is believed this is a reciprocal awareness in that according to Landreth (2002) while the child satisfies other individuals need for positive regard, the child also fills his/her own need. The Child-Centered approach is all encompassing and is extremely focused on the child, seeing things through the child's expression and the child's play rather than the therapist making observation and assuming what is happening with the child. Generally, the therapist who is engaged in a Child Centered approach should be warm, caring, and accepting of the child for whom he is expressing himself to be. To allow the child to explore his environment, the therapist also needs to have a sense of understanding and sensitivity.

Along with the overview of what the Child Centered approach is, there are some specific guidelines as how to carry out this form of play therapy. The main tools of play therapy are the toys. Landreth (2002) gives this guideline for choosing toys to use when engaging in child centered play therapy; "Rule of thumb: Toys and materials should be selected, not collected" (p. 133).This means all toys should be selected with a purpose in mind to contribute toward the objective of play therapy, which is to bring about a

therapeutic resolution to a child's issue or emotions. The toys should represent whatever the child chooses, which is why it is not recommended to have mechanical or electronic toys. Toys, according to Landreth, should encourage seven essentials in play therapy "establishment of a positive relationship with the child, expression of a wide range of feelings, exploration of real-life experiences, reality testing of limits, development of positive self-image, development of self-understanding, and opportunity to develop self-control" (p. 134). In Child-Centered play therapy the therapist uses specific techniques to guide the child during play, known as facilitative responses. When engaged in play, the responses given by the therapist should not be long and drawn out but rather like a conversation that flows with the child's current state.

The therapist also uses tracking responses which are responses that state what the child is currently doing. For instance, if the child hits a doll with great force the therapist could track this behavior by saying "oh, I see you hit that doll hard." This response avoids passing judgment or preventing the child from hitting the doll again if he should so desire. When engaged in play the therapist should return responsibility to the child to help her develop a sense of self. For example if a child picked up a car and asked the therapist "what is this thing?" the therapist may respond "that can be whatever you want it to be." This facilitates a sense of independence in being able to make decisions. It is important to note that even though the child seems to have free reign in the play room when using the Child-Centered approach, there are therapeutic limits which must be set. Landreth suggests the limits are minimal and enforceable, such as "you may pinch me, but you may not hurt me" (p. 246). Limit-setting usually depends on the patience capacity of the therapist. Landreth suggest that if the limits are not enforceable they interfere with the therapist's ability to build trust with the child. Landreth goes on to state "limits are based on clear and definable criteria supported by a clearly thought-out rationale with the

furtherance of the therapeutic relationship in mind" (p. 249). Thus limits need to be reasonable and geared around safety within the play room. Landreth further clarifies limits further by stating "All feelings, desires, and wishes of the child are accepted, but not all behaviors are accepted" (p. 249). When the child engages in behaviors that are destructive in nature such as breaking toys or hitting the therapist or others engaged in the play process, the behavior may be stopped. Overall, limits should protect the wellbeing of the therapist and the child, encourage the child to make good decisions, and display self-control and responsibility. Child-Centered therapy as noted, is a non-directive approach that depends on the therapist allowing the child to direct her own play process while providing a road map of sorts through facilitated responses that lead the child toward resolving conflicts externally or internally that she has a need to resolve.

Adlerian Theory

Alfred Adler developed his theory in the early 20th century based on constructs of individual psychology. Adler based his theory on four ideas; people are socially embedded; people are goal directed; people are subjective, and finally that people are creative beings who must be viewed from a holistic perspective (Kottman, 2003). The first idea is that people are socially embedded. According to Kottman (2003) children observe their world to determine a way to establish a sense of belonging. The first group to which a child belongs is his family. The child, as he grows, will test various behaviors to see how various family members will respond. He will take note which behaviors promote attention and belonging and which do not. Suppose the child's behaviors are not promoting a sense of belonging with the family structure positively; he will revert to negative behaviors in order to achieve the desired outcome. This, in essence, will become the lifestyle of the child and will have a domino effect on his interaction with various social and cultural contexts throughout his life cycle. Kottman states; "the belief in social

embeddedness dictates that the Adlerian play therapist must consider the child and the child's behaviors in the context of other human beings rather than in isolation" (p. 21). This is true for a deaf child since the lack of communication ability can cause misunderstandings with the family members, resulting in frustration that can lead to negative behaviors to gain belonging. At this stage it is important for the play therapist to consult with the parents by inviting them in for a few sessions to establish the context in which the child interacts with her family members. If possible, it would also be beneficial to observe the child in her educational setting to gain an understanding of her participation in that environment.

The second idea of Adler was that people are goal directed. He believed people are motivated by various life goals. Kottman points out that the Adlerian therapist needs to look at the client's behavior to explore the goal of the behavior exhibited. Kottman also noted that children who come to play therapy are striving toward goals of misbehavior, not goals of positive behavior. As a play therapist using the Adlerian play therapy approach one would need to be aware of both goals the child has even though the primary aim of the therapeutic session is to assist the child toward the positive goals of behavior.

