

PLAY THERAPY in MIDDLE CHILDHOOD



Edited by
Athena A. Drewes and Charles E. Schaefer

12

PLAY THERAPY FOR SCHOOL-AGE CHILDREN WITH HIGH-FUNCTIONING AUTISM

KAREN STAGNITTI

Children with high-functioning autism may no longer be diagnosed under the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition [DSM-5], American Psychiatric Association, 2013; Turygin, Matson, Beighley, & Adams, 2013) as being on the spectrum for autism. This is because under the DSM-5, children with autism spectrum disorder (ASD) are diagnosed on the basis of significant and persistent impairments in the area of social/communication and significant and persistent impairments in the area of restricted and/or repetitive behaviour (Turygin, Matson, Beighley, et al., 2013; Turygin, Matson, Adams, & Belva, 2013). Turygin and colleagues argued that children diagnosed with ASD using the DSM-5 will have more severe symptoms than children diagnosed on the DSM-IV-TR or DSM-IV. However, they conceded that children with high-functioning autism still required intervention as they will continue to present with social difficulties.

Diagnosis for ASD under the *International Classification of Diseases* (10th ed; ICD-10; World Health Organization [WHO], 2015) includes

<http://dx.doi.org/10.1037/14776-013>

Play Therapy in Middle Childhood, A. A. Drewes and C. E. Schaefer (Editors)

Copyright © 2016 by the American Psychological Association. All rights reserved.

children diagnosed with childhood autism showing impaired development before three years of age with abnormal functioning in social interaction, communication, and behaviour that is repetitive and stereotyped. Asperger's syndrome is included as a separate section under the *ICD-10* (WHO, 2015) with children showing similar characteristics to those with childhood autism but having no general delay in language or cognitive development.

This chapter outlines the basic rationale and theory underlying the Learn to Play program, the play ability of children with high-functioning autism (or Asperger's syndrome as described in the *ICD-10* [Version: 2015]), the Learn to Play intervention, the empirical support, and a case study.

BASIC RATIONALE AND THEORY

The main aim of the Learn to Play program is to develop in children who cannot play the ability to spontaneously initiate their own play. This therapy program grew out of clinical work with children who were referred for treatment to specialist early intervention childhood teams because of concerns related to their development. Research on the development of the Child-Initiated Pretend Play Assessment (Stagnitti, 2007) had led to the realization that the majority of children who were referred to early intervention childhood services had low developmental levels in pretend play. It is not uncommon for these children to be 2 to 4 years delayed in their development in pretend play. The rationale behind the Learn to Play program is that a child's ability to self-initiate their own play is vital for their well-being as play gives a foundation for the child's self-regulation, language, and social-emotional development (see Gray, 2011).

The theory behind the Learn to Play program (Stagnitti, 1998, 2009, 2014) draws from Axline (based on Rogerian psychology, 1974), cognitive developmental play theories, and developmental theory. Virginia Axline worked in the 1940s and developed nondirective play therapy after being influenced by Carl Rogers and his person-centered therapy. With Axline's technique, the child enters a room with toys displayed and is instructed to play with whatever he or she would like. Destruction of the toys and harm to the therapist are not acceptable and children are told the session will be ending five minutes before the session ends. The principles of Axline's approach underpin the Learn to Play program. These are: a warm relationship is developed by the therapist with the child; the therapist accepts the child unconditionally; the therapist creates an atmosphere of permissiveness so the child is free to self-initiate; the therapist respects the child's capacity to develop; the child leads the way; the therapist responds to the

child; and the only limits established are those that allow the play to flow. Unlike Axline's approach, the therapist predetermines which toys are placed out for the child to play with and the child is praised during the play. The reason for these two departures from Axline's approach are that children with low developmental levels of play are overwhelmed by large numbers of toys, so limiting the toys is one way to help them focus, and children who cannot play do not find play interesting, and so praising their engagement in play is one method to enhance their motivation to continue in the play scene.

Vygotsky's approach to the developmental cognitive theories of play has been more influential in the Learn to Play program than Piaget's approach. Vygotsky (2004) maintained that play "was a creative reworking of the impressions he has acquired" (p. 11). In play, then, children experiment with what they have experienced, seen, or physically engaged in. Vygotsky (1976) maintained that through play children developed cognitive skills. Most important, he took a constructivist approach and asserted that children's development could be extended by capable peers or adults (Vygotsky, 1976).

One of the assumptions of the Learn to Play program is that pretend play is an ability. It is influenced by a child's natural ability and physical and social environments. However, not all children develop ability in pretend play, which is understood to be the most complex, or mature, form of play between the ages of 12 months and 10 to 12 years (Vygotsky, 1976). Children who are developing typically tend to engage spontaneously in pretend play because it is the most intellectually and emotionally challenging play type within this age group. Pretend play includes the skills of (a) play scripts (i.e., the stories in the play), (b) logical sequencing of play actions, (c) object substitution (i.e., symbols used in play), (d) social interaction, (e) role play, and (f) play with an object outside of the self (e.g., a doll or teddy, also called *decentration*; Stagnitti, 1998). Pretend play, as it is understood in the Learn to Play program, encompasses both solitary play and social play, simple single actions of pretend to complex sequences with scripts carried out over 3 weeks. Symbolic play, role play, sociodramatic play, projection play, construction play and narrative play are embedded within pretend play. When children begin to engage in pretend play, they use single actions with single objects and symbols represent physically similar objects (Stagnitti, 1998). By 5 years of age, children can engage in any story script—over 2 to 3 weeks—with a group of peers, using roles and ambiguous symbols, and can incorporate an object outside the self, such as puppets, dolls, or teddy bears. For children with delays in pretend play, skills within pretend play can be varied and uneven.

