

Chapter 7

PLAY IN SPECIAL POPULATIONS

The Sandersons were pleased when their 7-year-old son Todd announced that he had been invited to a classmate's birthday party. Their pleasure changed to apprehension, however, when they discovered that the party was in honor of a child who was both mentally and physically impaired. Roger, who had been admitted to Todd's class as a result of the school's new mainstreaming policy, was judged to be moderately mentally retarded and was confined to a wheelchair as well.

Mr. and Mrs. Sanderson had no negative feelings about impaired children. In fact, they were strong advocates of the mainstreaming concept. Nevertheless, they now found themselves wondering whether they should prepare Todd in some way for the experience of attending Roger's party. What would the party be like? Would the children play games? Would Roger be able to participate in games? What kind of gift should Todd bring? What kind of toy would a child like Roger play with? Do children like Roger play at all?

The Sandersons's confusion about an appropriate birthday gift for Roger should not be surprising. Little is known, even by child development professionals, about the play of children with disabilities, and the scarcity of information is attributable to the shortage of carefully designed studies of the subject (Rubin, Fein, & Vandenberg, 1983). Furthermore, even the findings from well-constructed studies tell us little about the reasons for observed play differences. Too often it has been assumed that disabled children have inherent play deficits when, in fact, differences in play might be explained more easily by environmental variables. Children like Roger differ from the norm by virtue of their disabilities, but they also grow up in a different sociocultural environment from that of the average child.

Learning Objectives

After reading Chapter 7, a student should be able to:

- ◆ Describe the observed differences in play between children with and without visual impairments, explain these differences in terms of adult expectations, and identify suggestions offered by psychologists and educators that might help all children play to their fullest potential.
- ◆ Identify the differences in symbolic play between typically developing children and those with language impairment.
- ◆ Describe the differences between the object and symbolic play of typical children and that of children with intellectual and emotional disabilities and understand the frequently cited explanations for these differences.
- ◆ Understand the basic characteristics of childhood autism and the relationship between autism and play. Describe the intervention approaches used to enhance the play of children with autism.
- ◆ Explain the concept of a theory of mind and why it is central to successful social development.
- ◆ Identify and describe the various forms of hospital play programs that have appeared in the United States in the past 50 years.
- ◆ List and describe what have been called the necessary conditions for play in the hospitalized child.
- ◆ Describe the characteristics of the play of children who are victims of physical and/or sexual abuse.

In this chapter, we shall deal with the play of children whose development is atypical for a variety of reasons. Included will be a discussion of children with impaired vision or hearing, cognitive delays, chronic emotional problems, and temporary life stresses (see Table 7.1). The drive to play is fundamental in all children, and it will be shown that not only do all children play, whether they are typically developing or not, but play can be particularly beneficial to children dealing with particular life difficulties.

CHILDREN WITH PHYSICAL DISABILITIES

Studies of play among children with physical disabilities have been concentrated in the three areas of visual impairment, hearing impairment, and language disorder. It should be remembered, however, that these areas are not completely independent. For example, children with visual impairments often experience delays in language and motor skills as well (Warren, 1984), and impairments in hearing are correlated with impairments in speech.

TABLE 7.1 Characteristics of the Play of Children Whose Development Is Atypical Compared With That of Typically Developing Children

Condition	Characteristics of Play
<i>Visual Impairment</i>	Greater amount of solitary play Less imaginative in fantasy play Less likely to explore the physical environment in play Less varied and less flexible in play
<i>Hearing Impairment</i>	Less likely to engage in cooperative make-believe play Less likely to use objects symbolically
<i>Intellectual Deficit</i>	More interested in the physical characteristics of play materials than in their representational possibilities More likely to simply manipulate and handle play materials More repetitive and less varied in toy play Later appearance of symbolic play and lower likelihood of reaching higher levels of sophistication
<i>Language Impairment</i>	Less make-believe play More likely to receive a negative reaction from peers when making efforts to join them in play
<i>Autism</i>	More likely to engage in repetitive, stereotyped manipulation of play materials Less likely to use objects symbolically in make-believe

Children With Visual Impairments

Research on the play of children with visual impairments (e.g., Parsons, 1986a; Recchia, 1997; Rettig, 1994; Troster & Brambring, 1994) leads to two general conclusions. First—and perhaps most important—visual impairments do not result in a basic inability to play. Like all children, blind children *do* play. Second, despite the universal similarities in play, some play differences related to visual impairments have been observed.

One of the most striking differences between the play of blind children and that of the sighted is that children with limited vision engage in greater amounts of solitary play (Celeste, 2006, 2007; Erwin, 1993; Rettig, 1994; Schneekloth, 1989). For example, Schneekloth found that the amount of solitary play was related to the severity of the visual impairment: Children with the

PUTTING THEORY INTO PRACTICE 7.1**Enhancing the Feel of the Environment**

Recognize that all children have a natural tendency to play, even though some are limited in their opportunities to do so.

Make certain that the physical environment of children with visual impairments is an inviting play atmosphere:

- Explain to the children what can be found in the physical environment. Identify and describe the play materials and the play equipment. Tell them where in the room these are located. Tell them about the other children in the room. How many are there? How many are boys, and how many are girls? What are their names?
- Make clear to them that it is fully expected that they will take full advantage of the play environment by asking them what activities they like and how they plan to play with the available materials.
- Encourage and provide adequate time for children with visual impairments to freely explore the physical environment.
- Make the environment as "colorful" for a child with a visual impairment as it is for a sighted child by providing as much variety as possible in the feel of the materials in the classroom. Talk about the way things feel, as well as about the way they look. Have the sighted children engage in tactile exploration by asking them to close their eyes and explore materials just by feeling.
- If possible, use distinctive texturing on the floors, walls, or ground in different areas of the room or playground. This will help children with visual impairments recognize different areas by their feel.

most severe visual limitations spent 56% of their time playing alone, those with partial limits on their vision were alone at play 33% of the time, and sighted children played alone only 14% of the time. A possible reason for the greater tendency of children with visual limitations to play alone is that the play of young children is often sporadic, with rapid movement from one activity to another, and children with low vision may be disoriented by the unpredictable transitions (Recchia, 1997).

A second distinction between the play of blind children and that of the sighted is that those with visual limitations are less imaginative in their fantasy play and less likely to manipulate and explore the physical environment (Parsons, 1986b; Recchia, 1997; Rettig, 1994; Warren, 1984). For example, Singer and Streiner (1966) found that blind elementary school children played

in a manner that was more concrete, less varied, and less flexible than what ordinarily occurs among sighted children.