The third idea of Adler's theory is that people view life subjectively. Adler believed people make their decisions based on subjective interpretation of the facts presented to them rather than the actual facts given. Kottman points out children are excellent at observing; however they very often interpret the observations in an adverse way. This is very similar to a deaf child who may gain a nonverbal cue from another individual and interpret that nonverbal cue incorrectly due to the lack of communication and clear understanding between the two. It can also fuel the cycle of dependency in a deaf child if he is protected and sheltered because of his disability. This cycle of

dependence may be incorporated throughout his life cycle to aid him. The Adlerain play therapist must be aware of the subjective interpretation of situations. The counselor must be aware that there is no correct interpretation of reality. The counselor must also offer alternative interpretations tentatively. For instance, if the therapist sees things differently than the child, the therapist needs to present another way of looking at the situation as an alternative not necessarily as a better interpretation (Kottman, 2003).

The fourth and final idea of Adlerian theory is that people are creative. Adler celebrated the fact that individuals are creative and unique, and the Adlerian counselor needs to explore this creativity and uniqueness in the client. Working with children the Adlerian play therapist; "is to discover how each child expresses his or her special and wonderful self and to convey a sense of celebration in his or her uniqueness to the child, the parent(s), and the other people who interact with him or her" (Kottman, p. 27). This is important to the therapist working with a deaf child to not focus solely on the disability but rather on the uniqueness and the creativity of the child to bring out the positive social and educational behaviors of the child through play. In summary, the major goals of Adlerian play therapy according to Kottman (2003) are to:

> Move the child from destructive goals and misbehavior toward constructive goals; enhance attainment of the Crucial Cs; increase the child's social interest; adjust self-defeating perceptions in the child's beliefs about self, others, and the world; reduce discouragement; and help the child to understand and "own" his or her personal assets. (p. 28)

With an understanding of how Adlerian theory can apply to play therapy, the four phases of Adlerian play therapy as established by Terry Kottman can now be analyzed. Adlerian play therapy has four overlapping categories of the therapeutic process. The Adlerian approach mixes some of the non-directive approach that is utilized with the

Child-Centered approach with some directive techniques in which the therapist chooses the activity for a specific therapeutic purpose. The four overlapping categories are: (a) building an egalitarian relationship with the child, (b) exploring the child's lifestyle, (c) helping the child gain insight, and (d) finally reorienting /reeducating the child.

The first phase of the therapeutic process is to build an egalitarian relationship with the child. Since the relationship is based on mutual trust and respect Kottman (2003) states that the main job of the play therapist is to communicate respect and trust in the child and his or her abilities. In this phase it is important for the therapist to respect what the child chooses to do or not do within the play room as well as respect the child's wishes not to answer a question. This allows the therapist to build trust and not turn the child away from building an egalitarian relationship. It is important when the therapist first meets with the child to address him on his level and greet him by name. Once this has been established and the child and therapist are ready to go into the play room the therapist can tell the child it is time to go in and that parents or guardians will be out waiting when the play session is over. Kottman points out that it is important not to give a choice of going into the play room. This sets up some sense of limitation with the child that some things are controlled by the child and others by the therapist. If a child is reluctant to go into the play therapy room the therapist can have the parent come in for a few minutes, or for a full session, only to observe, or the parent can watch from the hallway. At this time it is important for building egalitarian relationship as well as trust in the therapeutic relationship to inform the child that what happens in the play room is confidential except for certain things including abuse, neglect, or harm to self or others. The egalitarian relationship is not a one-time thing; it is important to keep in mind that this therapeutic relationship and trust building will overlap with all of the phases of therapeutic play process.

The second phase of the Adlerian play therapy process is the exploring of the child's lifestyle. "The counselor gathers information about the child's lifestyle in order to be able to help the child and the parents better understand the patterns of the child's thoughts, emotions, and actions" (Kottman, 177). This component of the therapeutic process can involve gathering information about family members, peers, goals of misbehaviors and so forth. The information that is gathered during this phase helps the counselor formulate hypotheses about how the child views herself and her environment. This can be done through questions, the use of art techniques and/or the use of genograms, and family constellations that explore the birth order and family atmosphere. All of the information gathered during play in regards to this phase is important for the therapist to be able to form a clearer picture of the child and her social environment. The information is useful for the third and fourth phase of Adlerian play therapy as well, which will be discussed later.

Phase three of the Adlerian Play therapy process involves the therapist helping the child gain insight into her lifestyle. During this phase the therapist begins to connect the events taking place within the context of the child's play to the rest of her life. This can be done in several different ways such as the use of tentative hypotheses, the use of metaphors, directed role play, art, and many other play therapy techniques. This allows the play therapist to assist the child in gaining insight into her lifestyle. It also allows the therapist to guide the child toward thinking about her feelings and what behaviors she exhibits. During this process the child will eventually be able to make changes based on her new understanding of self. This is an important step within the play process when the therapist begins to understand the goals of the misbehaviors that the child is receiving therapy for, and can essentially allow the therapist to lead into the reorienting and reeducating phase of the therapeutic process.

The fourth and final phase of the Adlerian play therapy session is the reorienting and reeducating. This is when the therapist becomes more directive and is more like a teacher for the purpose of helping the child understand his new perspective. Kottman states "The primary goal of therapy during the reorientation/reeducation phase of the Adlerian play therapy is for children to generate new ways of (a) viewing themselves, others and the world; (b) feeling and behaving in various situations; and (c) relating to other people" (p. 83). The play therapist uses the tools within the play room to help the child practice her newly discovered perspectives and behaviors while also having a chance to report back to the therapist on what has taken place regarding the newly discovered perspectives and behaviors.