DEVELOPMENTAL ISSUES

The focus of this chapter is on children with high-functioning autism. High-functioning autism is also used interchangeably with Asperger's syndrome (Lawson, 2008). Using the ICD-10 (Version: 2015; WHO, 2015), children who are diagnosed with Asperger's syndrome would present similarly to children with high-functioning autism as there is no delay in language or cognitive function while still showing abnormalities in social interaction and repetitive or restricted interests. While controversy persists over the finer details of the diagnoses of autism, Asperger's syndrome, and even pervasive developmental disorders (PDD; Volkmar, Klin, & McPartland, 2014), these children have significant functional issues (Turygin, Matson, Beighley, et al., 2013; Volkmar et al., 2014).

Children with autism, regardless of whether they have a diagnosis of high-functioning autism or Asperger's syndrome, have difficulty with pretend play development, and this is one reason these children are literal in their thinking. A boy who was traveling on a train serves as an example of literal thinking. He had bought a ticket and put it in his pocket. When the conductor came through the train to check on tickets, the conductor asked, "Can I see your ticket?" The boy said, "No." He had interpreted the conductor's words literally because his ticket was in his pocket and the conductor couldn't see it. Such literal thinking can result in social difficulties. In the example of the train ticket, the conductor was about to throw the boy off the train when his friend, who was traveling with him, asked him to take his ticket out of his pocket and show the conductor. Children with high-functioning autism or Asperger's syndrome have impairments in complex social skills (Lawson, 2008; Volkmar et al., 2014). Pierce-Jordon and Lifter (2005) found that children with PDD, compared with typically developing children, had less complex play within a social interaction than outside a social interaction.

Functioning within society is not an easy task for children who have high-functioning autism. Apart from difficulties in complex social interactions and in reading emotional cues and others' nonverbal behaviors and intentions (i.e., *theory of mind*; see Hughes & Leekam, 2004), these children have restricted repetitive and stereotyped patterns of behaviors, interests, and activities, inflexibility, stereotyped mannerisms, and preoccupation with parts of objects (Lawson, 2008).

Children with high-functioning autism may have some ability in pretend play, but this is limited. Pretend play involves reading socioemotional cues and nonverbal behavior and understanding the imposed meanings within play scenarios. When children engage in pretend play, they undertake roles and use objects outside of themselves (e.g., a doll or teddy). Children who play well self-initiate their play and can play on their own or negotiate and

cooperate with peers in play. Children with autism play with fewer objects, can become intensely preoccupied with parts of an object or toy, spend less time playing, and tend to be more functional than symbolic in their play (Charman & Baron-Cohen, 1997; Naber et al., 2008). An example of functional play is when a child plays with objects by relating them together (e.g., putting animals in a truck or pushing the truck) but the play has no narrative or no complexity as there are no logical sequences, object substitutions, character development, or overall script. For children with autism, play actions can be repetitive, and they experience difficulties with spontaneous, self-initiated pretend play (Charman & Baron-Cohen, 1997; Naber et al., 2008). Earlier play scripts that reflect body scripts (e.g., pretending to drink, eat or sleep) are commonly missed in the play development of children with high-functioning autism; instead, they may appear to have a higher level of play script ability because their play script is an imitation of a screen scene (e.g., television, iPad) that has captured their intense interest. Poor ability to play is linked with difficulties in social interaction and play with peers (Naber et al., 2008). As a consequence, these children can often be observed on the sidelines of the play, disconnected socially.

Repetition of play actions, fewer play actions, and difficulty with self-initiated pretend play are associated with poor narrative understanding (Stagnitti, in press). Narrative is storytelling, and this in turn is associated with understanding context of the play scene. If a child understands narrative, then she or he can “think forward” (Stagnitti, in press), meaning she or he can think about what might happen next. For children with autism, thinking forward (or predictive thinking within a narrative) is not the way they think, and this also contributes to their literality. Another example of this is David (pseudonym), who used to watch over a holiday house (i.e., a vacation home/accommodation) when his mother was away. David had a diagnosis of Asperger’s syndrome. When a neighbor came over to check if David was coping with the new guests, she reminded him to “take the dirty sheets off the bed after the guests had left.” When David’s mother came home, the dirty sheets were in a pile on the floor. David had carried out the instruction literally, and in so doing, had missed the unsaid narrative of the context. The unsaid narrative of “taking dirty sheets off the bed” meant that you took the sheets off the bed, washed them, dried them, folded them, put them in the cupboard, and in the meantime, put a clean set of sheets on the bed. For children with high-functioning autism, it cannot be assumed that they know the narrative. Another example is of a friend of mine; who, when she was a girl, would scream and cry each time her mother said, “Put your shoes on, we are going out.” As my friend has a diagnosis of high-functioning autism, the comment “Put your shoes on, we are going out” was her complete understanding of the situation. If this is all you know, then you don’t know what is going to

happen. Will you ever come back? Where are you going? So my friend would scream each time. If her mother had given her the full narrative, it would have sounded something like this: "Put your shoes on. We are going out. We are going to the shop to buy bread and milk, then we are going to pick up your brother, then we are coming back home. You can take your shoes off when we come back home." This would not have been scary, and my friend would have understood what was going to happen and most probably would not have screamed. When working with children with high-functioning autism, they will need the full narrative each time.