How can parents and teachers guarantee that children with visual impairments will be able to play to their full potential? Child development professionals (e.g., Cutter, 2007; Fazzi & Klein, 2002; Recchia, 1997; Rettig, 1994) have offered a number of suggestions. First, it is important for the teacher to plan for free play. The teacher should discuss with the children in advance all the options available in terms of play materials, equipment, activities, and playmates. The children should be encouraged to identify their favorite activities and to tell how they plan to use the upcoming playtime. Second, adults should resist the tendency to discourage blind children from exploring their environments since it is through such exploration that concepts are formed; even in a safe environment, a blind child may acquire a few bumps and bruises from exploration, but the same is true of sighted children. Third, adults should suggest

make-believe activities to blind children, beginning with simple objects or routines that the children are already familiar with (e.g., “Let’s pretend to be a cat”), graduating to make-believe activities that involve more than one player, and eventually increasing the level of abstraction, such as by using the same object to represent different things at different times (Fazzi & Klein, 2002). Adults might need to offer blind children specific instruction in symbolic play. They might demonstrate pretend activities, encourage the children to try them for themselves, and reinforce the children for doing so.

Fourth, adults should provide real-world playthings (e.g., keys, sponges, pots and pans, doorknobs) for the child to manipulate since hands-on experience is necessary for children with visual limitations to gain information about the world. Fifth, adults should remember to choose play materials for their tactile qualities as well as for their appearance. In fact, they should attempt to create a sensory-rich play environment—a setting with sensory cues to guide the child with a visual impairment. Materials that vary in texture might be used; tactile maps might be placed in strategic locations throughout the environment, as might audiocassette recorders with taped directions. Areas of the room or outdoor playground might be made distinctive through the use of texturing, such as by placing sand or wood chips on the ground or different styles of carpeting



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One of the most meaningful findings from research on play in special populations of children is that all children want and need to play.

or linoleum on the floor. Such an environment will provide tactile stimulation and help a child with low vision feel comfortable and secure enough to explore. As Rettig (1994) concluded, the ideal play environment for children with visual limits is a place where they feel free to throw their bodies around.

Finally, to prevent a blind child from feeling overwhelmed in a large group setting, a teacher might select just one sighted peer as a playmate at first and then gradually increase the number of sighted children in the play group. As preparation for this experience, the teacher might discuss with the sighted playmate(s) the practical implications of visual limitations.

Children With Language Impairment

Human language and symbolic, or make-believe, play both require the ability to use symbols: to let one thing stand for, or represent, something else (McCune, 1995). Because of the relationship between the two, it should not be surprising that language and symbolic play assume parallel courses of development. As pointed out in Chapter 3, both initially appear at the same time, early in the child's second year, and the shift in symbolic play from an uncoordinated collection of activities to one that is coordinated and schematic parallels the transition at the end of the second year from one-word utterances to original two-word combinations in speech. What is more, individual differences among children in their rates of language development seem to mirror individual differences in the development of symbolic play (Gould, 1986).

The language-symbolic play relationship raises interesting questions about the make-believe play of children who have specific language impairment, which is the atypical development of language in the absence of neurological, emotional, or intellectual deficits or hearing difficulties. Would children delayed in language but free of specific intellectual impairments show symbolic play deficits as well? In fact, a number of researchers have discovered a relationship between language deficits and deficits in symbolic play (Lewis, Boucher, Lupton, & Watson, 2000; Lyytinen, Poikkeus, Laakso, Eklund, & Lyytinen, 2001; McCune, 1995; Watt, Wetherby, & Shumway, 2006). But what do these findings mean? Do children with delayed speech exhibit basic deficits in overall symbolic functioning?

Some psychologists argue that the research fails to demonstrate the existence of a broad symbolic deficit among speech-delayed children because in many of these studies the children actually do engage in make-believe play, although less often than typically developing children. In addition, preschool children who have difficulty understanding the language of other children or expressing themselves in words tend to receive a negative reaction from peers and in turn may

behave aggressively or simply withdraw. They tend to be less capable of handling peer conflict (Brinton & Fujiki, 2004; Horowitz, Westlund, & Ljungberg, 2007). They are not adequately assertive, get frustrated easily, and are more dependent on adults for assistance than are other children (McCabe & Marshall, 2006; Picone & McCabe, 2005). It is not surprising, therefore, that they are less likely than the typically developing child to engage in cooperative make-believe play. In other words, the explanation may be environmental in nature rather than the result of a representational deficit. Language can make it easier for children to engage in social varieties of make-believe, as in the case of complex forms of sociodramatic play (McCune, 1995).

Children With Hearing Difficulties

As noted in the previous section, children whose speech is delayed often exhibit less mature forms of play during the early childhood years, particularly with regard to their interest in social forms of make-believe. A similar—and related—finding is that young children with hearing difficulties engage in lesser amounts of cooperative make-believe play and are less likely to make symbolic use of objects than are children of normal hearing ability (Esposito & Koorland, 1989; Hughes, 1998; Mann, 1984; Morelock, Brown, & Morrissey, 2003). Again, however, it has not been demonstrated that such children have specific play deficits. It seems more likely that the play differences observed in comparisons of children with and without hearing impairments are differences in performance rather than potential. Depending on their surroundings and on cultural expectations, children do not always display the behaviors of which they are truly capable.

Esposito and Koorland (1989) discovered, for example, that the play of the same children in settings that were integrated (i.e., with non-hearing-impaired children) or segregated (i.e., with other hearing-impaired children) was substantially different. Three-year-old Michael and 5-year-old Vicki, both diagnosed as having severe hearing loss, were observed at play in their self-contained class for hearing-impaired children and in the regular day care centers they also attended. The number of children in the play groups and the specific roles of the adults were the same in both environments.

The play of children in the integrated settings was judged by observers to be more socially sophisticated. Parallel play was more often seen in the class for hearing-impaired children, while associative play was more typical in the day care centers. Remember from Chapter 4 that parallel play is thought to be less socially mature than associative play and more typical of the very young preschooler.

CHILDREN WITH INTELLECTUAL IMPAIRMENTS

As is the case for all children whose development is atypical, it is difficult to separate how children with intellectual deficits actually play from how they are able to play in ideal circumstances. This is because so much of the typically developing young child's play is social, and if a child has difficulty initiating and maintaining social interaction, his or her play will be restricted as well. Children with even minor intellectual deficits seem to be at risk for social isolation, are less likely to be accepted by peers, and have fewer friendships that are reciprocated. Those with more significant impairments such as Down syndrome have a good deal of difficulty interacting with peers and few peer contacts other than siblings, and 1 in 3 has no play contacts at all (Guralnick, 2002). Nevertheless, children with a range of intellectual deficits will play if given the opportunity. Opportunity is critical because these children benefit greatly from having adults arrange play experiences for them. Arranging could include inviting a playmate to one's house, suggesting play activities, and checking on the children when they are playing.

Object Play

Throughout the years there have been many studies of the uses of toys in free play by children with cognitive deficits, and the group most often studied is children with Down syndrome. The findings from these studies are that, compared with typically developing children, children with cognitive deficits display a variety of characteristics. They are interested in the physical rather than the representational characteristics of objects. They spend more time than the typical young child in nonspecific manipulation of objects, such as simply touching or holding them, dropping them, throwing them, or mouthing them. They have more difficulty sustaining an interest in the toys. Their toy play is repetitive and lacks variety. They are less likely to combine toys in play, less goal oriented, and more passive. In general, they seem to derive less pleasure from the toys than do typically developing children (Vig, 2007).