The four phases of Adlerian play therapy are overlapping, with no established timeline as each child will go through each phase over the course of the therapeutic process. The key is for the therapist to be alert to the child's lifestyle and goals of his behaviors or feelings in order to hopefully bring about a new perspective to the child's lifestyle and goals. Adlerian therapy would be a good fit in working with a deaf child in that it presents a balance between the child's independence along with structured goals to increase social interest. Adlerian play therapy with a deaf child in theory would allow the child to develop a sense of what his "personal assets" are as Kottman calls them. It may help the deaf child understand he is able and does not have a need for the dependency he has become accustomed. Adlerian therapy clearly mixes the Child-Centered approach with a directive approach and finds a delicate balance. An interesting aspect of the Adlerian approach is the incorporation of the caregiver in some parts of the process; a form of play therapy known as Filial play therapy.

Filial Therapy

"Many parents occupy time and space with their children but do not *know* or *understand* their children (Landreth, p. 365)." This statement is often true in the case of deaf children. It is not so much that the caregiver does not want to know his child; it is simply that the caregiver must begin to understand the deafness of the child first and then later understand the child. Filial therapy was first coined by Bernard Guerney in 1964 as a means of working with children with emotional problems. Filial therapy is a form of play in which both the parent and the child participate in the sessions, which normally take place in the home. Landreth best sums up Filial therapy;

> In my work, filial therapy is defined as a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions in a supportive atmosphere. (p. 370)

Since caregivers who have a deaf child are often struggling to communicate and understand deafness, Filial therapy in theory seems like a natural fit for allowing the caregiver and child to develop a relationship without focusing on signed communication right off the bat. Play is the natural medium of communication for any child, deaf or hearing, and it is only natural to facilitate this in a therapeutic way between a deaf child and his caregiver. The common theme that arises with deaf children thus far is language and communication in allowing them to express themselves without boundaries. A final type of play therapy to consider using with deaf children is Sandtray therapy.

Sandtray Therapy

Sandtray Therapy, also known as the World Technique, was originally used as a technique in the 1920's by Dr. Margaret Lownfeld. There has been debate over the terms Sandtray and Sandplay, and which one is the proper term for this form of therapy. Dora M. Kalff a noted Jungian therapist is known as the founder of Sandplay therapy which is

derived from the Jungian school of thought developed by Carl Jung. Jungian theory focuses on the wholeness of the individual. Sandplay is often used to gain insight into the unconscious aspects of the individuals thought. It is a process that is completely nonverbal and fully manipulative by the individual. Through the use of miniature figures and a sand tray of specific dimensions, the individual is able to set up a "world" in the way they see it. The toys and style of sandtray that Kalff recommends is as follows

> Specially proportioned sandbox (approximately 19.5 x 28.5 x 2.75 inches; floor and sides painted with water-resistant bright blue paint). Boxes of dry and moist sand are provided. Clients also have at their disposal a number of small figures with which they give formal realization to their internal worlds. The figures from which they can choose should represent as complete as possible a cross-section of all inanimate and animate beings which we encounter in the external world as well as the inner imaginative world: trees, plants, stones, marbles, mosaics, wild and domesticated animals, ordinary women and men pursuing various activities, soldiers, fairytale figures, religious figures from diverse cultural spheres, houses, fountains, bridges, ships, vehicles etc. (Kalff, 1991)).

Kalff (1991) also states two important prerequisites of the therapist. The first is to have a profound understanding of symbolic language as per the Jungian theory which is rooted in interpretation of symbols. The second is to create a free and protected space for the client to work in. This space should be a place in which the client can create her world and feel protected while doing so. The therapist should not interrupt the client while engaged in sand play, and at no time should she touch the world the client has made. Instead, the therapist must give this world the utmost respect when doing the analytical portion of therapy in relation to the created world. Sandplay, in theory, can be considered

a very useful tool in working with deaf children in play therapy. As Kalff points out, the client feels secure and protected, and is free to set up the world through his eyes. There is no dismissing the child's creation and there is no inhibiting his play thereby allowing the child to set up his world and express that world as he understands it free of barriers. There exists an abundance of research that shows play therapy to be an effective medium in working with children but there is limited research that shows the effectiveness of these techniques with deaf children.

Play Therapy with Deaf Children

Deaf children are a unique set of individuals, they can have normal cognitive development yet be delayed in language, social, behavioral and emotional abilities. Play therapy can be applied to deaf children and any other "labeled" child. Johnson & Fall published a study that was done with "labeled" children in schools. It involved six subjects that ranged in disabilities from attention-deficit/hyperactivity disorder to autism. The results of this study were as follows; "Results of this study, showed that nondirective child centered play therapy facilitated the labeled children's expression of feelings. In the play therapy sessions, the children controlled the toys, the therapist, and the environment (1997)." A study by Patricia Spencer was done to see if a relation existed in the association between language and symbolic play with deaf toddlers at the age of two. This study was conducted with 10 toddlers and their mothers separated into three groups: (a) deaf children of hearing mothers, (b) deaf children with deaf mothers, and (c) hearing children with hearing mothers. The only factor in the study was that the children had language acquisition delay. The interesting finding from this study was that despite the small number of subjects and the caution toward interpreting the findings, there was a pattern between language acquisition and symbolic play. However, it was not found that any pattern existed based on hearing status. The only time Spencer found any relation

