

2005

# Child-Centered Play Therapy with Deaf Children: Exploring Linguistic and Cultural Implications

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Running head: CCPT WITH DEAF CHILDREN

Child-Centered Play Therapy with Deaf Children: Exploring Linguistic and Cultural Implications

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## Acknowledgements

To Gary and Brendan, my ever-loving and patient family,  
to my loyal and encouraging friends,  
and to the Deaf people in my life, both friends and clients,  
who continue to teach me how to see.

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### Abstract

This paper describes an exploratory study of a fifteen-week program of child-centered play therapy provided to four deaf children by a hearing therapist fluent in sign language. Historical and contemporary perspectives on Deaf culture and American Sign Language (ASL) are described, along with implications for appropriate mental health services. Discussions of the behavioral and emotional health of deaf children and child-centered play therapy provide context for the study. Methods and procedures are detailed, followed by results obtained from the Behavior Assessment System for Children, the Roberts Apperception Test for Children, and therapist observation. Overall, the results were not statistically significant, however two of the children improved on some measures, and therapist's observations indicated that those children were progressing through the stages of play therapy at the time the study was concluded. Upon analysis of therapist-child interactions, it was concluded that the divided attention phenomenon of visual languages may impact the delivery of child-centered play therapy. Further study of the cross-cultural implications of child-centered play therapy are recommended.

## Child-Centered Play Therapy with Deaf Children

The past thirty years have brought a surge of interest in the field of mental health treatment for deaf adults (Anderson & Watson, 1985; Glickman & Harvey, 1996; Gough, 1990; Harvey, 1989; Leigh, 1999; Vernon, 1984; Pollard, 1996; Sussman, 1988; Sussman & Brauer, 1999), and in studies of the emotional and psychological development of deaf children (Calderon, R. & Greenberg, 2003; Greenberg & Kusché 1989; Marschark, 1993; Marschark & Clark, 1993-1998; Meadow & Dyssegaard, 1983). These studies have found that deaf children are at increased risk for cognitive, emotional and behavior delays, in large part due to a combination of effects from parent and peer interactions, the educational environment, and inhibited access to incidental learning (Hindley, 2000; Greenberg & Kusché, 1989). Under these circumstances, it appears that deaf children often struggle to develop self-acceptance and a secure identity (Calderon & Greenberg, 2003).

Although behavioral and cognitive-behavioral approaches have been suggested as efficacious interventions for use with deaf children (Calderon & Greenberg, 2003; Greenberg & Kusché, 1993), the problematic issues of identity and self-acceptance may be well suited to the benefits that have been claimed by client-directed approaches such as child-centered play therapy (CCPT) (Axline, 1947; Guerney, 1983; Landreth, 2002). Several studies have explored the efficacy of CCPT with deaf children (Oulline, 1975; Sisco, Kranz, Lund, & Schwarz, 1979; Troester, 1996; and Landreth 2004), however, none of these included descriptions of the unique historical, cultural, social, developmental and linguistic implications of working with deaf children in that modality. Previous research on the topic has also overlooked the potential of cross-cultural effects between hearing therapists and deaf children, who may view the world from significantly different socio-cultural and linguistic frames of reference (Corker, 1994;

Glickman & Harvey, 1996; Pollard, 1998). The purpose of the current study was to explore the linguistic and cultural implications of working with deaf children in the CCPT modality, and to assess the efficacy of a treatment that had as its aim sensitivity to those issues.

### Review of Literature

The following sections provide an overview of germane topics in deafness and psychology in order to establish the context for this study. A section orienting the reader to the history of pathological perspectives on deafness is followed by an argument for a cultural perspective, including descriptions of some important features of Deaf culture and language. Then, applications of the cultural perspective to mental health services are discussed, and literature describing the particular concerns of deaf children is presented. A brief overview of play therapy is then presented, concluding with a discussion of the applicability of child-centered play therapy for deaf children.