When comparing children who vary in intellectual ability, the quality of toy play seems to relate more to mental age than to chronological age (Malone, 2006), and this suggests that cognitive impairment is more of a developmental delay than a qualitatively different developmental path. In addition, it is important to remember when examining the toy play of children with Down syndrome that the complexity of object play depends on the social context. For example, play at home seems to be a better predictor of

mental age than play in a school setting, and independent play looks to be more sophisticated than play in groups (Malone). Finally, children play with what is made available to them, and adults often provide children with Down syndrome with toys that have less creative potential. In fact, even in supposedly free-play situations, mothers of Down syndrome children tend to be very controlling and very directive, choosing the toys for their children and showing them exactly how the toys should be used (Hauser-Cram & Howell, 2003).

Symbolic Play

Symbolic, or make-believe, play emerges during the second year of life as children acquire the ability to mentally represent the world. As discussed in Chapter 3, the normal pattern is a gradual developmental progression into the world of make-believe. But what can be said about the make-believe play of children with cognitive delays? Three main conclusions can be drawn.

First, symbolic play has been observed consistently in such children; there is no evidence that intellectual impairment prevents children from engaging in imaginative acts of make-believe (McCune, 1995; O'Toole & Chiat, 2006; Venuti, deFalco, Giusti, & Bornstein, 2008). Second, mental age is a better predictor of the onset of symbolic play than is chronological age; thus, symbolic play typically appears later in children with intellectual deficits than in those whose intellectual development is typical. For example, Wing, Gould, Yeates, and Brierly (1977) examined the symbolic play of 108 children with severe intellectual deficits who ranged in age from 5 to 14 years. Symbolic play was found, but it did not occur before the children had attained a mental age of 20 months. As indicated in Chapter 3, this mental age is approximately the same as the age at which typical children begin to become involved in make-believe.

The third conclusion is that play is related to language skills in children with Down syndrome. In one study, children with Down syndrome were observed in three play sessions with their mothers (Fewell & Ogura, 1997). The mothers and children were supplied with a variety of play materials (e.g., dolls, toy eating and cooking utensils, blocks). It was found that the children who demonstrated the most sophisticated ability to play were also the most likely to make spontaneous utterances during the sessions. They spoke more, they used a greater variety of words, and their utterances were longer.

A final conclusion pertains to the fact that symbolic play does not appear suddenly; its onset is gradual, and there seems to be a series of stages through

which children progress, as discussed in Chapter 3. While the stage progression seems to be identical in children at all levels of intellectual ability, children with impairments lag behind able children and are less likely to reach the most sophisticated levels (McCune, 1995; O'Toole & Chiat, 2006).

In conclusion, it seems that children of all intellectual levels involve themselves in functional play with objects, and children at all levels engage in make-believe play. While the research tends to emphasize group differences, the overwhelming impression is one of similarity. That is, it appears that children of different intellectual levels are not qualitatively different in their attitudes toward and their approaches to play. Those with impairments are simply delayed but can play as other children do if groups are equated in terms of mental rather than chronological age.

CHILDREN WITH AUTISM

Play in the preschool years is intimately connected with a child's ability to communicate with others and to engage in successful social interactions. There are a number of conditions (e.g., childhood autism, Asperger's syndrome, pervasive developmental disorder) that are characterized by social interaction difficulties, and these conditions typically have some but not all of their symptoms in common. For example, Asperger's syndrome is characterized by the social difficulties and repetitive behaviors found in autism, but autism is also characterized by significant communication problems. As a group, these conditions are referred to as autism spectrum disorders (Bishop & Lord, 2006; Risi et al., 2006). The specific disorder that has received the most attention from researchers in terms of its impact on play is childhood autism.

Childhood autism, a neurologically based emotional disorder that affects 34 in every 10,000 children, is characterized by significant impairments in social interaction and communication skills, as well as restrictive, repetitive, stereotyped patterns of behaviors, activities, and interests (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 2000). Children with autism may also be diagnosed as having cognitive deficits, although many are of average or above-average intelligence. The common characteristic shared by all of them, however, is a basic communication difficulty, a profound inability to understand and function within the normal social environment; the child with autism apparently fails to differentiate between the self and the external world (Baron-Cohen & Swettenham, 1997; Kanner, 1971; Rutter, 1983).

The Lack of a Theory of Mind

Children with autism have been found to lack representational skills. They seem to lack the ability to impute mental states to themselves and other people, an ability described as a **theory of mind** (Baron-Cohen, 1987; Baron-Cohen, Leslie, & Frith, 1985; Baron-Cohen & Swettenham, 1997). A theory of mind allows a person to understand that there is sometimes a difference between one's feelings, thoughts, and beliefs about reality and actual reality itself. It is acquired in the typically developing child between 3 and 5 years of age, and it allows the toddler to go from literally observing human behavior to understanding that there is motivation behind it (Slaughter & Repacholi, 2003). This is an important component of overall social understanding that is essential for making sense of and predicting other people's behavior (Colle, Baron-Cohen, & Hill, 2007).

The lack of a theory of mind becomes evident in situations when belief contradicts reality, as illustrated in the false-belief experiment, which is the most widely used task to indicate the presence of a theory of mind (Slaughter & Repacholi, 2003). An interesting example is the classic "Sally and Anne" study conducted by Baron-Cohen and colleagues (1985). The researchers included three groups of preschoolers, one including children whose development was typical, one including children diagnosed with autism, and one including children diagnosed as having Down syndrome. The children were seated at a table and shown two dolls, Sally and Anne, as well as a basket for Sally and a box for Anne. Sally placed a marble in her basket and then departed. Anne removed the marble from Sally's basket and placed it in her box. Then the children were asked three questions. First, "Where is the marble really?" The answer to this would indicate the child's understanding of reality. Second, "Where was the marble at the beginning?" This was designed to test their memory. Finally, "Where will Sally look for her marble?" was a question designed to determine if the children realized that Sally had a belief system independent of their own. In other words, the children knew that the marble was in Anne's box, but one might expect that Sally would hold the false belief that it was in her own basket, since she put it there before she went away.

All three groups of children answered the first two questions correctly. All apparently had the same sense of reality and the same ability to remember the placement of the marble. However, the responses to the third question were quite revealing. Neither the typically developing children nor the children with Down syndrome had difficulty realizing that Sally would *think* the marble was still in her basket, even though they knew that it was not. Of the children with autism, however, 4 out of 5 failed the belief question; they indicated that Sally would look for the marble in the box, apparently failing to differentiate between their knowledge of the situation and that of the doll.

The Sally and Anne study obviously required the use of language, leading to speculation that the difficulties faced by children with autism may really be linguistic deficits. Is it possible that children with autism may simply not understand what is being asked of them on false-belief tests? Language requires representational ability, and autism is characterized by language deficits. Early estimates were that as many as one third of children with autism show no signs of language at all, although these estimates have been revised downward as autism has become better understood (Baird et al., 2001; Rutter, 1978). In fact, like those with autism, children who do not have autism but have specific language deficits do not perform well on verbal false-belief tests. However, in false-belief experiments that are presented nonverbally, children with specific language deficits perform as well as typically developing children, while children with autism still cannot impute a theory of mind to other people. In other words, the lack of a theory of mind cannot be explained simply as a result of a language deficit (Colle et al., 2007).

