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Play is Hard Work: Using Integrated Play Therapy to Build Social Skills

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Abstract

In the midst of the current changes in family structure, increasing school violence, and children spending more time socializing with media than with people, developing social skills in young children have been a continual challenge. Additionally, children who have experienced trauma, have ADHD or Autism, or have a challenging home environment, also struggle to relate to others in healthy ways. The language of young children is play. Throughout history, children have learned social norms, roles, as well as social skills through play. This article will review the Play is Hard Work social skills group for four to six-year-old children. This group utilizes games and playful interaction to allow children to connect with each other in meaningful ways. Children are intentionally given opportunities to dysregulate their emotions so that they may then be taught skills to regulate them. Some of the therapeutic interventions drawn upon include: Trust Based Relational Intervention (TBRI), child centered play therapy, Theraplay, and adventure-based counseling. The ultimate goal of this play group is to help children enter the classroom with the skills needed to be more productive and successful, as well as having the skills they need to become fully integrated into their family life. Children become connected and successful by using the learned skills of self-regulation, problem solving, sharing, teamwork, giving and receiving care, perspective taking, negotiation, and showing respect. The content and theoretical practices used in the social skills group are discussed.

Keywords: Self-Regulation, Play Therapy, Social Skills, TBRI

1 Introduction

Social play should be one of the most intuitive activities for children, and yet, countless children have difficulty making friends, getting along with others, waiting their turn, and taking turns. Social skills are a key component to satisfying play. According to Lynch and Simpson (2010), "Social skills are behaviors that promote positive interaction with others and the environment" (p. 3). Some of these skills include: showing empathy, communicating with others, participating in group activities, generosity, helpfulness, negotiating, and problem solving (Lynch & Simpson, 2010). Other examples of social skills include: making eye contact, initiating interactions with others, maintaining reciprocal conversation, and understanding and using nonverbal communication such as gestures and facial expressions (Bohlander, Orlich, & Varley, 2012). Social skills help children get along with others, make friends, and develop healthy relationships. They enable individuals to interact appropriately with others throughout their lives (Green, 2018). Social skills are considered key building blocks in overall adaptation and adjustment (Matson & Fodstad, 2010). They are developed in children through play and interactions with others, observing others, and modeling the behavior of others. Playing allows children the opportunity to develop, improve, and learn a vast array of social skills. For children who are socially isolated, play offers important occasions for social interactions and skill development (Lynch & Simpson, 2010). Many children with disorders such as attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) tend to show deficits in these social skills. Additionally, children and adolescence with a diagnosis of oppositional defiant disorder (ODD) also experience significant impairments across several domains of social functioning. Children with ODD tend to display more negative play behaviors

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and less social competence when compared to children without ODD (Greene et al., 2002).

Furthermore, children with these diagnoses, along with those who have sensory processing issues often struggle with self-regulation. Self-regulation is important, as children rely on self-regulation skills in school and in everyday life. Self-regulation and self-control can be easily confused. While the two are related, they are not the same thing. Self-control is primarily a social skill, which children use to keep their behaviors, emotions, and impulses in check. Self-regulation is a different type of skill (Morin, n.d.). Self-regulation is the ability to manage emotions and behavior in accordance with the demands of the situation. It is a set of skills that enables children to direct their own behavior towards a goal, despite the unpredictability of the world (Child Mind Institute, 2018). Self-regulation allows children to manage their emotions, behavior, and body movements when they are faced with a situation that is tough to handle and allows them to do so while remaining focused and paying attention. Children who are able to self-regulate know how to calm themselves down when they get upset, resist giving into frustrated outbursts, and be flexible when expectations change (Morin, n.d.). Despite its value and importance, children with a diagnosis of ADHD or ASD, or any other disorders that affect executive functioning and sensory processing, have difficulty with self-regulation, along with social skills. For children diagnosed with these disorders, play is especially important.

One of the most commonly used interventions for young children with social deficits is social skills training, many of which include play therapy techniques (Bohlander et al., 2012). Play is one of the best ways for children to learn social skills because children learn best when they are having fun. While social skills training may be individual, or group based, there are several benefits to using a group format when applying the intervention to children. In a group format, children can learn from each other, encourage each other, solve problems together, and share joys and disappointments. Group play interventions offer a dynamic approach for developing and refining social skills for children (Reddy, 2012). Group work allows children and adolescents the opportunities to maximize their self-control and practice their social skills within the context of a controlled environment (Rose & Anketell, 2009). Group play interventions can create a "teaching social laboratory" for children. The group serves as a practice arena in which children can experiment with old and new behaviors, identify feelings and behaviors in themselves and others, and learn how their behaviors affect others as well as the environment (Reddy, 2012).