Children with high-functioning autism have difficulty with pretend play. This results in (a) decreased use of symbols in play, (b) decreased play actions in a logical sequence, (c) decreased use of role play or characters in play, and (d) decreased understanding of the play context and narrative. The next section explains the Learn to Play program, which aims to build in children the capacity to self-initiate their own pretend play.

PLAY INTERVENTION PROCEDURES

The Learn to Play program was first published in 1998 (Stagnitti, 1998). It was developed as a one-on-one therapist-child program. The aim the program is to give children the ability to self-initiate their own play to the highest level of complexity that is possible for the particular child.

Self-initiation of play is vital to a child's ability to play because it comes from within. Neurologically effective play is self-controlled and self-directed by the child (Gray, 2011; Sunderland, 2007). Ayres (1972) noted that when children engaged in self-initiated play within therapy, "the child must organize his own brain" (p. 256). Play is meaningful to a child if the play ideas have been developed from within the child because then he or she takes control of the play.

The following are the principles and then an explanation of the techniques involved in the Learn to Play program. This is then followed by an explanation of the Learn to Play School-Based program and the evidence supporting this approach to building a child's self-initiated play ability.

Accept Children for Who They Are

When working with children with high-functioning autism, the therapist accepts that they need routine and structure, and they are less anxious if they are given an explanation of what is going to happen. During the therapy session, if the child becomes distracted, the therapist will need to bring the child back to the play scene, but in so doing, it may be necessary for the child

to finish their train of thought. For example, Rodney (pseudonym) was playing with a train and animals. The animals were going for a ride and coming home. After several repetitions of this play scenario, the therapist asked, "What will the animals do now?" This question requires predictive thinking and is linked to narrative understanding. Rodney could not answer the question in relation to the play scene. Being a bright boy, he answered by explaining a computer game that included animals. However, in his explanation, he began to talk about his prowess in playing computer games and was no longer engaged with the play scene. When bringing Rodney back to the play, the therapist was aware that he needed to finish his explanation of his computer prowess before he could reengage once more with the play.

Introduce Play Skills That Match the Child's Developmental Level

Before you begin to work with children, it is necessary to understand their developmental play level. For children with high-functioning autism, it is not uncommon for their developmental play age to be on the 18-month-old level of pretend play development, even though their chronological age may be 6 years. That is, their play reflects body scripts (e.g., drinking, eating, sleeping), no logical sequences of pretend play actions, repetition of play actions, no object substitutions, and minimal use of a character in play such as a doll or teddy bear. Even though children with high-functioning autism may have a play level that is 2 to 4 years below their chronological age, they may show obsessions in their play. For example, they may have a focused interest in trains or a movie they have seen. In such cases, trains or characters from the movies will appear repeatedly in their play. This is also called *scripting* or *template play*, where the child reproduces exactly what they have seen on a screen. This is not self-initiated original play. It is imitating verbatim what has been seen. While these play scenes may be used to initially engage a child in play, these play scenes are a false level of developmental ability in self-initiated play.

Use Both Variation and Repetition

When working with a child with high-functioning autism to build his or her ability to self-initiate play, the therapist begins by introducing play scenes at the child's developmental play level and repeats these scenes with variation until the child's interest wanes. This is one of the key principles of the Learn to Play program. As long as children are engaged in the play scene, keep playing out the scene but vary the scene each time the scenario is played out. For example, when playing tea parties, the therapist continues to engage in "drinking" their tea for as long as the child is interested. As the therapist

repeats the drinking imitation, the scene can be varied by (a) blowing on the "hot" tea, (b) stirring a spoon in the cup, (c) putting the cup up to the mouth, (d) making sipping noises, (e) offering the cup to a teddy bear, (f) offering a drink to the child, (g) having more sips of tea, or (h) spilling the tea.

Gain the Child's Focused Attention

Focused attention is necessary for neurological change (Doidge, 2010). If the child is not focusing on the toys or play materials, the therapist cannot begin to model the play actions for the play scene. Gaining the focused attention of a child with high-functioning autism is one of the challenging principles in the Learn to Play program. This is because children with high-functioning autism who cannot play, do not recognize the play, and are not interested in what the therapist is doing. Hence the therapist exaggerates their pleasure in playing by using their voice, face, body, and actions. Initially, the child may focus on the task only because the therapist is so animated about the play. Focused attention is getting the child's engagement in the play. Therapy cannot proceed until the therapist establishes the child's attention. With children with high-functioning autism, focused attention can also be aligned with interest. A child's strong interest can be used to gain her or his focus on the play. For example, the therapist may start by pushing a train along the floor or using a figure from the child's movie passion. However, as the child engages in and begins to understand the play, her or his obsession is used less and less as the child begins to develop their original play ideas.