Autism and Play

In terms of their toy and object play, children with autism are more likely than typical children to engage in repetitive, stereotyped manipulation and less likely to use objects symbolically in make-believe (Thomas & Smith, 2004; Vig, 2007; Wing et al., 1977). Compared with typical children, children with autism are less likely to engage in complex toy play and less likely to use toys appropriately. This is because they apparently do not see the toys as representative of other objects. Instead of playing with toys, a child with autism might simply line them up in a very specific way and then become upset if anyone arranges them differently (Nebel-Schwalm & Matson, 2008). Or instead of seeing a toy car as representing a real car and “driving” it by pushing it around the floor, a child with autism might simply spin the wheels repeatedly (Bishop & Lord, 2006).

The most extensive area of research on the play of children with autism concerns the use of symbolic play. When children pretend, they are by definition holding a view of the world that differs from reality, a theory of mind. Children who are autistic, however, have difficulty understanding pretense and are unable to generate ideas for pretend play (Bigham, 2008). It is not surprising, therefore, that children with autism rarely engage in symbolic play, and when they attempt to do so, they are less successful than the typically developing child (Baron-Cohen & Swettenham, 1997; Bishop & Lord, 2006; Keenan, 2003; Schwebel, Rosen, & Singer, 1999). The extent of the deficit in symbolic play is related to the extent of the child’s cognitive impairment, as well as the extent of the impairment in the child’s expressive language (Stanley & Konstantareas, 2007).

Intervention Approaches With Autism

Difficulties with representational ability certainly make social interaction, including social play, particularly challenging for a child with autism. Nevertheless, children with autism can experience dramatic improvements in the quality of their play if provided with instruction and a supportive social environment. Specific play training has resulted in significant improvement in symbolic play skills, appropriate language use, and what is known as joint attention (coordinated looking at toys and people, showing toys to others, or pointing to events and objects) in children with autism (Herrera et al., 2008; Kasari, Freeman, & Paparella, 2006; Kasari, Paparella, Freeman, & Jahromi, 2008; Liber, Frea, & Symon, 2008). Consider as an illustration the research of psychologist Connie Kasari and her associates (2006), who worked with 58 children aged 3 and 4 years for a half-hour a day for 5 or 6 weeks. The specific skills that were taught depended on the child's individual profile of developmentally appropriate skills that had not yet been mastered. For example, the skill in question might be showing an object to another person. The interventionist would sit on the floor with one child and use a teaching approach that included following the child's interest in activities, talking about and elaborating on what the child was doing, repeating what the child had just said, giving corrective feedback, making eye contact, and making environmental adjustments to maintain the child's attention. The results were very encouraging. There were improvements not only in joint attention and symbolic play but also in communication skills, and these changes seemed to last until at least a year after the training sessions.

The characteristics of the social environment, even in the absence of specific skill training, can influence the play of children with autism. For example, when preschool children with autism are closely attached to the caregiver in a play environment, their play is more sophisticated than when they are not closely attached. In fact, when developmental age is taken into account, closeness of attachment to a caregiver is a better predictor of the quality of play than is the presence or absence of autism itself (Naber et al., 2008). Improvements in the symbolic play of a child with autism have also resulted from one's involvement in an integrated play group (Wolfberg & Schuler, 1993): The child is encouraged by an adult to join a small group of peers, individually selected on the basis of their familiarity and the degree to which their interests, interaction styles, social skills, and personality characteristics complement those of the child with autism. The child entering the group is taught to negotiate play routines, to respond to the social cues of peers, and to initiate social activities. The adult takes an active role at first but gradually withdraws as the child's social skills

improve. In other words, this is not a spontaneous coming together of children but the intentional creation of a supportive environment for socialization and play with peers. In such a setting, dramatic improvements have been seen in the make-believe play of children with autism, reinforcing the view that autism is not necessarily characterized by a deficit in representational skills.

THE SPECIAL CHILD IN THE CLASSROOM

While we cannot draw sweeping conclusions about the play of children with special needs, it seems clear that (a) all children play, regardless of their physical condition, level of intellectual functioning, emotional state, or environmental circumstance, and (b) children with disabilities play less effectively than those without them since they are less likely to explore the physical environment, to form mental representations of reality, or to initiate and sustain social play.

For some groups, such as children with intellectual impairments, the issue is primarily one of delay, and compared with groups of normal children of the same mental age instead of the same chronological age, the play differences disappear. For others, including children with physical disabilities and children who have been abused, the issue may be one of opportunity. The observed play differences are most easily explained by circumstances in the social environment that are not conducive to play but might be made so with appropriate intervention. In fact, the social environment can have a major influence on children's play. Consider the findings of Skellenger and Hill (1994), who demonstrated the value of teacher-child play experiences. Working with three children aged 5 to 7 years, a teacher modeled appropriate play activities, served as a play partner, and followed the children's lead in play. Over a period of 4 months, the sophistication of the children's play improved markedly.

Unfortunately, the social environment of children with disabilities may not be at all supportive of play. Some adults may believe that children with disabilities are unable to play and may therefore neglect to plan for and encourage their play. Adults may also allow children with disabilities to associate only with similar children in early childhood special education programs that put greater emphasis on academic skills and less on free play than is found in typical early childhood programs. Since social interaction occurs more often during play than during preschool academic activities (Odom, Peterson, McConnell, & Ostrosky, 1990), children with disabilities may simply have fewer opportunities to socialize with peers. This is despite the fact that numerous studies have found that when they are included in groups with typically developing children, the play of special children is richer, more varied, and more sophisticated than when they are placed in separate settings (Buysse, Goldman, & Skinner, 2002; Guralnick, 1999).

An obvious approach to increasing their opportunities for social play is to include children with special needs in programs that also contain children whose development is typical. The inclusion approach is increasingly common today, and even 20 years ago 3 out of every 4 preschool classrooms included at least one child with a disability (Diamond & Hestenes, 1994; Wolery et al., 1993). Physical integration does not guarantee social integration, however, as evidenced by what actually happens in mainstream preschool settings. Children with disabilities are not totally isolated, but neither are they completely accepted. Young children usually prefer a playmate whose development is normal to a playmate with a disability (Guralnick, Connor, Hammond, Gottman, & Kinnish, 1996). Positive social interaction is considerably more likely among children without disabilities than among children who have them (Roberts, Pratt, & Leach, 1991), and there may be very little spontaneous interaction between the two groups (Beh-Pajooh, 1991). On the whole, children with special needs develop fewer friendships and are rated lower in terms of popularity (File, 1994). In summary, inclusion doesn't guarantee that typical children will play with—or even interact with—children with disabilities (Odom et al., 2005), and this is probably a major reason why the evidence for the success of inclusion is somewhat inconsistent (Lindsay, 2007; Odom et al., 2004; Webster & Carter, 2007).