Attention-Deficit/Hyperactivity Disorder

Attention-deficit/hyperactivity disorder is a mental disorder characterized by three core symptoms: inattention, hyperactivity, and impulsivity. ADHD is one of the most common disorders among children, affecting 3-7% of the school population (Kilgus, Maxmen, & Ward, 2015). Children with a diagnosis of ADHD tend to be physically overactive, distracted, disorganized, impulsive, and forgetful. They tend to fidget, talk excessively, take unnecessary risks, and interrupt others. They also have difficulty paying attention, waiting their turn, and staying on task (Centers for Disease Control and Prevention [CDC], 2017). Due to these behaviors, it is often difficult for children with ADHD to make friends and have successful social interactions. Attention-deficit/hyperactivity disorder permeates every aspect of a child's life. For the complete diagnostic criteria for ADHD, refer to Table A1.

Autism Spectrum Disorder

According to the Centers for Disease Control and Prevention (CDC, 2018), ASD is a "developmental disability that can cause significant social, communication, and behavioral challenges" (para. 1). Prior to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), conditions such as autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome were diagnosed separately. Now, these conditions are all referred to ASD. Individuals with ASD tend to have different ways of learning, paying attention, communicating, behaving, interacting, and reacting to things when compared to other people (CDC, 2018). The nature of the symptoms of ASD leads to shortfalls in social abilities. In fact, social issues are one of the most common symptoms in all types of ASD (CDC, 2015; Cotugno, 2009).

Children with ASD present with a range of behaviors including an inability to understand and interpret nonverbal behaviors in others, a failure to develop age-appropriate peer relationships, a lack of interest or enjoyment in social interactions, and a lack of social or emotional reciprocity (Cotugno, 2009). Children with ASD tend to avoid eye contact, have trouble relating to others, have difficulty expressing needs using typical words or motions, and have unusual reactions to the way things smell, taste, feel, or sound. They often repeat actions over and over again, and echo words or phrases. They also have trouble adapting to change (CDC, 2018). Due to these issues, children with ASD often avoid social contacts, experience an over-arousal in social situations, and demonstrate an inability to understand and follow social rules and expectations. These issues create significant problems in engaging in normal and typical peer social interactions, which often result in tacit or explicit social rejection (Cotugno, 2009). For the complete diagnostic criteria for ASD, refer to Table A2.

The Importance of Play

According to Landreth (2012), "The natural medium of communication for children is play and activity" (p. 7). The toys are viewed as a child's words and play is considered a child's language (Landreth & Bratton, 1999; Landreth, 2012). Using play, therapists may help children learn more adaptive behaviors, especially when emotional or social skill deficits are present (Pedro-Carroll & Reddy, 2005). Play allows children to use their creativity while developing their imagination, dexterity, and physical, emotional, and cognitive strength. It is essential to development because it contributes to the cognitive, physical, social, and emotional well-being of children (Ginsburg, 2007). For children, play is a medium of expressing feelings, exploring relationships, describing experiences, and disclosing wishes. Developmentally, children lack the cognitive, verbal facility to express what they feel, and emotionally are unable to focus on the intensity of what they feel in a manner that can be adequately expressed in a verbal exchange. Therefore, children express themselves more fully and more directly through self-initiated, spontaneous play. Children are able to use toys to say what they are unable to say and do things they would feel uncomfortable doing. Feelings and attitudes that are too threatening for a child to express directly can be safely projected

through self-chosen toys. Play is considered the concrete expression of the child and is the child's way of coping with his or her world (Landreth, 2012). While there are many different approaches to teach children social skills, this article specifically looks at the efficacy of social skills groups that use therapeutic techniques that integrate play.

Play Therapy

The Association for Play Therapy (1997) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (p. 7). Through play therapy, children learn to communicate with others, express feelings, modify behavior, and develop problem-solving skills, as well as learn a variety of ways of relating to others. For children, play provides a safe psychological distance from their problems, and allows expression of thoughts and feelings that are appropriate to their development (Association for Play Therapy, 2016). Play therapy involves the use of specific directive or non-directive techniques to teach children the cognitive and behavioral skills that they may be lacking.