Talk About the Play as the Play Progresses

For children with high-functioning autism, talking about the play as it progresses is a principle because (a) it gives the child the language for the play scene and (b) you cannot assume the child knows how to use the toys. Talking about the play as you play describes for the child how to use the toys. You cannot assume that because a child has a truck or a teddy bear at home, they know how to play with it. An early Learn to Play session may be the therapist showing the child how to use a truck with the accompanying talk reflecting exactly the play actions: "We are pushing the truck. The truck is driving. The truck is stopping. Go. Stop. Go. Stop." In the earlier sessions for Learn to Play, the therapist will be describing what they are doing (Stagnitti, 2009). As the child begins to understand play and recognize what the therapist is doing, the therapist's language changes to the narrative of the play. For example, "The teddy is going for a ride. Let's take teddy to the park. Teddy is going to the park. Drive. Drive. Teddy is happy he is going to the park." By talking about the play as you play, the play action and the language

that accompanies it will connect more strongly neurologically (Doidge, 2010; Stagnitti, 2014, p. 158).

Engage Emotionally in the Play With the Child

For children with high-functioning autism, emotional engagement in the play is connected with increased understanding of the play (Sherratt, 2002; Stagnitti & Casey, 2011). Play brings joy, which is one of its benefits for the mental health of a child (Gray, 2011). Joy is an emotion that brings with it a sense of happiness and well-being. The child's emotional engagement in play brings a deeper, more meaningful experience for the child and embeds the learning in a deeper way. The therapist and child emotionally engage together in the play.

Allow the Child to Self-Initiate Play Ideas

The therapist sets up the sessions so that there is a permissive atmosphere in which the child is given the opportunity to initiate his or her own ideas within the play. The aim of the Learn to Play program is for children to take over the play by adding their own ideas that are logical and sequential to the play scene. Ayres (1972) noted that when setting up a session with permissiveness that allowed the child to initiate their own play, that "often the child takes over the direction of the treatment" (p. 257) and that the "child's response is often characterized by intense emotional involvement and excitement" (p. 257). This emotional engagement together with the child's own initiation of play ideas is a powerful combination for change in the child's play ability to attain a higher level of complexity.

TECHNIQUES AND SETTINGS

The techniques of Learn to Play are detailed in Table 12.1. This table sets out more specific information in how to build a child's play ability.

The Learn to Play program has also been developed into a program for use in schools. For the Learn to Play School Program, teachers and therapists working in the schools are trained in the Learn to Play program by understanding 10 play skills. These play skills are: (a) sequences of play actions, (b) describing the play, (c) object substitution, (d) decentration (i.e., the use of an object outside of the self, such as a puppet, doll, or teddy bear, as if it is alive), (e) play scripts, (f) role play, (g) property attributions, (h) reference to absent objects, (i) adding problems to the play narrative, and (j) predicting what will happen next. The Learn to Play School program was developed from

TABLE 12.1
Techniques of Learn to Play When Working With Children
With High-Functioning Autism

Technique	Reason
Early sessions, therapist chooses the toys.	When beginning the program, the therapist chooses play scenes that match the child's developmental play level and that will raise some interest for the child. The therapist has spoken with the parent or guardian about any particular interests the child may have.
Early sessions, minimal toys are used.	Children with limited play ability are overwhelmed by large numbers of toys. They cannot focus. They are distracted and will want to move from toy to toy instead of focusing and playing with the toys.
No other toys are visible to the child.	The toys and play materials for the sessions are put aside in the playroom but out of reach of the child. As each toy set for each play scene is played with, the therapist puts them out of sight.
Use the floor.	Using the floor space allows greater freedom of movement and physically allows the play to move around the room.
Begin with play scenes that reflect the child's life experiences.	Children with autism are literal thinkers with limited play skills. For meaningful engagement in play, the play scene needs to reflect the child's life experience (do not include traumatic events). For example, eating, drinking, shopping, school.
The therapist models the play action/s.	The therapist shows the child how to use the toys in play by modeling play actions with the toys. As the child imitates the therapist, the child learns how to use the toys and in turn, how to play using the toys. The therapist needs to be playful and be able to play in order to engage a child to do the same.
Move from directed to cofacilitated to non-directed therapist play.	The Play Therapy Dimensions Model by Yassenik and Gardner (2012) has four quadrants. Of these quadrants, Learn to Play techniques fit in their Quadrant III and Quadrant IV. This is respectively, nonintrusive responding and co-facilitation. In Learn to Play, the therapist begins in Quadrant IV, co-facilitation, by modeling the play action for the child and then cofacilitating the play. As the child begins to add logical sequential actions to their play showing an increasing understanding of narrative and character utilization and role play, the therapist moves to Quadrant III, where the child takes over the play completely and the therapist responds to the child. In Learn to Play the therapist will need to move back and forth from co-facilitation to nonintrusive responding as the therapist challenges the child to increase the complexity of their play ability, support the child in the challenge, and consolidate the child's play ability. Put another way, the therapist models the play actions and as the child initiates their own play ideas, the therapist consolidates the child's play before challenging the child to the next developmental level of play.