It seems likely that the lack of complete acceptance by peers is related to a lack of social skills rather than to a specific disability. What looks like inability to play is often an aspect of a larger communication difficulty. For example, young children with cognitive delays typically lack the social skills needed to gain entry into the peer group and have trouble sustaining social activities and resolving the inevitable conflicts that arise in social relationships (Guralnick, 1999; Guralnick, Hammond, Connor, & Neville, 2006; Guralnick, Neville, Hammond, & Connor, 2007). Children with disabilities have a tendency to be overly direct and even disruptive when making an effort to enter a play group (Lieber, 1993), and even among children with no disabilities such a pushy approach tends to lead to peer rejection. Finally, children with disabilities engage in a greater amount of solitary play and a lesser amount of cooperative play than expected (Beh-Pajooh, 1991; Hestenes, Carroll, Whitley, & Stephenson, 1997).

Despite the fact that physical integration does not guarantee total social integration, mainstreaming can have a strongly positive effect on the play of young children with disabilities and on their social competence (Esposito & Koorland, 1989; Pickett, Griffith, & Rogers-Adkinson, 1993). An essential component of the mainstreaming experience, however, is some degree of adult intervention. What type of intervention should it be? First of all, it should not be overly directive. Adults may assume that children with certain disabling conditions, particularly those that are intellectual in origin, need a greater amount of direction in

order to play. This direction, however well intentioned, may become intrusive and may reduce the spontaneity of play and diminish its quality. Odom, Skellenger, and Ostrosky (1993) found, for example, that teacher-initiated activity occurs more often in special education classes than in early childhood education classes for able children, and play was three times as likely to be seen in the classes of typically developing children.

Children with disabilities need direction, but it should be of a different type. For example, if teachers engage in direct social skills training with these children, emphasizing such skills as sharing, asking to share, asking for help, and persisting with an activity, social interaction ability improves significantly (Odom et al., 1999). In one successful program the staff used peer modeling, puppets, role-playing, and generous amounts of reinforcement to teach children how to greet one another, ask for things appropriately, share, and initiate play. They also taught children that it is socially inappropriate to behave too aggressively, such as by grabbing toys away from other children who are playing with them (Matson, Fee, Coe, & Smith, 1991).

When children with disabilities are given specific training in the social skills necessary to initiate and sustain social play, there seems to be an increase in positive peer responsiveness to them, in the amount and sophistication of the peer interactions they engage in, and in the amount of social play that is observed (Hundert & Houghton, 1992). As a matter of fact, when teachers are trained to encourage peer interaction in preschool children, there is an increase in peer interaction among *all* children, whether they have a disability or not, although it isn't clear from the research that such educational experiences generalize from one social situation to another (Hundert & Houghton; Lifter, Sulzer-Azaroff, Anderson, & Cowdery, 1993).

Finally, it should be mentioned that structured approaches can do more than facilitate social play. The use of modeling and reinforcement by teachers can also encourage imaginative play, even in the case of children who are least likely to engage in acts of make-believe. In one study, children with autism who were taught to engage in dramatic play by the use of scripts and teacher prompts did, in fact, display more spontaneous theme-related social behavior (Goldstein & Cisar, 1992). In a variety of other successful approaches, teachers would select a typically developing classmate to work with a child with autism, and this classmate would ask the child to play, would suggest play activities, would offer to share toys, and would prompt, model, and verbally reinforce appropriate behaviors in the child with autism (Harrower & Dunlap, 2001; McConnell, 2002; Odom et al., 2003).

The necessity of staff intervention to facilitate the play of children with disabilities suggests that it is not enough to remove the physical or social barriers to play. Affirmative action is also needed. The special child may need special

support and encouragement from adults in order to play to his or her maximum potential—similar, perhaps, to the support that all children need to play when they are very young.

CHILDREN UNDER STRESS

As pointed out many times in this book, children's play is most likely to occur in the absence of stress. In fact, the quality of play might be seen as an indicator of the degree of stress a child is experiencing. Securely attached children, for example, are more likely to engage in free play, and children play more freely when their surroundings are safe and familiar, as when they are with playmates they are acquainted with. Furthermore, it was pointed out in Chapter 4 that the stress of marital disruption appears to have a negative effect on the play of preschoolers.

Let us turn now to examination of play in two populations of children who differ from the norm in the amount of stress that is occurring in their lives. First, we shall look at the play of children who are victims of abuse—emotional, physical, sexual, or multiple abuse—at the hands of their caretakers. Second, we shall discuss the play of children who are ill and facing the stress of hospitalization and look at the ways in which play can make the hospital experience a more positive one for the child, the parents, and the hospital staff.

Victims of Child Abuse

The maltreatment of children, whether physical, sexual, emotional, or a combination of these, seems to have an impact on their play, although the impact differs depending on the age of the child. In a study of 1-year-old infants, the researchers found that those identified as maltreated displayed more imitation and less independent behavior in a free-play session with their mothers than did children who had not been maltreated. However, the overall intellectual maturity of the play did not differ between the two groups (Valentino, Cicchetti, Toth, & Rogosch, 2006). The researchers suggested that the lack of an impact on the cognitive sophistication reflects the fact that infant play is primarily biologically determined. It is primarily sensory and motor in nature, as discussed in Chapter 3. However, the excessive imitation and lack of independence could reveal another type of developmental delay—a delay in the normal process of differentiation between oneself and other people. This in turn could be a predictor of later difficulties in relating to peers.

In an older preschool child, play relies more heavily on cognitive factors and social skills, and one might expect the effects of maltreatment to be more pronounced. In fact, this is the case. For example, Allesandri (1991) compared the play of 15 children in a preschool program, aged 4 to 5 years, who had a history of being abused with that of 15 matched (on gender, socioeconomic status, parents' age, ethnic background, parents' education, number of siblings, etc.) controls. The maltreated children played in less mature ways, both socially and cognitively, than did the children who had not been maltreated. The maltreated children engaged in less play overall, involved themselves less often in group and parallel play, and used the play materials in less imaginative and more stereotyped ways. In addition, their fantasy themes were more imitative and less creative. They repeatedly played out domestic scenes, for example, whereas the control group also played the roles of fantasy characters, such as monsters or superheroes.

The relationship between maltreatment and a lack of social skills in preschool children has been found in other studies as well. For example, Darwish, Esquivel, Houtz, and Alfonso (2001) found maltreated children to have significantly poorer skills in initiating interactions with peers and maintaining self-control, although, in contrast with Allesandri's (1991) results, there were no differences in the cognitive aspects of play.

Even though young victims of various forms of maltreatment are often grouped together for research purposes, some researchers have attempted to compare the play of the different abused groups. For example, Fagot, Hagan, Youngblade, and Potter (1989) observed the free-play behavior of three groups of preschool children: sexually abused, physically abused, and not abused. Consistent with other studies was the finding that the nonabused children played more than the children in the other two groups and spent less time doing nothing. They also reacted more positively to other children, spoke more to them, and engaged in a greater amount of associative play.

The differences between the victims of sexual abuse (SA) and the victims of physical abuse (PA) were quite interesting. The SA children were more passive than the children in the control group, but they were not antisocial or negative. They didn't make trouble and usually played quietly by themselves. By contrast, the PA children, although generally passive, engaged in quite a bit more aggression than the norm. They were disruptive, uncommunicative, and antisocial, offering clues that might lead a teacher to suspect there were problems in their lives that needed closer examination. The SA children, however, did not call attention to themselves. Their play was certainly different from the norm, but this difference might not have been noticed by someone who knew little about normal play and failed to realize that play can offer fascinating glimpses into a child's psychological world (Fagot et al., 1989).