Theraplay

Theraplay is an "engaging, playful, relationship-focused treatment method that is interactive, physical, personal, and fun" (Booth & Jernberg, 2010, p. 3). It is a short-term attachment-based intervention that uses elements of play therapy to strengthen parent-child bonds and promote secure attachments, self-regulation, and communication skills in children (Theraplay, 2018). Theraplay interactions focus on four essential qualities found in parent-child relationships. These four qualities include: structure, engagement, nurture, and challenge (The Theraplay Institute, 2017). The dimension of structure is especially important for children with ASD because it not only provides a sense of safety and predictability for the child, but it also allows the counselor to keep the child with them physically and emotionally. After the safety of structure is established, engagement is the key Theraplay dimension when working with children with a diagnosis of ASD. The Theraplay principle of becoming an intriguing force that the child notices and takes into account is crucial because children with ASD find it difficult to engage with others. Nurturing provides comfort and a sense of safety, as it is the most fundamental connection between human beings. Because many children with ASD have a discomfort with being touched, it is especially important to find nurturing activities that are truly soothing to the child. The challenge dimension of Theraplay is often used in small increments with children with ASD. Gradually introducing new activities and new challenges helps expand children's range of abilities to interact with others and helps them tolerate a variety of new activities. Instead of overtly teaching the social skills children with ASD lack, Theraplay helps children learn these skills in a variety of more subtle ways (Booth & Jernberg, 2010).

Trust-Based Relational Intervention

Trust-based relational intervention (TBRI) is an, "attachment-based, trauma-informed intervention that is designed to meet the complex needs of vulnerable children" (Karyn Purvis Institute of Child Development, 2018, para. 1). TBRI is an intervention grounded in attachment theory. It seeks to improve outcomes for vulnerable children by helping caregivers see the needs of children who have experienced relational trauma and by helping caregivers do what is necessary to meet those needs. It consists of three sets of principles that facilitate felt-safety, self-regulation, and connection. These three principles include: Empowering Principles, Connecting Principles, and Correcting Principles (Purvis et al., 2015). TBRI uses Empowering Principles to address physical needs, Connecting Principles for attachment needs, and Correcting Principles to disarm fear-based behaviors and teach self-regulation (Purvis, Cross, Dansereau, & Parris, 2013). While the intervention is based on years of attachment, sensory processing, and neuroscience research, the heartbeat of TBRI is connection (Karyn Purvis Institute of Child Development, 2018). Each set of principles has two associated sets of strategies. Ecological strategies and physiological strategies are associated with Empowering Principles. Ecological strategies include recognizing and managing transitions and establishing rituals, while physiological strategies include providing physical activity and sensory experiences, as well as meeting nutritional and hydration needs. The basic idea of Empowering Principles is that by attending to these principles and strategies, caregivers or adults can enhance a child's capacity for self-regulation, decrease the likelihood of negative or disruptive incidents, and increase the likelihood of successful correcting and connecting. The sets of strategies associated with Connecting Principles are mindfulness awareness and engagement strategies. Mindfulness awareness involves awareness of the child, self, and environment. Engagement strategies involve things such as valuing eye contact, healthy touch, and playful interaction. The Connecting Principles are essential mechanisms for building trusting relationships and help both the Empowering and the Correcting principles work in practice. Finally, within Correcting Principles, there are two types of strategies: proactive and responsive. Proactive strategies are about balancing structure and nurture to build trust. They are designed to teach social skills to children during calm times. Responsive strategies provide caregivers with tools for responding to challenging behavior, such as using the IDEAL Response technique. The Correcting Principles are used to deliberately shape behavior (Purvis et al., 2015).

Integrative Therapy

Integrative therapy is "a combined approach to psychotherapy that brings together different elements of specific therapies" (Counselling Directory, 2018). This approach posits that counseling techniques must be tailored to each client's individual needs. When applying this approach to therapeutic techniques that integrate play therapy, integrative therapy is the use of several methods of play to teach children social skills. These methods need to be tailored to the child's specific needs, using empirically supported techniques that will help the child with their specific disorder and social deficits.