### *The Deaf Community*

#### *The Pathological Perspective: A Long Legacy*

For hundreds of years, deaf people were widely believed to be intellectually inferior to hearing people, a belief justified by Aristotle's assertion that deaf people's inability to speak and hear prohibited them from developing intellectually beyond the capacity of animals (Pollard, 1993). The manual gestures, facial expressions and body movements that deaf people use to silently "speak" was assumed, even by deaf people themselves, to be "an unsophisticated communication pattern of mimed pictures in the air, or perhaps a crude representation of English" (Pollard, 1996, p.390).

The field of psychology has been at least as susceptible as popular culture to biases and false assumptions regarding deaf people. For years, many professionals in the mental health field

assumed that “deaf persons were somehow destined to psychopathology by virtue of their hearing loss alone or by the use of sign language” (Pollard, 1996, p. 390-391). Assessment tools that were standardized to the experiences of hearing people and heavily reliant upon fluency in English frequently appeared to provide empirical evidence that the condition of deafness carried with it co-morbid disturbances in social, cognitive, emotional, and behavioral functions (Lane, 1999; Pollard, 1993). The bias in this approach was recognized as long ago as 1929, when psychologist and researcher Rudolph Pintner advocated for the use of more appropriate testing methods (Pollard, 1993). Also in the first half of the century, Heider & Heider (1941) argued that mental health professionals needed to understand the context of the deaf person, and to recognize the adaptive mechanisms that healthy deaf people use to adjust to their situation. It was, however, many years before psychology as a whole began to understand the implications of Heider and Heider’s relativistic conceptualization that what is “normal” varies according to the phenomenological reality of the person’s life. Working from an ethnocentric perspective, professionals in the field of deafness too often “superimpos[ed the] image of the familiar world of hearing people on the unfamiliar world of deaf people” (Lane, 1999, p. 37).

Psychological treatment for deaf people was limited commensurate to the degree that their capabilities were unrecognized: “The prevailing attitude at the time was that deaf people, due to their traditionally imputed deficiencies such as language difficulties, communication problems, lack of English skills, inability to reason on the abstract level, and personality issues, were not appropriate or feasible candidates for in-depth, insight-developing, affectively oriented, psychoanalytically oriented, and cognitively oriented psychotherapies” (Sussman & Brauer, 1999, p. 3). Noted expert in the field of deaf psychology, McCay Vernon (1967), suggested that it was best to keep interventions with deaf people at a concrete level, because “the immaturity



and the communication limitations of many deaf people often made abstract procedures a useless tour de force” (p. 10).

Prior to the late 1960s, American Sign Language (ASL) was not recognized as a legitimate language capable of communicating abstract or sophisticated ideas, and options for treatment with deaf people who used ASL were circumscribed accordingly. Vernon (1967), for example, rejected Rogerian psychotherapy for deaf people on the basis of his belief that ASL was not capable of expressing reflections or indicating unconditional positive regard and accurate, empathic understanding. Overall, the literature recommended directive interventions for the deaf population, “reflecting a view that deaf persons were psychologically and socially unsophisticated, inarticulate, and unable to engage in introspection or to benefit from therapies requiring reflection or insight” (Gutman, 2002).

The prevailing belief among mental health professionals that deaf people were unlikely candidates for psychotherapy, and the fact that there were very few, if any, among them who knew sign language or understood the special issues facing deaf people, effectively discouraged deaf individuals from seeking services from the psychotherapeutic community. Instead, deaf people usually turned to those to whom they had easier access: members of the clergy, teachers, coaches, rehabilitation counselors, and social workers (Gutman, 2002; Sussman & Brauer, 1999). Often, these helpers offered support by way of “advice, directions, instructions, lectures, and admonishments” (Sussman & Brauer, 1999, p. 3).