between hearing status and the child's symbolic play was based on the total time spent engaging in symbolic play. In the conclusion of Spencer's study it was stated that there seemed to be a strong link between the child's ability to engage in expressive language and her play at around the age of two, while language is developing at a rapid pace. Spencer did suggest that language is an important factor that can guide the child to develop more symbolic play. Spencer ended the research with this in mind; "access to a fluently functioning linguistic system may be necessary to support age appropriate play" (p. 875). This conclusion makes the author wonder if the lack of functioning linguistic ability is what causes problems to arise at a later age during the play sessions as were reported by therapists who were interviewed by the author. This idea will be presented later in the research. Research supports using play therapy with deaf individual even though it is limited and much of the research raises more questions than it answers. In considering doing play therapy with a deaf child and furthering the establishment of techniques that are effective with a deaf child it is good to know what issues have already arisen in using this approach.

Sally M. Moore (2002) wrote an article for the American Play Therapy newsletter that addressed play therapy with deaf children. Several dilemmas and concerns were raised along with some suggestions. The first dilemma raised was regarding a technique related to the Child-Centered approach in which the therapist indicates the play room is a special place and the child is free to do almost anything, with consideration that there are some therapeutic limits that are established. Moore stated that this type of phrase does not translate well from its English version to the language of deaf individuals which is American Sign Language (ASL). Moore suggested using the phrase as follows "This is play time. This play is different than play at home or play in the dorm. You decide what to do in play. I will not tell you what to do; and if you are puzzled about something, you

can ask me" (p. 25). The reason behind such a lengthy description is that the child may not have the language ability to understand a statement that says "you can do almost anything in the play room." Translation of the word "almost" is difficult as it is a word deaf children do not tend to see. Hearing children, however, hear the term "almost" frequently in daily language usage. In use of sign language most caregivers or signers will sign "soon" in relation to "almost getting there" these are two different conceptual signs.

A second dilemma that Moore expressed related to the naming of objects. In using the Child-Centered approach, the therapist refrains from naming the object because the goal is to have the child use and name the object as whatever they believe it to be. With the known language delay in many deaf children born to hearing parents it is clear they do not have the vocabulary to create symbolic representations of the object. Therefore they might ask the therapist, "What is this?" The therapist is then faced with the dilemma of wanting the child to name the object for themselves and the balance of developing the child's vocabulary. It should be noted that Moore does state deaf children who are born to deaf adults are typically on par with their hearing counterparts, though this is only true for about 10% of the deaf population. Moore does support play therapy as a tool for deaf children because play therapy establishes a safe and barrier free way for the child to express himself and develop skills for application in his life.

Elizabeth Urban (1990) did a case study that involved a 10-year-old deaf girl in London. In the study, the therapist's own signing ability has much to do with the effectiveness of play therapy with a deaf child. Urban states

> I had some signing skills, but the demands of trying to concentrate on what was to me a foreign language (initially poorly expressed by Virginia), of trying to understand what she was trying to communicate of

> her feelings, and of managing her impulses to run out of the medical suite, often were too much for me to be able to think clearly. At the outset, I relied upon projective identifications to understand Virginia's feelings, but in the course of time we developed a "good enough" way of communicating based up on a kind of pidgin sign language, gestures, mime, drawing, and simple written messages. This served until her command of sign language significantly outmatched my own. (pp. 63-64)

This is critical to note because even though play therapy is considered to be a child's form of communication there still needs to be effective language communication between therapist and child. This is critical as the child already struggles within the home with communication and to be forced to struggle again in the play therapy sessions puts an undue burden upon the child which will duplicate her frustrations. Urban goes on to state that toward the end of the sessions Virginia would become more frustrated, impatient, and contemptuous with the therapist. It is important to note that from Urban's case study, Virginia developed and was able to better control her behaviors within the classroom and the play therapy sessions despite her frustration with the language barriers between herself and the therapist. Using play therapy, Virginia was able to work through behavioral and emotional issues through the construct of her play.

Landreth and Smith (2004) did a study that incorporated Filial therapy with teachers of the deaf. Landreth and Smith stated they needed to modify much of the techniques and the responses to fit with American Sign Language. There is not a sign for every word. Often is the case with American Sign Language, there is one sign to express multiple meanings of the same word. For instance Landreth and Smith note

> Instead of attempting to communicate the more complicated "You feel happy playing with that dinosaur," or, as the teachers were inclined to ask

> the question: "Are you happy playing with that dinosaur?" they decided to respond "You look happy…the dinosaur is fun…you like playing with it." Similar issues arose regarding concept of "choose" and "decide" central to the language of giving choices and setting limits. (p. 23)

Changing how things are signed is based upon the child's ability to think in hypothetical logic. Despite the language barrier and the constant changing of how things were signed, it was found that through implementation of Filial therapy teachers became agents of change with their students.

Research shows that Play therapy can be used with deaf children through an understanding of developmental issues which seem to stem from language acquisition, to the techniques applied in play therapy, to the existing research that does say play is an effective agent of change. It is now time to break down which techniques should be recommended using in play with a deaf child. Also, what the therapists in the field today have suggested in relation to twelve questions presented to them that stems from issues and developmental research presented above.