Literature Review

Research has shown that social skills curriculum implemented in a group therapy format is beneficial and effective in improving social skills in children and adolescents with disruptive behavior disorders (DBD) and/or ASD (DeRosier, Swick, Davis, McMillen, & Matthews, 2010; Mathews, Erkfritz-Gay, Knight, Lancaster, & Kupzyk, 2013; Rose & Anketell, 2009). Mathews et al., (2013) investigated the effects of a social skills group that focused on verbal and nonverbal skills on the social functioning of children and adolescents with ASD or DBD. The groups were small, limited to a total of eight individuals in each group. When comparing pre- and post- test scores, results indicated an increase in all five skills being observed. For sharing ideas, complimenting others, offer-

ing help and encouragement, recommending changes nicely, and exercising self-control, the mean increase was 28.6%, 20.3%, 30.7%, 29.9%, and 23.7%, respectively. The results from the study conducted by Mathews et al. (2013) suggest that when skills are directly targeted with social skills training, participants with ASD and/or DBD perform significantly better than when they have not received training on a specific skill. In a study conducted by DeRosier et al., (2010), parents in the treatment group reported improvements in children's social skills and sense of social self-efficacy, whereas parents in the control group reported a decline. Children in the intervention group also exhibited significantly greater mastery of social skills. The study conducted by DeRosier et al., (2010) supports the efficacy of a social skills group intervention for improving social behaviors in children with high functioning autism spectrum disorders.

Research also recommends applying a high level of structure or consistency and using the same or similar routine each session when running a social skills group for children with ASD (Cotugno, 2009; Rose & Anketell, 2009). The use of a highly structured group resulted in positive parental ratings, with 60-80% of parents rating that their child found every session "useful" or "very useful." The majority of improvements were in areas such as social difficulties, communication difficulties, and withdrawal (Rose & Anketell, 2009). Cotugno (2009) also found that implementing a group intervention that maintained a high degree of consistency from session to session, resulted in significant improvements in stress and anxiety management, joint attention, and flexibility and transitions in children diagnosed with ASD. It should also be noted, the group of younger children (ages 7-8 years old) showed the greatest improvement on teacher-preferred and peer-preferred behavior. This group also demonstrated a greater shift to more positive and effective ways of managing and coping (Cotugno, 2009).

Allen and Barber (2015) investigated the effects of teaching play-based social skill strategies on off-task behaviors in young children. These researchers found that a focused social skills program that incorporated play resulted in a decrease in off-task behaviors in children ages five and six years old. The program allowed the students to learn how to express themselves and develop interpersonal skills by practicing social skills through play activities. The group format helped the boys practice their social skills in a safe, non-threatening environment that allowed for free expression and understanding among group members (Allen & Barber 2015).

In addition to specific approaches, chewing gum is also beneficial for children with ADHD or ASD. There are many therapeutic uses of chewing gum. Chewing gum tends to provide the right kind of sensory feedback that some children crave. Nearly all children chew gum, and in doing so, a child with ASD may avert social stigmatization that may be a cause of concern (Stillman, 2007). Additionally, chewing gum can relieve stress, increase attentiveness, boost concentration, and aid in accessing memory (Allen & Smith, 2012; Johnson, Muneem, & Miles, 2013; Stillman, 2007). Allen and Smith (2012) investigated the benefits of chewing gun on alertness and attention. They found that chewing gun increased reported alertness and hedonic tone and improved performance on the categoric search task. These results suggest that chewing gum has a positive effect on selective attention. Additionally, Johnson et al. (2013) examined the effects of chewing gum on sustained attention and associated changes in subjective alertness. Following the chewing of gum, subjective measures of alertness, contentedness, and calmness were all higher. The findings indicate that chewing gum was associated with improved attentional task performance. These results support and show the benefits of chewing gum.