The attitudes of both the psychotherapeutic community and of these other helpers were commonly paternalistic; the deaf client was deemed incapable of determining the methods and goals of treatment, and hearing professionals felt justified in making decisions for, rather than with, the client. (Pollard, 1996; Sussman & Brauer, 1996; Lane, 1992). Such practices

frequently lead to two opposite but equally unfortunate results: clients either become habituated to dependency upon the helper, and abdicate independent decision-making, or they begin to avoid psychological services altogether rather than risk the loss of their independence, even when they recognize that help is needed (Gutman, 2002). Although the effects of these practices may still be seen in the deaf community, the last thirty years have brought political events, changing social norms, and advances in the fields of linguistics, sociolinguistics, and psychology that have begun to turn attitudes and practices in the field of psychology and deafness in a more enlightened direction.

### *The Cultural Perspective*

William Stokoe's groundbreaking linguistic analysis of sign language in the 1960's legitimized not only the language of deaf people, but by extension, the community of deaf people who used it (Pollard, 1996). Armed with newfound pride in their language, deaf people since that time have come forward to describe the well-adapted, psychologically healthy deaf individual's perspective (Corker, 1995; Jacobs, L; Leigh, et. al, 1996; Padden & Humphries, 1988; Sheridan, 2001). This emerging literature has given hearing people a new view of the positive aspects of deafness, allowing them to see, often for the first time, that "the deaf world has a beauty, a richness and a vibrancy which is at least equal to that of the hearing world, and certainly complementary to it" (Corker, 1995, p. xxvi).

There are approximately 28 million Americans who have a hearing loss (World Health Organization, 1997), two million of whom are audiologically deaf, meaning that their hearing loss prohibits effective communication through speech (Pollard, Miner, & Cioffi, 2000). This group is heterogeneous: the degree of hearing loss, the ability to speech read and speak, and educational and family experiences all vary tremendously, not to mention the multitudes of

communication preferences, described by Sussman & Brauer (1999) as a “dizzying array of variations and combinations” ranging from speaking and lipreading to ASL (p. 16). There are people who are audiologically deaf, yet use (with varying degrees of success) speech reading and speaking to communicate, and choose to interact primarily with people who can hear. There are others with a milder degree of hearing loss (perhaps even able, with the help of hearing aids, to use the telephone), who consider themselves culturally, socially, and politically Deaf (Hall, 1983). Following the tradition initiated by Padden (1980), a capital “D” is often used (and will be in this paper) to designate those who identify themselves as culturally Deaf (rather than simply audiologically impaired).

Many in the field of deafness have adopted Padden’s (1980) description of the difference between the culture of Deaf people and the larger community of deaf people:

...a deaf community has not only Deaf members, but also hearing and deaf people who are not culturally Deaf, and who interact on a daily basis with Deaf people and see themselves as working with Deaf people in various common concerns. The culture of Deaf people, however, is more closed than the deaf community. Members of the Deaf culture behave as Deaf people do, use the language of Deaf people, and share the beliefs of Deaf people towards themselves and other people who are not Deaf. (p. 92-3)

The legitimacy of a Deaf culture, although commonly accepted today, has not always been endorsed. Educators, for example, have argued that courses in ASL ought not to be accepted in fulfillment of foreign language requirements because deaf people are not an ethnic group and can not lay claim to specific ethnic foods, clothing, arts or folklore, the cultural identifiers that traditionally form the core of cultural studies courses (Corwin & Wilcox, 1985). The concept of culture, however, is unnecessarily constricted when it is identified with ethnicity:

Goodenough (1957) operationalized the term in a more useful way as “whatever it is one has to know or believe in order to operate in a manner acceptable to [a society’s] members” (p. 167). According to those criteria, Deaf culture, as described by Smith (1996), has a legitimate claim: “Deaf culture informs the way people work, the way they conceive of work, the meaning of work in their lives. It informs their conceptions and the meaning of family, relationships, time, space, and every other significant piece of a world view” (p. 2).