Current Play Therapy Techniques with Deaf Children

Twelve questions were presented to eight play therapists who use play therapy with deaf children. Four of these therapists responded to the request for an interview and their answers were then looked at for commonalities in their methods of using play therapy to come up with the best approach and or suggestion for using play with a deaf child.

Question one inquired "How do you set up the play room to accommodate a signing child due to unique language interaction?" The therapists who responded stated that many of the deaf children are seen in the schools, and recommend that a traditional set up is okay but that there should be minimal distractions including as few windows as

possible since the deaf child will gravitate toward people walking by due to their dependency on visual stimulation around them. It was also recommended that there be open space for the therapist to get around the child in order to position herself within the signing view of the child. Two therapists suggested the use of mirrors so the child is able to look into the mirror and see the therapist signing from behind him during play. This eliminates the need for the child to stop play to turn around and look at the therapist. One therapist suggested a type of disc that is see through that creates the illusion of a curtain. The therapist can be behind the disc and interact with the child without forcing the child to engage in direct eye contact during his/her play. Additionally, the therapist is still able to see the child engaged in the play process.

Question two inquired "What toys do you use with deaf children?" All four therapists suggested that traditional toys typically used in play therapy are good. All also suggested having toys that are disability specific such as signing puppets in which hands can be inserted into the puppet and still be able to sign through the puppets arms. Dolls with exaggerated and interchangeable ears were also a suggestion. With this doll the child could change the size of the ears on the doll. Two therapists suggested having musical instruments and toys that are hearing-oriented for the deaf child to play with and express frustration of inability to use, or to try different identities. One therapist suggested that this is good for gaining insight into the child's home communication patterns especially with deaf children born to hearing parents. The use of a digital camera was suggested. Since deaf children are very visually oriented the digital camera gives the child a visual representation of play and can aid the therapist in helping the child gain insight into the process and/or behaviors that may be exhibited during play.

Question three inquired "Are there any specific theoretical based play therapy methods that have proven consistently effective with deaf children? Ie: Jungian, Adlerian,

Person Centered, Filial and so forth…" Each therapist was expected to be different in their theoretical orientation toward play therapy. However, the general consensus with this question was that most often directive therapy, such as the use of Cognitive Behavioral Therapy, Filial Therapy, and Gestalt therapy is more effective with a child. It was suggested that a therapist start with the child centered approach and then lead into the directive approach. It was mentioned by one therapist that children tend to be more dynamic in their play and a directive approach can be useful if the child is too active. If a child ends up moving around from object to object, interpreting their play can prove difficult for the therapist to get a grasp on the issues that the child may be working through. This is similar to when a client in a therapy session starts talking about one issue and then randomly starts talking about different topics without really discussing the original issue that was brought up. One approach that was consistent with all of the therapists' answers was the involvement of caregivers, especially when the caregivers are hearing and the child is deaf. Filial therapy was suggested as an approach for this integration. Another technique not familiar to the author that was brought up by one therapist for involving parents was called Theraplay. Theraplay as stated by the Theraplay Institute is described as follows;

> Theraplay® is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others and joyful engagement. The method is fun, physical, personal and interactive and replicates the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal

> problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, Theraplay has been used successfully for many years with foster and adoptive families (Theraplay, 2009).

Theraplay relies heavily on nonverbal cues which makes it useful with deaf children due to their natural use of a nonverbal language. One therapist strongly encouraged the use of Sandtray therapy, which as noted earlier, is based on the Jungian approach and is not dependent on either cognition ability or language ability since Sandtray play is the child creating a world within the sand tray.

Question four inquired "When working with deaf play therapy clients, do you find non-directive techniques or direction techniques most effective? Or Neither? Why or why not?" Two therapists suggested starting with the non-directive approach such as the Child-Centered approach toward play to build a relationship with the child and then move into the directive approaches after a relationship has been established with the child. Another therapist suggested paying attention to the age, developmental stage and how the child responds to play therapy. The therapist did suggest that both approaches have been effective. Using non-directive approaches for general issues such as being accepted for whom they are was suggested. This is important to note since the child is often isolated and tends to be ignored throughout his day and within his family. For more specific issues such as harassment about their disability, the child's acting out, or if the child appears to be in distress due to play therapy being a new experience for him the therapist can use a more directive approach.

Question five inquired "Play therapy has some unique counseling techniques such as tracking and reflecting content during the child's play. Do you believe it is possible to incorporate skills like tracking, reflecting content, etc. into the play therapy

when working with a deaf child without interrupting their play process, and if so, how?" The therapists were varied in their responses to this question. Two of the therapists mentioned this was challenging and that it was best to wait until the breaks or use directive role-play during or after the child is done playing. Both mentioned that the therapist does not want to interrupt the play process which is why the beginning or end of sessions is a good time to reflect content and summarize the play with the child. One therapist suggested the use of mirrors, and continuing to reflect and track, leaving it up to the child to look at the therapist or not. Another therapist gave the same sentiment that she just continues to do the tracking and reflecting the content through signs and body and/or facial expressions regardless of if child is looking or not. Each therapist suggested positioning oneself within the visual field of the child. It seems as though the reflection and tracking can be a challenging portion during the play; finding the right balance of when to use this is critical during the play session. It appears that using directive techniques would aid in facilitating the tracking and reflecting content since the goal of the activity would be specific and the therapist would be involved in the process from the beginning.