Research has also shown that social skills groups and play therapy are effective in addressing behavioral problems and social deficits in children with ADHD (Gol & Jarus, 2007; Robinson, Simpson, & Hott, 2017; Wilkes-Gillan, Bundy, Cordier, Lincoln & Chen, 2016). Wilkes-Gillan et al. (2016) completed a randomized controlled trial to test the efficacy of play therapy techniques on developing social skills in 29 children with ADHD. Playfulness and social skills were measured using the Test of Playfulness (ToP). The study found that all of the participants' mean ToP scores improved significantly following treatment. More specifically and relevant to this current study, the social items on the ToP scale showed a significant increase. These findings support the use of peer and parent mediated play therapy as a means to increase social skills in children with ADHD. Robinson et al. (2017) conducted a study on the effects of six weeks of child-centered play therapy on the behavior performance of three first-grade students with a diagnosis of ADHD. Even though only two participants completed the entire six weeks, the results of all participants in the study are significant and relevant. One participant only completed two weeks of the study, however his results were promising. Out of all three participants, his behavior was most severe. Even with an impending move and the birth of a younger sibling, he showed positive changes in six out of 10 subscales on the Direct Observation Form (DOF) after only one week of treatment. This suggests that child-centered play therapy helped him cope with stressors and changes in and outside of school. For the two participants who completed all six weeks of treatment, results showed improvement on seven out of 10 subscales on the DOF. These findings demonstrate that child-centered play therapy in most effective in reducing severe behaviors in children with ADHD (Robinson et al., 2017).

Tucker, Schieffer, Wills, Hull, and Murphy (2017) investigated the effects of group-based Theraplay on social-emotional skills in at-risk preschool students. Following the intervention, they found that students in the play-based groups improved significantly in social-emotional skills, behavioral regulation, problem-solving, and fine motor control. Tucker et al. (2017) noted that specific improvements occurred in domains of managing feelings, cooperation, accepting limits, peer interactions and friendships, and solving social problems. Siu (2014) also found a Group Theraplay program to be effective in enhancing social skills among children with developmental disabilities. Compared to those in the control group, children in the intervention group showed significant improvements in social cognition, social awareness, social communication, and social motivation. The greatest pre- to postintervention differences were found in social motivation and social communication, which included skills such as picking up social cues and learning to reciprocate social behavior. Results from Siu (2014) and Tucker et al. (2017) show that the more positive experience children have in working with others and the more comfortable they are in attending to and caring for one another, the more successful they are in their social relationships. These studies support the effectiveness of using Theraplay techniques in a group format as a method of improving social skills in children.

2 Method

Participant

Participants in this study were randomly selected from a rural community in Florida. Participants included six boys and six girls (n=12) with an age range of 4 to 6 years old. Of these participants, six children were diagnosed as having ASD and attachment disorder, four were diagnosed as having ADHD, one participant was diagnosed as having ODD, and one participant was neurotypical but showed signs of social difficulties. Additionally, it should be noted that five of the participants have a significant history of early childhood trauma. All participants attended a total of 10 two-hour group sessions every other week.

Instrument

The Test of Playfulness (ToP) was utilized to rate participants' level of playfulness and social skills both before and after the social skills intervention was held. This 29-item measure uses observational data collected by researchers involved in the group to determine the changes in each child's social behavior during play. The ToP uses a 4-point scale to score the extent, intensity, and skillfulness of each area of social skills while observing peer-to-peer play interactions. For the purpose of this study, only the data gained through the ToP on the nine items that relate to the development of social skills will be utilized. These nine items include: the skill of initiating social interactions, the skill of negotiating, the skill of sharing, the skill of supporting another, the extent of time engaged in social interactions, the intensity of involvement with another in social interactions, the social skill when interacting with another, the skill of giving verbal and non-verbal cues, and the skill of responding to others' verbal and non-verbal cues (Wilkes-Gillan et al., 2016). The nine items that rate social skills on the ToP can be gauged by their extent, intensity, or skill. The ToP does not measure the extent, intensity, and skill for all of these nine items, it is dependent on which item is being rated. Extent is rated on a scale ranging from: N/A= not applicable, 0= rarely or never, 1= some of the time, 2= much of the time, and 3= almost always. Intensity is rated by: N/A= not applicable, 0= not, 1= mildly, 2=moderately, and 3= highly. Skill is rated by: N/A= not applicable, 0= unskilled, 1= slightly skilled, 2= moderately skilled, and 3=highly skilled. For a list of items that rate participant social skills and whether extent, intensity, and skill are rated for the item, refer to Table 3. This measure was chosen due to its empirically supported inter-rater reliability, moderate test-retest reliability, and inter-rater reliability coefficients (.50-.89).