An interesting line of research involving child victims of sexual abuse has been to observe their play with anatomically correct dolls. Since 1977, dolls with realistic-looking genitals have been used in interviews with children suspected of being abused, under the assumption that a child in play will reveal what he or she cannot reveal in words (August & Forman, 1989; Cohn, 1991; Everson & Boat, 2002; Freidemann & Morgan, 1985; Leventhal, Hamilton, Rekedal, Tebano-Micci, & Eyster, 1989). It is important to note, however, that the research findings on the effectiveness of anatomically correct dolls in eliciting information from children are definitely mixed. In the first place, few studies have compared allegedly abused children to those who have not been abused. Most studies include only those children who have allegedly been abused, so there is little opportunity for comparison with the “norm.” We should point out, however, that in those studies where comparisons have been made, it has been found that sexually abused children play in more sexualized ways with anatomically correct dolls (August & Forman; Faller, 2007; Jampole & Webber, 1987; White, Strom, Santilli, & Halpin, 1986). For example, August and Forman compared the play of 16 sexually abused girls, aged 5 to 8 years, with that of 16 nonabused girls, offering them anatomically correct dolls to play with while an adult interviewer left the room for 5 minutes. The girls who had been abused engaged in less overall free play, a finding consistent with the results of other studies of maltreated children, and were more likely to attend to the sexual features of the dolls. They would touch the dolls’ breasts or genitals, for example, and giggle when they did so, and they would remove and examine the undergarments.

When preschool children are involved, the use of anatomically correct dolls seems to be particularly questionable. The use of dolls seems to be a less effective technique than simply asking young children to point to areas on their bodies that a suspected abuser may have touched. This is because children aged 4 years and younger often fail to understand that in an abuse interview the doll is intended to represent them (DeLoache, 1995; Hungerford, 2005) and because they provide a greater amount of inconsistent information with the dolls than without them (Bruck, Ceci, & Francoeur, 2000; Goodman, Quas, Batterman-Faunce, Riddlesberger, & Kuhn, 1997; Thierry, Lamb, Orbach, & Pipe, 2005). It is particularly troubling that when interviewers use suggestive questions pertaining to dolls (e.g., “Show me on the doll how he touched your butt,” when touching did not occur) the responses from 3- and 4-year-olds are less accurate than the responses they give when asked suggestive questions not pertaining to dolls (Bruck et al.).

It is critical to point out that sexual play with dolls does not in itself constitute proof of sexual abuse. In fact, evidence of this type has frequently been challenged in courts of law. This is because, as already mentioned, few studies have been done on this subject. To complicate the matter, most sexually abused children never play in sexual ways with the dolls (Friedrich et al., 2001; Friedrich &

Trane, 2002: In one study abused and nonabused children were equally likely to play in sexual ways with dolls (Cohn, 1991), and sexual play with dolls is more likely to indicate a child's knowledge about sex, however it was obtained, rather than to constitute proof of sexual abuse (Faller, 2007).

There is an important lesson here about the need for caution in interpreting the play of children. Children's play reflects their psychological world and allows them to express themselves more freely than they do in words. Nevertheless, while an episode of play can offer clues to a child's emotional state and may lead trained professionals to ask further questions, play alone cannot provide the final answers, especially when the subject is as serious as child abuse.

The Stress of Hospitalization

The experience of hospitalization contains a number of specific stressors for a child, as well as many stressors for adults. Children are stressed by doctors' examinations and tests, limits placed on their physical activity, separation from their families, a general sense of loss of control, and, of course, physical pain (Bowden & Greenberg, 2008; Hendon & Bohon, 2008). Hospitalization is often so stressful an experience for young children that it can actually delay recovery since negative emotions increase stimulation of the sympathetic nervous system, increasing heart rate and blood pressure (Rozanski & Kubzansky, 2005). Hospitalization can result in emotional withdrawal, various regressive behaviors, prolonged crying, disrupted sleep patterns, and forms of destructiveness as children lash out in anger at the indignities being forced upon them (Bolig, 1984; Wilson, 1986).

The stress of hospitalization results from the fact that a stay in a hospital represents a radical departure from everything that is comfortable, safe, and familiar in a child's world. There is a temporary loss not only of family and friends but also of the many rituals that structure a child's life, ranging from eating and sleeping patterns to favorite television programs. And what is more normal in the everyday life of a child—and more alien to the routine of the hospital environment—than play? It is interesting that the feeling of being happy and the experience of laughing can actually promote physical recovery, and laughter and happiness are intimately connected to the experience of play (Garipey & Howe, 2003).

To reduce the stresses of hospitalization for children, it is important to bring to the hospital ward as many as possible of the elements that are familiar in the child's outside world. These elements include familiar people, articles of clothing, stuffed animals, favorite toys (if it seems reasonable to do so), and opportunities for play with other children. Let us look now at some of the research on the ways in which play has been incorporated into the hospital routine and the subsequent benefits for the hospitalized child.

PUTTING THEORY INTO PRACTICE 7.2**Playing With a Medical Theme**

Since no one can predict when hospitalization will be necessary, all young children should have the opportunity to play with miniature life toys or dramatic play props that pertain to medical treatment.

Medical experiences are often frightening to young children as well as to many adults. Fears about illness, pain, and separation can be lessened if a child has an opportunity to deal with these fears in play, and play in hospital settings is widely recognized as a right of children and their families. Medical play, however, should be encouraged before children undergo medical procedures, and such play is beneficial for all children, whether or not they have been hospitalized or expect to be in the near future. Medical play belongs in a preschool classroom.

When providing props for sociodramatic play, teachers should include materials that pertain to medical or hospitalization experiences. Included should be toy syringes, toy stethoscopes, hospital gowns, surgical masks and hats, bandages, and tongue depressors. Hand puppets are especially useful in helping children deal with anxieties about medical procedures, and doctor and nurse puppets make it easy for children to express their feelings about illness. In addition, there are many excellent books for children that deal with hospitalization, including the perennial favorite *Curious George Goes to the Hospital* by H. A. and Margret Rey.

Finally, the fear of medical procedures will be lessened if children are familiar with the setting in which these procedures are carried out. It is unfortunate that the first visit to a hospital or clinic is often the time at which a medical procedure occurs. An advance visit, during which no procedure is done, will relieve some of a child's anxiety. Many hospitals allow children to tour their pediatric facilities, and even if group visits cannot be arranged, parents should be encouraged to consider a hospital field trip for their own children.

Hospital Play Programs

Because play is a natural component of every child's life and because adults usually recognize this fact, play seems to occur wherever children are found. When children are hospitalized, there is play in the hospital. It was not until the 20th century, however, that formally organized programs of play were seen in U.S. hospitals. Some of the earliest programs were developed during the 1920s and 1930s, but the greatest period of expansion occurred during the 1960s and 1970s (Wilson, 1986).