At a broad level, the values described by Padden (1980) and widely espoused by many who identify as members of Deaf culture are: a) a deep respect for American Sign Language, b) a disassociation from speech, c) a strong emphasis on social interactions with other Deaf people, d) enculturation through Deaf stories and literature, and e) pride in the Deaf way of life, i.e., a strong belief “that it is good and right to be Deaf” (p. 180). The first value listed above, the importance of ASL, cannot be overestimated; it is the primary marker of Deaf identity (Lane, 1999). Deaf people treasure sign language in a way that perhaps those of us who are allowed the luxury of taking our language for granted might not fully understand (Mindess, 1999). For over one hundred years, educators and others commonly prohibited the use of signs because they (erroneously) believed that the use of sign language undermined the acquisition of English (Lane, 1999). The perseverance of Deaf culture and the survival of American Sign Language is a matter of great pride to Deaf people, who commonly perceive the suppression of their language as the worst kind of oppression. It was not unheard of for educators in the days of strict oralism to punish children caught signing by hitting them with a ruler, or tying their hands behind their backs (Graybill, personal communication, 1990). As one 19<sup>th</sup> century Deaf educator lamented: “What heinous crime have the deaf been guilty of that their language should be proscribed?” (quoted in Lane, 1984). Many deaf people today have acclaimed their personal discovery of the

language, after years of frustration struggling to communicate through lip reading and speaking, as no less than liberation (Mindess, 1999). Theresa Smith (1996) has thus aptly called ASL the “jewel of the culture” (p. 297).

Another important feature of Deaf cultural identity listed by Padden, the pride taken in the “Deaf way of life” is intensified by the fact that it is, to a large extent, a chosen path. Unlike other cultures, Deaf culture is not typically passed down from parents to their offspring, due to the fact that approximately 90% of deaf children are born to hearing parents (Moore, 2001). As Trybus (1980) explained, deaf people, to a large extent, make a choice whether or not to identify with Deaf culture, although that does not mean the decision “is made easily or without significant influences and consequences” (p. 208). In the past, the choice was made, *ipso facto*, when parents sent their deaf children, often as young as three years old, to live in residential schools for the deaf, historically the center of Deaf enculturation (van Cleve & Coruch, 1989). At these schools, the Deaf identity was modeled and nurtured, not by teachers (the majority of whom have been, since the beginning of the 20<sup>th</sup> century hearing [Lane, 1984]), but by their peers, with crucial influence from the few Deaf children who had been exposed to the language and culture since birth by Deaf parents and/or older Deaf siblings (Smith, 1996). In more recent years, however, the choice to identify as a Deaf person has been made with more intention by increasingly older adolescents and young adults, as the passage of Public Law 94-142 in 1975, and the resulting push for the “least restrictive environment” in education encouraged the popularity of mainstreamed education for deaf children, and schools for the Deaf and their influence on enculturation have since dramatically diminished (Lane, 1999).

Glickman (1996) has identified four types of deaf identity along a continuum of enculturation into Deaf culture: a) culturally hearing, in which the individual subscribes to

hearing norms and views their deafness as a pathological condition, b) culturally marginal, in which the individual feels confused about his or her identity and does not belong to either the Deaf or hearing society, c) immersed in Deaf culture, in which the individual identifies strongly as Deaf, and idealizes the Deaf world while expressing anger towards hearing people, and d) bicultural, in which the individual embraces Deaf culture and also values interactions with hearing society, and accepts the strengths and weaknesses of both worlds (p. 51). Although generally deaf people move developmentally through these stages, life circumstances and opportunities may lead a deaf person towards either end of the continuum, as they search for the identity which suits them best at any given time in life (Leigh & Lewis, 1999).

The matter of “dissociation with speech” as a cultural identity marker has been complicated by recent technologies for improving audition, namely, cochlear implants. Although these devices may help profoundly deaf people make better use of their residual hearing as an aid to speech reading, and/or help them to become more sensitive to environmental noises, they do not, despite some promoters’ claims, make deaf people become “hearing” (Lane, 1999). The decision to surgically implant a deaf child with such a device has been interpreted as denying the child the freedom to choose to join the Deaf community and identify in a positive way as a Deaf person: “The family’s commitment to the implant process, the child’s program of speech and hearing training, whatever auditory benefit the implant provides, its visual appearance, and a likely delay in acquiring ASL, may all hinder the child’s developing an identity as a Deaf person” (Lane, 1999, p. 227). Understandably, then, the development of cochlear implants has been extremely controversial in the Deaf community, and has highlighted the value that Deaf people hold most dear, the inherent value of being Deaf (Padden, 1980).