Table 3

ToP Scoring of Social Items

ToP Items Measuring Social Skills			
Item	**Extent**	**Intensity**	**Skill**
1.Incorporates objects or other people in play			
2. Negotiates with others to have needs/desires met			
3. Engages in social play			
4. Supports play of others			
5. Enters a group already engaged in an activity			
6. Initiates play with others			
7. Shares (toys, equipment, friends, ideas)			
8. Gives readily understandable cues (facial, verbal, body) that say, "This is how you should act towards me"			
9. Responds to others' cues			

Design

This study utilized a pretest-posttest design with a random sample of children ages four to six years old. The dependent variable was the participants' social skills based on their ToP scores while the independent variable was the treatment plan which involved a social skills group that utilized an integrative approach to play therapy. The baseline was found using the participants' ToP scores prior to the intervention, while the results were found using the posttest ToP scores. The pretest and posttest data were then compared to find the significance in the change of scores.

Procedure

The trials consisted of 10 bi-weekly two-hour sessions led by a licensed mental health professional along with assistance from other trained mental health professionals. Each session began with an "opening circle" in which the three rules were discussed and reviewed. The three rules included: no hurts (the children explained what that meant), stick together (the children were assigned a partner or team), and have fun (above all, it is important for learning to be fun). Following the discussion of rules, the children were asked if anyone needed bubble gum. This is very important as it is calming for children and requires working strong muscles to move it around. Due to its beneficial effects, the children were allowed have and chew gum throughout the group sessions. Group leaders asked participants to complete a variety of tasks that come from an integrative approach. These sessions utilized techniques from child-centered

play therapy, cognitive behavioral therapy (CBT), adventure-based counseling, Theraplay, group therapy, and TBRI. The tasks were meant to improve the social skills and behavioral problems of the children involved in the group. There were also various tasks meant to improve the home life skills of the children to help integrate them fully into their home life. For a complete list of the tasks and their purposes utilized in this group, refer to Table 4.

Activities Utilized in Session and Their Purpose

Skill	Activity/Task Completed
Self-regulation	Pass the giant water beads; Blow on your soup; Silly string outside; Red light green light
Establishment of boundaries	Pass the giant water beads; Discuss group rules
Cooperation	Team Giant Jenga; Team builds a tower with materials
Problem Solving	Team Giant Jenga; Off the ground (walk around without touching ground using tools)
Sensory dysregulation	Crash and bump
Teamwork**	Clean up backyard with plastic balls; Giant team memory game; Treasure hunt puzzle pieces; Off the ground
Focus	Giant team memory game; Red handed circle game (child stands in center and guesses who has red marble); Disappearing Act (memorize items on table, close eyes, open eyes, see what is missing)
Memory	Giant team memory game; Disappearing Act
Accepting No	Silly String outside
Waiting their turn**	Crash and Bump
Identify Zones	Zones of regulation puppets
Home living skills	Set the table; Refrigerator/cabinet game (Where does the food go?)
Compliance	Red light green light
Being able to give/receive care**	Place band aids on each other
Socialization**	Staring contest with teams of two; Name game (sit in a circle, pass ball to person and say their name)
Attunement	Staring contest with teams of two; Mirroring (facing each other and mirroring movements)
Engaging even when uncomfortable**	Staring contest with teams of two
Perspective Taking**	Feelings Charades; Self-portrait (discuss emotions expressed)
Self-Esteem	Rock climbing wall; Outside fun day
Negotiation	Bubble gum/sucker choice as opportunity to use skill
Showing Respect	Asking permission before touching someone else

** Identifies activities specifically meant for increasing social skills deficits in participants*

3 Results

When analyzing the data from the pretest and posttest, the results of this study demonstrate that the ten-week structured social skills group using an integrative approach to play therapy increased scores of all participants by at least one degree. The extent, intensity, and skill of each of the nine items that test social skills on the ToP all showed an increase of one degree, where applicable. For a comparison of pretest and posttest ToP scores of participants, refer to Table 5. Of special interest, one result to note is that one participant that is diagnosed with ASD with selective mutism was able to use four words without the assistance of other traditional therapies, such as ABA therapy or speech therapy, following this treatment.

Table 5.