TABLE 12.1
Techniques of Learn to Play When Working With Children
With High-Functioning Autism *(Continued)*

Technique	Reason
Variety of play scenes on the same developmental level.	Playing is not rote learning. Playing reflects the ability of the child to process their world, to understand it, and to act upon it. Using a variety of play scenes from the same developmental level will expand the child's attention and assist the child in generalizing the play skills across different play scenarios. For example, the therapist is not showing the child how to place a block to their face and talk; they are demonstrating that a block can be a cell phone. As the child develops in ability, the therapist will also use the block in various other representations such as a pillow, a train, a tree trunk, and so on.
Therapist reinforces the child's play ability.	When the child varies the play action or adds their own self-initiated ideas to the play, the therapist imitates the action, or talks about what the child is doing, or adds to the child's action. In this way the therapist is reinforcing to the child that the child is a capable being, and is giving power to the child.
Watch the child for fatigue.	When children with high-functioning autism begin Learn to Play sessions, they will become tired as they are working very hard during the sessions. They are interacting in ways that are new to them. Some children may only be able to cope with 20 minutes for the first session. As their play skills increase, they will be able to easily play for one hour. However, stop the session when the child shows signs of fatigue as children don't want to play when they are too tired.
Challenge the child when ready.	For children with high-functioning autism, pretending in play is a new way to interact with the world. When they reach new levels of play ability, often they will be content to stay at this level. More than any other group of children, children with high-functioning autism will need to be challenged to move their play to more complex levels. The therapist challenges the child in several ways such as adding: (a) more actions to the play sequence, (b) a character such as a doll, (c) a problem to the play scenario, or (d) symbols in play (i.e., object substitution).
The therapist is always cognizant of the child's play ability across six domains.	Play is a complex ability and when working with children to increase their ability to self-initiate their play, the therapist is aware of the child's play development across the domains of: (a) play scripts, (b) sequences of play actions, (c) object substitution, (d) social interaction, (e) role play, and (f) doll or teddy play (see Stagnitti, 1998). Working with children on an individual level, the therapist is always aware of the child's ability in: (a) play scripts, (b) number of actions in a sequence, (c) object substitution, (d) use of the doll or teddy in play, and (e) child's role play ability.

(continues)

TABLE 12.1
Techniques of Learn to Play When Working With Children
With High-Functioning Autism (Continued)

Technique	Reason
Therapist can focus on one or several play skills.	During the Learn to Play sessions, the therapist may be focusing on one particular play skill. For example, the therapist may spend several sessions focusing on object substitution ability. However, when doing this, the therapist is also aware to plan for the child's developmental ability in play scripts and sequences of play actions and doll or teddy play that may be part of the play scenarios where object substitution is used. For example, the therapist may introduce using a block as a cell phone (20 months) within the play script of ringing a friend (play script inside of the home [20–24 months]), short logical sequence of play actions (24 months), friend is a teddy bear—the teddy bear is real (24 months).

the Parent Learn to Play program (see Stagnitti, 2014). In 2015 in Australia, the program was launched in specialist schools, which are schools that specifically cater to children with multiple developmental issues, including autism, who have an IQ between 55 and 70.

In the specialist schools, the Learn to Play School program has been incorporated as part of the school curriculum, and therapists and teachers work together in the classroom. One school that had been running the program for 2 years when this chapter was written had a dedicated space for the program. Each week, in preparation, teachers and therapists create four short videos demonstrating the play scenarios that were set up in the room. These videos are recorded on iPads. When a class comes to the dedicated space for the program, the class is shown the videos. The children enjoy these as they recognize the staff from the school who are playing in the videos. The teacher then discusses each of the play scenarios with the group. The children then choose which play area they wish to go to. One child is designated as the reporter for the group. Each play area is set up with props for one of the play scenarios they have just seen on the video. For example, four scenarios could be “going to the hairdresser,” “shopping,” “playing with a train set,” and “cooking a meal in the kitchen.” The play areas that reflect these scenarios would be: (a) a hairdresser with props being a chair, combs, brushes, towels, and rollers; (b) a table with food items on it, a basket, and money; (c) a train with people; and (d) a play kitchen with table, chairs, sink, stove, saucepans, utensils, and plates. The children spend time in their chosen play area and there is at least one staff member for each area. After 45 minutes, the children are given a 5-minute warning that play time is nearly over, then they gather

together and the reporter tells the teacher what the children played. The teacher encourages the other class members to ask the reporter questions and vice versa. The play scenarios for the week are also embedded within the daily classroom activities, and children engage in the Learn to Play School program each week of the year.

EMPIRICAL SUPPORT

The Learn to Play program evidence to date has been reported as case studies. A longitudinal case study of a child with autism found that after 18 months in the program, the child had improved 2 standard deviations in the ability to self-initiate play as assessed on the Child-Initiated Pretend Play Assessment (ChIPPA; Stagnitti, 2004, 2007). Symbolic play was within normal limits for his age when the child was 6 years old. This child completed schooling when he was 18 years old, showing some difficulties in higher level problem solving in his final year at school.