Question six inquired "An important part of play is when children "name" the objects they are playing with. Much of the research I have read talks about the language delay of deaf children. Some therapists have noted that deaf children will ask what an object is due to not having the language to be able to "name" the object. Do you find this to be true in the process of play? How do you handle this situation when/if it arises?" One therapist responded this was not an issue. The other three therapists suggested using the return responsibility that is used in the Child-Centered approach in which the therapist gives the child the chance to decide what they want the object to be. One of the therapists suggested asking the child what the object is used for instead of giving the child the

"name" of the object. It seems to be a general consensus that despite the child's possible language delay it is important for the child to be encouraged to "name" their play objects the way they perceive them in the process of play. Keep in mind that deaf children already are dismissed and corrected often during the day, and their ability to express who and what they are is critical in the play process. By correcting and "naming" the object for the child the therapist may further the dismissing of the child.

Question seven inquired "Do you find that deaf children often struggle with identification of emotions during their play?" Three therapists pointed out indeed children do lack emotional vocabulary at home and their expressions of emotions in the play room are often basic and raw. One therapist agreed the deaf child struggles with identification but believes it to be no more of a struggle than a hearing child in the play room. The general consensus is that the deaf child does not have sufficient vocabulary and this is generally due to the delay in language acquisition and not a cognitive function delay. Gabriel Lomas wrote an article for the Odyssey in relation to teaching feelings to deaf students. Lomas (2007) wrote about a situation that shows the issue with deaf children and their misidentification of emotions. This is one isolated case and should be used with caution in applying to all deaf children.

> For example, one day I walked down a hall toward a classroom with deaf children. I could hear crying, and I saw a student sitting by the door of his kindergarten classroom. I walked up and attempted to engage the student in conversation. When I asked him how he was feeling, he signed he was happy. I was shocked! The only feeling the crying student could name was *happy* (p. 30).

Lomas points out in the article that even secondary students could only identify basic feelings. The author, through his work with deaf adults ages 18 to 65 in a mental health

capacity, notices often deaf individuals only know the basic feelings such as sad, happy and mad. Many of these deaf adults are unable to apply the correct feeling to a particular situation. The individual often misidentifies the emotion for particular situations, such as identifying sad for a situation in which the individual should be happy. This is a common trend and it does go back the individual lacking vocabulary to express appropriate emotions resulting in misidentification of emotions. Due to the individual's inability to identify what is going on around him as a result of no auditory input, correctly identifying feelings becomes difficult. One therapist noted that without affect vocabulary many children are not ready for therapy. This potentially could contribute to situations like Urban (1990) presented when the deaf child with limited communication is present, the child struggles with expressing emotions possibly leading to only the understanding of basic emotions.

Question eight inquired "What issues, if any, are common with deaf play therapy clientele?" The answers from all therapists were varied and are listed in no particular order as common themes with deaf children.; abuse, loss, control, boundaries, feeling undervalued, envy toward siblings, helplessness, who to trust, polarized thinking both good and bad, attachment issues particularly relating to language barriers between the child and the parent, delayed imagination, delayed creativity, and dependency primarily due to being taught to be dependent. This question was posed to see if there were any commonalities of issues that arise. It does show that attachment and dependency are issues that could be related to issues regarding language acquisition. The child becomes dependent on the caregiver to understand their environment and trust can be fractured when the child is dismissed or corrected.

Question nine inquired "What obstacles do you run into during the play process with a deaf child if any?" Again the answers to this question were varied as it often

depends on the therapist's own approach. In no particular order are some of the issues that arise; child's lack of vocabulary, cognitive delays, poor parenting, lack of follow through with therapy by caregiver, staff in schools not respecting play space and time, staff and parents wanting to know everything the child says or thinks, fluency of signing ability suggested native signing ability is better for the child and the therapeutic relationship and tracking. One thing that caught the author's attention was the mention of native signing ability. Native signing ability refers to a deaf adult who is trained in play therapy using sign language as their native language to interact with the deaf child. This is an important factor as research suggested that access to a fluent linguistic system is likely needed in order for the child to develop at age appropriate junctures. It is important to note that most children who are entering play therapy, based on the developmental aspect of language delay, are born into hearing families; their developmental issues tend not to be cognitive but resulting from delayed language acquisition.

Question ten inquired "What type of play do deaf children seem to engage in? Ie: Symbolic vs. Concrete." Two of the therapists stated that the deaf child engages in primarily concrete play. One of the two therapists stated that the child who engages in more symbolic play tends to have a higher cognition level than those that engage in concrete play. One therapist stated the type of play is dependent on the child's language level. The final therapist stated that children engage in both but did not elaborate beyond stating both types. Research supports that language acquisition delay impacts a deaf child's ability to engage in more symbolic play versus concrete play. Since symbolic play requires the child to be able to substitute objects and freely name objects and interchange those objects to be what he/she wants them to be the language delayed deaf child would struggle with more symbolic play versus concrete.