Pretest and Post Test ToP Scores

Mean of Pre-Test ToP Scores				*Mean of Post Test ToP Scores*			
Item	**Extent**	**Intensity**	**Skill**	**Item**	**Extent**	**Intensity**	**Skill**
Item 1	.8		.6	Item 1	1.6		1.5
Item 2			.75	Item 2			1.25
Item 3	1.08	.75	.6	Item 3	2.08	1.75	1.6
Item 4			.5	Item 4			1.4
Item 5			.6	Item 5			1.5
Item 6			.8	Item 6			1.8
Item 7			.9	Item 7			1.75
Item 8	.75		.6	Item 8	1.8		1.6
Item 9			.75	Item 9			1.4

3.1 Discussion

The current study investigated the effects of the Play is Hard Work social skills group on children ages four to six years old identified as having social deficits or impairments in social functioning. The Play is Hard Work social skills group is an integrative approach that utilizes techniques from child-centered play therapy, adventure-based counseling, group therapy, TBRI, and Theraplay. The purpose of the group was to help children gain or improve social skills and behaviors, which would allow them to live more productive and successful lives in a variety of settings. The findings of this study show that the Play is Hard Work social skills group is successful in improving children's social skills.. Following the group, the children displayed more positive behaviors. All participants showed an increase of at least one degree on the ToP. The results indicate that following participation in the group, the children showed improvements in skills such as self-regulation, problem-solving, sharing, teamwork, negotiation, showing respect, and giving and receiving care. By gaining such skills, children are better able to interact and connect with others in meaningful ways. Aside from being able to successfully interact with others, the skills gained in the Play is Hard Work social skills group allow children to become better integrated into their family life and be more productive in the classroom. By learning, understanding, and effectively using skills such as showing respect, self-regulation, accepting no,

and being able to give and receive care, children are able to integrate themselves into their home life in a more successful and positive manner. Mastering and using skills such as negotiation, socialization, cooperation, waiting turns, self-esteem, and engaging even when uncomfortable allow children the opportunity to successfully and effectively form meaningful relationships with others around them, including peers and adults. The findings from this study also align with previous research (Allen & Barber, 2015; DeRosier et al., 2010; Gol & Jarus, 2007). The results of this study demonstrate the importance and effectiveness of using an integrative approach which specifically included play techniques, as a way to increase social skills in children with a diagnosis of ASD, ADHD, or other related disorders, as well as those who display or present with social deficits. These findings can serve as a guide for future practitioners who wish to address and improve young children's impairments in social functioning.

Conflict of Interest: none declared.

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Appendix A

Diagnostic Criteria for ADHD and ASD

Table A1

Diagnostic Criteria for ADHD

Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

A. A persistent pattern or inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities.
    a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities.
    b. Often has difficulty sustaining attention in tasks or play activities.
    c. Often does not seem to listen when spoken to directly.
    d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.
    e. Often has difficulty organizing tasks and activities.
    f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.
    g. Often loses things necessary for tasks and activities.
    h. If often easily distracted by extraneous stimuli.
    i. Is often forgetful in daily activities.
2. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:
    a. Often fidgets with or taps hands or feet or squirms in seat.
    b. Often leaves seat in situations where remaining seated is expected.
    c. Often runs about or climbs in situations where it is inappropriate.
    d. Often unable to play or engage in leisure activities quietly.
    e. If often "on the go," acting as if "driven by a motor).
    f. Often talks excessively.
    g. Often blurts out an answer before a question has been completed.
    h. Often has difficulty waiting his or her turn.
    i. Often interrupts or intrudes on others.

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more setting.

D. There is clear evidence that the symptoms interfere with, or reduce the quality of social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and not better explained by another mental disorder.

Note: Reprinted from American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5.* Arlington, VA: American Psychiatric Publishing.

Table A2

Diagnostic Criteria for ASD

Diagnostic Criteria for Autism Spectrum Disorder

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive):
   1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
   2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
   3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

   Specify current severity:

   Severity is based on social communication impairments and restricted, repetitive patterns of behavior

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):
   1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
   2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
   3. High restricted, fixated interests that are abnormal in intensity and focus (e.g., strong attachment to or reoccupation with unusual objects, excessively circumscribed or preservative interests).
   4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

   Specify current severity:

   Severity is based on social communication impairments and restricted, repetitive patterns of behavior

C. Symptoms must be present in the early developmental period.

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability or global developmental delay.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder.

Note: Reprinted from American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5.* Arlington, VA: American Psychiatric Publishing.