A multiple case study of four children with autism found that after seven sessions, three of the four children reached levels of play ability that included (a) initiation of spontaneous actions within pretend play, (b) imposing on the doll independent thoughts from the child (i.e., decentration and evidence of understanding other's minds), (c) increased object substitution, (d) increased number of logical sequential play actions, (e) recognition of how to use the toys, (f) property attributions, and (g) the child's own emotional engagement in the play. After seven sessions of Learn to Play, the early childhood intervention staff reported, to their surprise, changes such as increases in the children's social turn-taking, play engagement in early childhood settings, and increased language utterances (Stagnitti & Casey, 2011). At the time of this writing, data were being analyzed from a study that included data on oxytocin and cortisol from saliva samples of parents and children pre- and post-four sessions over a 10-month period. Other data collected for this study were the Parent-Child Relationship Inventory, video footage of sessions, and the child's play ability. Clinical research over the past 16 years has determined that Learn to Play is effective with children who have at least a developmental age of 12 to 18 months, one meaningful gesture or word, or focused attention on a play action performed by an adult. If a child has no meaningful verbal or nonverbal communication, then Learn to Play is not appropriate for that child.

For the Learn to Play School program a pre-post group comparison research design was carried out in one specialist school over 22 weeks. It was found that children in the Learn to Play group significantly improved in their social interaction compared to the non-Learn to Play group. The Learn to Play

group also decreased significantly in play deficits and increased in language scores (O'Connor & Stagnitti, 2011; Stagnitti, O'Connor, & Sheppard, 2012).

To gauge the levels of evidence on the Learn to Play program, refer to the Australian National Health and Medical Research Council's Levels of Evidence (NHMRC, 1998, 2007) for quantitative studies. For the NHMRC (2007) there are six levels of evidence, with Level I being the highest (e.g., systematic reviews of randomized controlled trials) and Level IV being the lowest (e.g., case series with either posttest or pretest and posttest outcomes; NHMRC, 2007). The evidence level for the Learn to Play School research is level III–2. For the qualitative studies the NHMRC level of evidence is level VI. However, the Rosalind Franklin—Qualitative Research Appraisal Instrument (Henderson & Rheault, 2004) is specifically designed to measure the rigor in qualitative studies. Five levels of evidence are used to ascertain a study's credibility, transferability, dependability, and conformability (e.g., objectivity by reducing bias; Henderson & Rheault, 2004). Level I is assigned when the study meets all four criteria; Level II is assigned when the study meets three aspects, and so on to Level V. The multiple-case study is rated at Level I and the longitudinal-case study is rated at Level III. More research is needed on the Learn to Play program.

CASE ILLUSTRATION INCLUDING CAREGIVER OR PARENT INVOLVEMENT

Robert was 7 years old when he began the Learn to Play program. Robert had a diagnosis of high-functioning autism based on an assessment by his child psychiatrist. He had also been assessed by a speech therapist and an occupational therapist. On his first visit to the Learn to Play playroom, Robert was screaming. He did not want to come. His mother calmed him down, which took most of the session. On his second visit, he was still upset but calmed down in half the time. A play assessment (Stagnitti, 2007) was completed in this session to ascertain Robert's play ability. He was 3 standard deviations below his peers in his play ability, which translated to a 5-year delay in his pretend play ability. By the fourth session, Robert was beginning to realize that the Learn to Play playroom was a nonthreatening, safe place to come.

The program began on the 20- to 24-month developmental play skill level. This translated into repetitive single action play scenarios with some evidence of two to three logical-sequential actions, object substitution use with physically similar objects, interaction with a teddy bear on a repeated one-to-two play action basis, and play scripts on the body level such as drinking, eating, sleeping, as well as within the home. To meet Robert's play needs, the program began with play activities that he would succeed at, such as throwing

a ball to a large doll that had arms long enough to catch it. Robert would throw the ball in the air, and the doll—which was moved by the therapist—would make running movements to get it. When the therapist judged Robert was feeling safe and was laughing as the doll ran to the ball, the doll began to tackle Robert for the ball. The doll could do this as it was nonjudgmental and separate from the therapist. Robert enjoyed this and laughed even more. He engaged directly with the doll (i.e., decentration) and looked directly at her. He spoke to her and tried to hide the ball from her. This turn-taking between Robert and the doll continued until he began to disengage from this play scenario (repetition with variation and response to the child). A tea set was brought out. This play scenario involved short logical sequences of play actions (e.g., stir a spoon in the cup and drink from the cup), early play scripts (e.g., body and within the home), object substitution (e.g., ice-cream stick for a spoon), and allowed for decentration (i.e., the teddy joined us for a cup of tea which Robert offered to the teddy). The next few sessions remained on this level of play with increases in variations to the play actions. For example, food was introduced to the tea party. The therapist was careful not to include too many play objects as Robert would be overwhelmed. By the seventh session, Robert was beginning to recognize what was happening in the play and was beginning to initiate his own actions within the play scenes. For example, he could put plastic food items in a cooking pot, stir it, and offer a meal on a plate to his mother. His mother reported that at school, staff had reported that during recess he could spontaneously engage in play such as pretending to cook a toy pizza in a toy oven. Robert placed the pizza pieces on a plate, put on an oven mitt, turned the dials on the toy oven, opened the door, placed the pizza in the toy oven, closed the door, waited for a minute, and then took out the pizza and pretended to eat a slice. He was generalizing his skills across settings.