Hospital play programs vary considerably in their emphases, methods, and particular goals (Bolig, 1984). The type of program that exists depends on many factors, the first of which is the *degree of institutional support* that the

program receives. Do the hospital administrators view play as a necessary component of a child's life? Are they willing to staff a play program with regular employees, provide adequate space, and purchase the necessary play materials?

A second influence on the hospital play program is the *educational background of the staff*. Are the staff members familiar with basic principles of child development? More specifically, are they knowledgeable about the physical, intellectual, social, and emotional benefits of play? Do they know how to foster and support play, or is their training almost completely in the area of medical procedure?

Third, programs vary in emphasis depending on who is seen as the *primary intended beneficiary*. It may appear obvious that play programs are designed to benefit hospitalized children. However, an inquisitive parent might discover that play is often used less to promote the optimal development of the child than it is to make life easier for the staff. There is no reason, of course, why *both* patient and staff should not benefit from a play program, but programs that exist primarily for the convenience of staff are often based on a limited understanding of the needs of children and often treat play merely as a convenient way to distract a young patient while necessary hospital procedures are carried out.

The broad spectrum of play programs in U.S. hospitals has been conceptualized in terms of a continuum, with simple diversionary programs on one end and comprehensive "child life" programs on the other (Bolig, 1984). The basis of assignment to position within the range is the degree to which a program (a) recognizes the particular developmental needs of children and (b) strives to promote children's optimal psychological development through the use of play. We turn now to an examination of the types of programs that fit into the various categories.

Diversionary Programs

On one end of the continuum of hospital play programs are those that use play as a diversion, an activity that will keep children occupied, entertained, and relaxed during a hospital stay. Children are typically given toys or encouraged into product-oriented activities, such as drawing pictures, that are in no way related to the experience of hospitalization. In addition, children are often put into passive roles as they are entertained by music, films, clowns, or puppet shows that have distraction as their primary goal.

In **diversionary play programs**, there is rarely any recognition of developmental differences among children; all receive the same types of toys or attend the same types of performances. Furthermore, there is an implicit assumption that children are better off if they do not directly confront the stressful experience of hospitalization. The goal of the play program is to encourage them not to think about being in a hospital.

Diversionsary programs can certainly distract children, make them laugh, and make them happy. Listening to music, for example, has been found to make children smile more often and even to recover from their illnesses more quickly (Hendon & Bohon, 2008). Nevertheless, as more is known about the benefits of therapeutic play, the diversionsary hospital play program is becoming the rare exception. Such programs tend to be found in hospitals having no professionals trained to meet children's psychological needs, no consistent adult supervision of the play space, and limited access to a special area in which to play (Bolig, 1984).

Activity/Recreation Programs

A second type of program is based on the belief that active children are happy children. The emphasis of such **activity/recreation play programs** is on *doing* things, on work with arts-and-crafts projects so that the child can gain the sense of accomplishment that comes from being busy and productive. The purpose of the activity is not simply to distract the child but to enhance his or her sense of well-being.

Activities in such programs might include drawing, painting, woodworking, stringing beads, reading, playing cards, playing a musical instrument, or making paper sculptures. Often the activities that are planned are intended for adult patients as well as for children, and adults and children may even engage in them together (Bolig, 1984).

Play Therapy Programs

Some hospital play programs use play as a form of therapy for their young patients. The underlying assumption is that children are better adjusted if they can release their feelings freely. Only by confronting those feelings can children overcome the anxieties triggered by the various elements of a hospital stay. Since play therapy is a form of psychotherapy, it is conducted by a trained psychotherapist rather than by a member of the hospital staff (Bowden & Greenberg, 2008).

Children in **therapeutic play programs** are given materials designed to encourage the expression of feelings—for example, dolls, puppets, miniature hospital equipment, and creative art supplies. With these materials, children can confront and “work through” their fears and hostilities.

Consider as an example of this approach the case of 8-year-old Brian, who was confined to his bed for a lengthy hospital stay. Brian was grieving for his normal life. As one component of that grief, he was furious at his parents for putting him in the hospital and at the doctors and nurses for keeping him there.

He became rude and sarcastic each time his parents came to see him, and his father reacted by saying, “You have no reason to be mad at us. We couldn’t help it.” Brian’s mother remarked that if her son was going to be unpleasant when she came to visit, perhaps she should visit less often!

The hospital play therapist realized that Brian’s angry response to hospitalization was normal but felt that the boy would do better to release his anger in more constructive ways. She told Brian that exercise was an important element in his recovery and had a punching bag suspended from a wire above his bed. Brian was free to use it whenever he wanted to, and he did so with great enthusiasm—channeling his angry feelings into a form of expression that was safe and, in doing so, perhaps coming to understand the feelings a little better.

Child Development Programs

A number of hospital play programs in recent years have based their philosophical orientation on general principles and theories of child development. They tend to focus on the whole child—on his or her intellectual, social, physical, and emotional development—and they see the role of the adult supervisor of hospital play as both counselor and nondirective educator.

Typical **child development play programs** include curricula that are found in preschool or elementary school classrooms. Children may listen to stories, draw, paint, sculpture, assemble puzzles, build with blocks, and learn a variety of quantitative, scientific, and verbal skills. In that sense, life in the hospital comes to resemble life in the outside world, and because it appears relatively normal to the child, the hospitalization experience seems to be less threatening.

Child Life Programs

During the 1960s, there emerged a type of hospital play program that was referred to as child life (Bowden & Greenberg, 2008). Stimulated by the work of the Association for the Care of Children’s Health, the focus of **child life play programs** is on *all* aspects of the hospitalized child’s development, seen in both an individual and a social context. Most pediatric hospitals today have child life programs, and it is estimated that there are approximately 400 such programs throughout the United States, which is twice as many as there were in 1965 (American Academy of Pediatrics, 2006). The objective of such programs is to reduce children’s anxiety, as well as that of their families, and help them maintain their self-esteem throughout the hospital experience. Working toward that goal is a health care team that includes a child life specialist, an experienced counselor who is trained in such a field as education, psychology, or child development.

The child life specialist helps prepare the child and the family for the hospital experience. He or she works with entire families rather than only with children. Siblings are often confused or frightened by the illness of a hospitalized child, and parents may feel stressed and helpless because they are removed from their typical roles (Bowden & Greenberg, 2008; Dudley & Carr, 2004). The child life specialist educates the family about the child's illness and about hospital procedures, helps family members communicate with one another during their stressful ordeal, and encourages parents to maintain their positions of influence over their children's lives. In a sense, the child life specialist is an advocate for the family with the hospital staff.

Play is not the only emphasis of a child life program. Nevertheless, play retains a central position within the child life model. Children—and their parents—are encouraged to play in order that they can continue to grow intellectually, socially, and emotionally while in the hospital and in order that they can communicate their feelings and, in doing so, come to understand them better. In that sense, the comprehensive child life program represents a blend of both the child development and the release-oriented models (Bolig, 1984).