Question eleven inquired "What specific suggestions do you have in terms of a therapist wanting to serve a deaf child in the play room?" Three therapists suggested a therapist should be well trained in play therapy techniques and have an understanding of the foundations and the ins and outs of play therapy overall. Those three therapists also suggested that anyone doing play therapy with deaf children should be well versed in deaf culture and have an in-depth understanding of the issues that impact deaf children. The therapist should also have training on developmental issues related to deaf children and children overall. Fluency in American Sign Language is critical in the play room with a deaf child to foster language and understanding. One of the three therapists suggested getting supervision from a deaf therapist already rooted in the therapy techniques. It would appear that the general consensus is to be well versed and well trained in play therapy techniques regardless of whether it is deaf focused or not. This is critical as play therapy is a unique therapy approach and to be done effectively, training in the procedures and various theoretical frameworks is crucial.

Question twelve inquired "What issues have you or your colleagues encountered, if any, with using an interpreter in play sessions with a child? Would you recommend a therapist to use an interpreter in the play room?" All four therapists responded that it is preferable to have a signing therapist who can communicate directly with the child as often interpreters add inflections not intended by the therapist. For example if the therapist was really disapproving of a behavior, the way that the interpreter interprets this might appear as approving by the child. This is something that can be avoided through direct communication. It was suggested by two therapists that if an interpreter is needed they should receive training and be taught how the play process works to avoid influencing the child's play. The author had an inverse use of the interpreter in which play therapy sessions with a hearing child was conducted and an interpreter was in the

play room for the author's sake since the author is deaf. The author's interpreter was with him for the whole course, was instructed along the way, and had a direct understanding of the play process. The child noticed the interpreter was there for the first two out of nine total sessions. After the second play session the child quickly forgot about the interpreter in the room and the interpreter simply became a part of the sessions in the same manner the author was. Since the interpreter knew the play process well she was able to position herself to not interfere with the space in the play room. It was a critical component to the play process that the interpreter knew and was trained along with the author in how play therapy was conducted thus reducing potential flaws in the therapeutic process. It did help that the author was able to respond to the hearing child with direct verbal communication.

Play therapy is a proven valid technique for working with children in the therapeutic sense; play therapy has much potential value in working with deaf children due to not necessarily needing a fully developed linguistic ability. Through research and interviews it is clear that deaf children will benefit from this unique form of therapy to help them address the issues they face in their development.

Chapter 3: Summary, Critical Analysis, and Recommendations

This chapter will summarize the research findings from the previous chapter, as well as give a critical analysis in relation to play therapy with deaf children. This chapter will end with recommendations to improve future research.

Summary

Many developmental issues exist with deaf children as they do for hearing children. No one developmental aspect outweighs the other and for each child the developmental issues are unique. Humans depend on language for their learning process and developing an identity of who they are. Researchers such as Spencer (1996), Hoemann (1991), Ahrebeck (1995) and others have consistently shown that several of the developmental issues that are of concern with deaf children stem from the linguistic acquisition delay resulting from hearing loss. Keep in mind that while this is not the sole factor for the developmental delay in a deaf child, it is clearly a major factor. Deaf children are able to learn percepts and concepts given the chance by developing strong linguistic abilities or by being given a way to express their feelings that does not pose a barrier to their expression. Deaf children develop cognitively at the same pace as their peers, it is the result of the linguistic delay that makes it seem like deaf children are behind their hearing counterparts. This is often true barring any unforeseen additional mental disabilities.

One way to allow a deaf child to begin communicating without any barriers, without a developed linguistic ability being that verbal or signed communication is through the means of play. There are many forms of conducting play therapy that are all effective, none of which depend on fully developed linguistic ability. Children explore their world through play with the assistance of external stimulation toward understanding that world. For a deaf child who may be born into a hearing family with no experience or

knowledge of deaf services, deaf individuals, or language, starting some form of play therapy is shown to be beneficial. There are all kinds of evidence based techniques; Child Centered, Adlerian, Filial and Sandtray that would all be useful with a deaf child, and the child's caregivers, to provide a structured barrier free environment for that child. This allows the child and her family to develop the social, emotional and behavioral understanding of each other. This, in turn, fosters the development of the deaf child while also putting the caregivers at ease while developing and researching options for their child regarding services and language options. While the caregivers are in the learning process, the child is provided a way to express her needs and frustrations in her natural medium of play, in an environment where the caregivers are not stressed and there exists a therapist to help foster the child's understanding of her world through direct communication.

Research based on the effectiveness of play therapy has shown to be an effective tool to use with deaf children. This was clearly illustrated in Urban's (1990) study in which despite Urban's limited knowledge of the deaf child's natural language; the child did develop more control over her emotions and behaviors by the end of the sessions within the school year. Play therapy became the natural medium between the therapist and the child. Filial therapy, even though it was incorporated between the teachers of the deaf and the children they educate, showed that changing the approach of interaction between the teacher and the child develops a stronger rapport and understanding. This rapport and understanding was acquired through the process of play and learning to understanding the child from the child's perspective rather than the adult's perspective.

Therapists are using techniques that are evidenced by research on play therapy. It has been shown through interviews with therapists that play therapy is an effective tool to use with a deaf child if done correctly by a therapist who is trained in the techniques of

various play therapy theories, developmental issues of deaf children, and is knowledgeable and fluent in the language that deaf individuals use.