After 6 months in the program, the play scenarios had progressed to road scenes with cars, block buildings, and service stations. Robert could now include less physically similar object substitutions in his play. For example, he could use a thick crayon as a cell phone, he could use a box lid as a ramp from the gas station to the road, and he could use sticks as people. At this point, the Learn to Play sessions were now operating in Quadrant III of Yassenik and Gardner's (2012) play therapy dimensions model. The model is an integrative one that provides play therapists with a framework that conceptualizes decisions about therapy using two intersecting dimensions: directiveness and consciousness. Quadrant III of the model represents nonintrusive responding while relating to the child within the symbols of play. Within the Learn to Play program, children who move into Quadrant III are initiating their own play and showing more complex levels of symbols in their play. The therapist could now leave the toy cupboard door open on one side and Robert could now come in, look in the cupboard, and choose the toy he wanted to play

with. He would set up a play scene, play out a narrative, and use more complex object substitutions in the play (e.g., use a shoe as a cell phone). The therapist would respond to him and join in his play at his request. At his afterschool center, the staff were reporting that Robert could organize several pieces of equipment and create scenes. Staff commented to his mother that they needed to provide Robert with more complex play scenarios. As Robert's play ability increased, he also became a happy child. Gray (2011) included joy as a benefit of play, and this could be observed in Robert's behavior. He enjoyed himself. He saw pleasure in playing and being challenged, and he could include others in his play—albeit at a younger level than his chronological age.

Over the time period in the Learn to Play program, the therapist modeled to Robert's mother how to join her son in play and how to challenge him to achieve higher levels of complexity in his play. His mother could identify when to come into his play and extend his play ideas without disrupting his play. When she joined him in play—often on his invitation—he would smile and show greater enthusiasm in his social interactions. Robert was now a little boy who knew how to play and how to engage in his social world.

CONCLUSION AND FUTURE DIRECTIONS

The Learn to Play program provides therapists and parents with knowledge on the value of pretend play for children up to 8 years old. Pretend play during this time is the predominant form of play for children. Over the past 16 years, knowledge has been gained as to why the program is effective, how to engage children in play, and the importance of self-initiated pretend play. For children with high-functioning autism, the Learn to Play program provides a therapy that targets areas of their development in which they have difficulties. Children with high-functioning autism can be shown and can learn how to engage in pretend play. Many of the children who have gone through the program have generalized their skills to other settings, and school staff have commented on increases in social turn-taking, language, and ability to engage in play with peers.

Research in the future will be designed with Learn to Play as a complex intervention (Campbell et al., 2000). This is because the program has many elements, and randomized controlled trials are not always possible with young children with complex developmental needs. A study with a new intervention based on the Learn to Play program was given a trial with adolescents who had a diagnosis of high-functioning autism (Goldingay et al., 2015). This study was based on the assumption that adolescents who experience social interaction difficulties may be lacking in abilities that are based on pretend play abilities. This research found that parents rated

significant improvements in empathy and cooperation and decreases in hyperactivity.

Engaging with children to develop their ability to self-initiate their own play ideas is a powerful therapeutic intervention. For children with high-functioning autism, changes have included increases in happiness, in social turn-taking, in play ability, and in language utterances. Each of these areas contributes to a child's quality of life. Learn to Play is one program that specifically aims to increase a child's spontaneous ability to play. As Gray (2011) argued, play that is freely chosen and undertaken for its own sake is vital to a child's mental health and well-being. There is still much research to be done to understand the long-term benefits of a child's knowing how to self-initiate their own play. However, one consistent finding has been that these children become happier in themselves.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: Author.
- Axline, V. (1974). *Play Therapy*. New York: Ballantine Books.
- Ayres, J. (1972). *Sensory integration and learning disorders*. Los Angeles, CA: Western Psychological Services.
- Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D., & Tyrer, P. (2000). Framework for design and evaluation of complex interventions to improve health. *BMJ*, 321, 694–696. <http://dx.doi.org/10.1136/bmj.321.7262.694>
- Charman, T., & Baron-Cohen, S. (1997). Brief report: Prompted pretend play in autism. *Journal of Autism and Developmental Disorders*, 27, 325–332. <http://dx.doi.org/10.1023/A:1025806616149>
- Doidge, N. (2010). *The brain that changes itself*. Melbourne, Australia: Scribe.
- Goldingay, S., Stagnitti, K., Sheppard, L., McGillivray, J., McLean, B., & Pepin, G. (2015). An intervention to improve social participation for adolescents with autism spectrum disorder: Pilot study. *Developmental Neurorehabilitation*, 18, 122–130. <http://dx.doi.org/10.3109/17518423.2013.855275>
- Gray, P. (2011). The decline of play and rise of psychopathology in children and adolescents. *American Journal of Play*, 3, 443–463.
- Henderson, R., & Rheault, W. (2004). Appraising and incorporating qualitative research in evidence-based practice. *Journal, Physical Therapy Education*, 18(3), 35–40.
- Hughes, C., & Leekam, S. (2004). What are the links between theory of mind and social links? Review, reflections, and new directions for studies of typical and atypical development. *Social Development*, 13, 590–619.