Providing the Conditions Necessary for Play

The most effective hospital programs, by whatever names they are called, are those that most adequately provide the conditions necessary for play to occur. In order for play to occur in a hospital setting, the following three conditions must be present (Chance, 1979). First, there must be a *child-oriented atmosphere*. Second, there must be available a supply of *appropriate play materials*. Finally, an essential component is the guidance of a *supportive adult supervisor*.

A Child-Oriented Atmosphere

Unlike most other areas of the hospital, the children's ward should be a warm and inviting place, decorated with colorful mobiles, pictures, and wall paintings and containing a variety of toys and play materials. If possible, a separate playroom—a place to which children will want to come, one that they will see as a point halfway between the hospital and the home—should be made available. The playroom should be a sanctuary for children in that no medical procedures can be performed there, and it should be accessible to *all* children, even those who are not ambulatory. In the playroom, children should have the opportunity to demonstrate the kind of independent behaviors that may not be tolerated elsewhere in the hospital, to express all their feelings freely and openly, and to engage in social play with other young patients (Bolig, 1984).

Appropriate Play Materials

Play materials in the hospital should be familiar to the child so that the psychological distance between home and hospital is minimized. In addition, they should be characterized by a high degree of diversity in order to be suitable for children who vary in their developmental levels and their interests. Included might be art supplies, crafts, books, games, musical instruments, and electronic equipment, such as films, tape recorders, radios, record players, television sets, and video games. If such activities are possible, the hospitalized child might also benefit from the use of outdoor play equipment.

Hospital play materials should certainly include toys that are medically oriented: stethoscopes, syringes, bandages, blood pressure kits, nurse and doctor costumes, toy ambulances, and an assortment of dolls and puppets that can be assigned the various roles in a hospital drama. By rehearsing the medical procedures they expect to go through, children can come to understand them better and fear them less. In these rehearsals, children often reveal to adult observers some frightening misconceptions about hospital care.

In addition to educating children and helping them cope with their fears, dramatic play with a medical theme can give them a sense of control that is usually lacking during their hospital stay. The child can reverse roles in playing with dolls and become the powerful doctor instead of the helpless patient. This temporary illusion of power can help build self-confidence and make the hospital experience a less threatening one.

Finally, when children, medical staff, and parents are involved together in a dramatic play experience, a sense of community is formed—a sense that the child is not undergoing treatment alone. In fact, parents who participate in such play, as is desirable in the case of a preschool child, become more comfortable in the hospital setting and transmit to their children an increased sense of well-being about the hospital experience. The children tend to recover faster, as indicated by physiological measures like heart rate, temperature, and blood pressure, and the parents are enlisted as partners in the healing process rather than simply as supportive bystanders (Wilson, 1986).

A Warm, Accepting Supervisor

The hospital playroom should be directed by an adult who is warm, accepting, permissive, and consistent. In the absence of an adult supervisor, young children may simply not be able to play; even older children usually need caring adult support until they are ready to develop relationships with their hospitalized peers (Bolig, 1984).

Because separation from the family is largely responsible for a child's negative reaction to a hospital stay, it is important that the play supervisor be a consistent

figure, not just one of many. Such consistency promotes the development of attachment between caretaker and child and thereby reduces the child's sense of separation from his or her parents. In fact, for this very reason, it is increasingly common to have young patients cared for by fewer nurses assigned to them on a case basis rather than by many nurses assigned on the basis of task (Bolig, 1984).

Summary

Relatively little is known about the play of children with impairments, primarily because of numerous methodological problems that characterize much of the research on the topic. In addition, it has not been easy to determine the origins of differences that have been observed between typical children and those with disabilities. Children with disabilities experience physical, mental, emotional, or a combination of difficulties, but they also grow up in environments that are different from those of typical children. For example, they may lack appropriate physical surroundings to play in, adult supervisors to help them plan and carry out their play routines, and suitable playmates. These elements may conspire to foster an impression that children with disabilities experience basic play deficits. In fact, this impression may be completely false since the observed play differences could be environmental in origin.

Children with visual impairments play less imaginatively than sighted children and engage less often in games of make-believe. Nevertheless, they do enjoy play, and their play can be enhanced if adults encourage them by helping them plan for play and providing them with sensory-rich play environments. Children with language and hearing impairments engage less often than typical children in symbolic play, but the differences are quantitative rather than qualitative; there is no evidence of a far-reaching symbolic deficit in those with hearing difficulties or whose language is delayed.

In terms of their play with objects, children with intellectual deficits seem to prefer structured materials, such as puzzles and jacks, while typical children of the same mental age prefer open-ended materials (e.g., art supplies) that allow them to be creative and imaginative. In addition, children with intellectual deficits are less likely than other children to combine objects appropriately in play. Symbolic, or make-believe, play has been observed consistently in all children; there is no evidence that intellectual impairment prevents children from engaging in imaginative acts of make-believe. It should be noted, however, that mental age is better than chronological age as a predictor of the onset of symbolic play; thus, symbolic play typically appears later in children who are intellectually impaired than in those whose intellectual development is not impaired.

Children with autism show evidence of a basic communication difficulty, a profound inability to understand and function within the normal social environment; the child with autism apparently fails to differentiate between the self and the external world. In toy and object play, children with autism are likely to engage in repetitive, stereotyped manipulation and less likely than typically developing children to use objects symbolically in make-believe. They are also

less likely to engage in complex toy play or to use toys appropriately. Children with autism rarely engage in symbolic play, and the reasons for this pattern are not fully understood. Children who are undergoing severe stress in their lives, such as that caused by physical, emotional, or sexual abuse, or the temporary stress of hospitalization do not play as freely as they otherwise would. Children who have been abused play in less mature ways than do those who have not been abused. They play less often and with a more limited range to their imagination.

Play can be very beneficial for children undergoing temporary stress, such as that involved in the experience of hospitalization. In recognition of this fact, a broad range of hospital play programs has emerged, particularly within the past 40 years. Some merely attempt to distract the child so that hospital routines can be more efficiently carried out. Others are firmly rooted in child development principles and work to maintain the emotional, social, and intellectual well-being of hospitalized children and their families.

It seems clear that play is unlikely to occur in a hospital setting, however, unless certain conditions are present. There must be a child-oriented atmosphere, a supply of appropriate play materials, and the guidance of a supportive and continuing adult supervisor.

Key Terms

Activity/Recreation Play Programs	p. 204	Diversionary Play Programs	p. 204
Child Development Play Programs	p. 206	Theory of Mind	p. 193
Child Life Play Programs	p. 206	Therapeutic Play Programs	p. 205

Issues for Class Discussion

1. Choose a typical preschool play activity, such as building blocks, playing house, or singing “Farmer in the Dell,” and try to envision the experience from the perspective of a child with a sensory impairment, an intellectual deficit, or an emotional problem.
2. If a person didn’t have a theory of mind, how would he or she interpret the behaviors of other people in the social environment? Why is a theory of mind necessary for successful social interaction?
3. Why would anyone assume that a child with an intellectual impairment does not want or need to play? Is there anything in the behavior of such a child that might lead an adult to draw this conclusion?
4. If a person wanted to implement a play program in a hospital that never had one before, what kinds of resistance might he or she expect to face from the staff?