Critical Analysis

There are many forms of play therapy that can be applied with deaf children. There does not seem to be one specific form of play therapy that is most effective with this population. The research that currently exists on play therapy with deaf children clearly focuses on the linguistic development of the deaf child more than the therapeutic value of play. One of the issues with research existing on deaf children's play is the small number of dyads that are used as evidenced by Spencer (1996) in which only ten toddler-mother dyads were used with the deaf of deaf, deaf of hearing, hearing of hearing (896). While there are therapists who write articles in relation to play therapy with deaf children such as Bettman (2004), Lomas (2007), Greeves (2008) and Moore (2002) these are sporadic case studies, articles on how the play is used with this specific population, or the issues that seem to arise while engaged in play therapy with a deaf child. Very little research exists that establishes a blue print of best practices that are directly related and unique to this population in terms of using play therapy. Despite the best efforts of some therapists to promote play therapy with deaf children, the research that creates a cohesive blueprint for evidence based "best practices" for deaf children is still in its infancy. Part of this is due to the limited number of registered play therapist working in direct relation with deaf children who use play therapy as the main tool for the therapeutic relationship. Many therapists advertise the use of play therapy but like the research and the interviews show, those therapists should be extensively trained in play therapy and in deaf issues for it to be an effective therapeutic tool due to the uniqueness of the play therapy approach. An increase in the focus on specified techniques that are unique to the deaf population

should be looked at to create a theoretical best practice when training therapists for work with deaf children.

Recommendations for therapists

A first and foremost recommendation for a therapist working with a deaf child is to be trained and thoroughly educated on the developmental and academic issues that pertain to deaf children. The therapist should also be fluent in signed communication in order to facilitate direct communication with the child during the process of the play therapy sessions. A therapist considering working with a deaf child should also be well versed in established play therapy techniques through professional training and workshops that focus on the how-to regarding play therapy. It was recommended by a therapist through an interview; it is not deaf specific play therapy as much as how to implement play therapy in the appropriate therapeutic manner that is critical. The therapist should still be knowledgeable in a spectrum of deafness and the culture that is unique to the deaf to be effective.

Use of play therapy

One recommendation for the use of play therapy is that it should be implemented immediately in some form upon identification of deafness while services are being considered for the child. Identification of play therapists or therapists with play training in local communities is critical as research has shown that deaf children have developmental delays due to delayed language acquisition. For the child, play establishes a barrier free communication environment and an atmosphere for the caregiver to learn how to communicate with their child in the child's natural medium of communication. This also allows the parent to be introduced to signed communication while understanding what the child is trying to express and communicate. It is possible that

parents would be more receptive to play therapy as an avenue for connecting with the child and learning about communication methods to interact with their deaf child.

Future Research

Research on specific techniques that establish a method for how to engage in play therapy with a deaf child is still in the infancy stage. It is recommended that further research in this area be done by testing the techniques that are considered to be more deaf-specific such as but not limited to the use of mirrors, curtains, disability-specific toys and digital technology. By testing and re-testing some various techniques that are more specific toward working with children who are deaf, an evidence based research model can be created which would further validate the use of play therapy with deaf children. Focusing research more toward the therapeutic outcome of play therapy with deaf children using deaf specific techniques would give a holistic picture rather than research based heavily on linguistic or auditorial issues regarding play development. By focusing research on the therapeutic outcomes it is possible for a researcher to increase the dyads and eliminate the need for cross comparison. Research is currently abundant that evidences the linguistic and academic issues related to deaf children. Research is needed that evidences the therapeutic value of play therapy specifically for deaf children. Research is also needed to evidence what techniques are the best methods for facilitating therapeutic outcomes with deaf children.

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Appendix A: Interview Questionnaire

1) How do you set up the play room to accommodate a signing child due to unique language interaction?

1a) what set ups have proven effective?

1b) what set ups have proven less effective?

2) What toys do you use with deaf children?

3) Are there any specific theoretical based play thereapy methods that have proven consistently effective with deaf children? Ie: Jungian, Adlerian, Person Centered, Filial and so forth...

4) When working with deaf play therapy clients, do you find non-directive techniques or direction techniques most effective? Or neither? Why or why not?

5) Play therapy has some unique counseling techniques such as tracking and reflecting content during the child's play. Do you believe it is possible to incorporate skills like tracking, reflecting content, etc. into play therapy when working with a deaf child without interrupting their play process, and if so, how?

6) An important part of play is when children "name" the object they are playing with. Much of the research I have read talks about the language delay of deaf children. Some therapists have noted that deaf children will ask what an object is due to not having the language to be able to "name" the object. Do you find this to be true in the process of play? How do you handle this situation when/if it arises?

7) Do you find that deaf children often struggle with identification of emotions during their play?

8) What issues, if any, are common with deaf play therapy clientele?

9) What obstacles do you run into during the play process with a deaf child if any?

10) What type of play do deaf children seem to engage in? Ie: Symbolic vs Concrete.

11) What specific suggestions do you have in terms of a therapist wanting to serve a deaf child in the play room?

12) What issues have you or your colleagues encountered, if any, with using an interpreter in play sessions with a child? Would you recommend a therapist to use an interpreter in the play room?