- Lawson, W. (2008). *Concepts of normality*. London, England: Kingsley.
- Naber, F. B. A., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Swinkels, S. H. N., Buitelaar, J. K., Dietz, C., . . . van Engeland, H. (2008). Play behavior and attachment in toddlers with autism. *Journal of Autism and Developmental Disorders*, 38, 857–866. <http://dx.doi.org/10.1007/s10803-007-0454-5>
- National Health and Medical Research Council. (1998). *A guide to the development, implementation, and evaluation of clinical practice guidelines*. Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/cp30.pdf
- National Health and Medical Research Council. (2007). *NHMRC additional levels of evidence and grades or recommendations for developers of guidelines: Pilot Program 2005–2007*. Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/file/guidelines/levels_grades05.pdf
- O'Connor, C., & Stagnitti, K. (2011). Play, behavior, language and social skills: The comparison of a play and a non-play intervention within a specialist school setting. *Research in Developmental Disabilities*, 32, 1205–1211. <http://dx.doi.org/10.1016/j.ridd.2010.12.037>
- Pierce-Jordan, S., & Lifter, K. (2005). Interaction of social and play behaviors in pre-schoolers with and without pervasive developmental disorders. *Topics in Early Childhood Special Education*, 25(1), 34–47.
- Sherratt, D. (2002). Developing pretend play in children with autism: A case study. *Autism*, 6, 169–179. <http://dx.doi.org/10.1177/1362361302006002004>
- Stagnitti, K. (in press). Play, narrative, and children with Autism. In S. Douglas, L. Stirling, & A. Goncu (Eds.), *Children's play, pretence, and story: Studies in culture, context, and ASD*. Melbourne, Australia: Taylor & Francis.
- Stagnitti, K. (1998). *Learn to Play. A practical program to develop a child's imaginative play*. Melbourne, Australia: Coordinates.
- Stagnitti, K. (2004). Occupational performance in pretend play; implications for practice. In M. Mollineux (Ed.), *Occupation for occupational therapists* (pp. 103–121). Oxford, England: Blackwell.
- Stagnitti, K. (2007). *The Child-Initiated Pretend Play Assessment manual and kit*. Melbourne, Australia: Coordinates.
- Stagnitti, K. (2009). Play intervention: The Learn to Play program. In K. Stagnitti & R. Cooper (Eds.), *Play as therapy: Assessment and therapeutic interventions* (pp. 176–186). London: Kingsley.
- Stagnitti, K. (2014). The Parent Learn to Play program: Building relationships through play. In E. Prendiville and J. Howard (Eds.), *Play therapy today. Contemporary practice with individuals, groups, and carers* (pp. 149–162). Oxon, England: Routledge.
- Stagnitti, K., & Casey, S. (2011). Il programma *Learn to Play* con bambini con autismo: Considerazioni pratiche e evidenze [The program *Learn to Play* with children with Autism: Evidence and practical considerations]. *Autismo Oggi*, 20, 8–13.

- Stagnitti, K., O'Connor, C., & Sheppard, L. (2012). Impact of the Learn to Play program on play, social competence, and language for children aged 5–8 years who attend a specialist school. *Australian Occupational Therapy Journal*, 59, 302–311. <http://dx.doi.org/10.1111/j.1440-1630.2012.01018.x>
- Sunderland, M. (2007). *What every parent needs to know*. London, England: DK Books.
- Turygin, N. C., Matson, J. L., Adams, H., & Belva, B. (2013). The effect of DSM–5 criteria on externalizing, internalizing, behavioral, and adaptive symptoms in children diagnosed with autism. *Developmental Neurorehabilitation*, 16, 277–282. <http://dx.doi.org/10.3109/17518423.2013.769281>
- Turygin, N. C., Matson, J. L., Beighley, J., & Adams, H. (2013). The effect of DSM–5 criteria on the developmental quotient in toddlers diagnosed with autism spectrum disorder. *Developmental Neurorehabilitation*, 16, 38–43. <http://dx.doi.org/10.3109/17518423.2012.712065>
- Volkmar, F., Klin, A., & McPartland, J. (2014). Asperger syndrome: An overview. In J. McPartland, A. Klin, & F. Volkmar (Eds.), *Asperger syndrome: Assessing and treating high-functioning autism spectrum disorders* (pp. 1–42). New York, NY: Guilford Press.
- Vygotsky, L. (1976). Play and its role in the mental development of a child. In J. Bruner, A. Jolly, & K. Sylva (Eds.), *Play, its role in development and evolution* (pp. 537–554). Middlesex, England: Penguin.
- Vygotsky, L. (2004). Imagination and creativity in childhood. *Journal of Russian & East European Psychology*, 42(1), 4–84.
- World Health Organization. (2015). Chapter V. Mental and behavioral disorders (F00–F99). In *International Classification of Diseases and Related Health Problems 10th revision (ICD–10)* WHO Version. Retrieved from <http://apps.who.int/classifications/icd10/browse/2015/en#/F84.0>
- Yasenik, L., & Gardner, K. (2012). *Play therapy dimensions model*. London, England: Kingsley.