The “Deaf way of life” is shorthand for a complex worldview that differs significantly from that of the hearing, dominant culture. These differences have been articulated since the 1970s by many sociolinguists, anthropologists, and linguists (Eldridge, 1999; Padden & Humphries, 1988; Smith, 1996). Table 1 lists many of the differences that have been identified over the years. Several have a significant bearing on the provision of culturally appropriate mental health services for deaf people, and thus bear explication in this paper.

*High context/low context*

E.T. Hall’s (1976) description of high context/low context cultures has been used in recent years (Mindess, 1999; Smith, 1996) as a helpful way to understand some of the more salient differences between deaf and mainstream hearing culture

Hall (1976) described a continuum ranging from low context to high context upon which any culture, or for that matter, any transaction between people, can be located. Placement on the continuum helps to elucidate cultural values and the dynamics of interpersonal communication. According to Hall (1976), a high context culture is one in which there is an assumption among the members that they share, to a large extent, similar values and beliefs, and consequently, very little information needs to be made explicit in the communication between them; the important information is either embedded “in the physical context or internalized within the person” (p.91). Members of a low context culture, by contrast, do not assume that others share a similar perspective to their own, and thus the bulk of information is made explicit in the transmitted message. Hall (1976) made it clear that “although no culture exists exclusively at one end of the scale, some are (relatively) high while others are low” (p. 91).

Smith (1996) and Mindess (1999) have noted that Deaf culture is much closer to the high context end of the continuum than mainstream American hearing culture. This is evident in many

ways, from the grammatical structure of the language to prevalent social norms. The high context nature of ASL grammar rapidly becomes apparent to the student of ASL when he or she discovers, often with considerable confusion, that pronouns in ASL are not gender specific, and verbs are not marked with tense. Mindess explained the implications of this feature of the language: “If you miss the beginning of an ASL conversation, you may be lost as to what person is being talked about and in what tense” (p. 48). As disorienting as the linguistic differences may be, the social implications of high context/low context orientations may have an even greater impact on interactions between the deaf and hearing cultures.

#### *Collectivism vs. Individualism*

As is typical for high context cultures, Deaf culture is collectivist, meaning that there is a greater value placed on the welfare of the group than in mainstream hearing society. One of the many implications of this difference is the importance of the distinction between who is an “insider” and who is not. Often, the qualifications for membership in Deaf culture are comparatively rigid; for example, children of deaf adults, interpreters, and students of sign language are typically welcomed, to varying degrees, to the circles around Deaf culture, but they do not normally enter the inner, center ring (Mindess, 1999).

For people from individualist cultures, where group memberships are generally more fluid (Hall, 1987), this norm can be perceived as a rejection; once, for example, when this writer was explaining the distinct boundaries normally observed around Deaf culture membership, a hearing participant stridently objected, saying that it was “unfair.”



Table 1

Comparison of English-speaking, Mainstream and Deaf Cultures

English mainstream	Deaf
Low context	High context
Individualistic	Collectivist
Future-oriented	Past or present oriented
Personal info is private	Personal info is public
Extreme time consciousness	Relationships more important than time
Book learning	Story telling
Possession oriented	People oriented
Touch and eye contact not common among acquaintances	Touch and eye contact common, even among acquaintances
Reliance on objective evidence	Reliance on subjective experience
Auditory access to communication	Visual access to communication
Pay as you go	Reciprocity
Indirectness	Directness

*Note.* Compiled from Eldridge, 1999; Mindess, 1999; Smith, 1996.

In a similar vein, Austen & Coleman (2004) described the tendency of the Deaf community to define clear boundaries as “out grouping,” a phenomenon they defined as a group’s tendency to “exclude people in an attempt to have a strong sense of identity in its ‘in’ group” (p. 14). A culturally relativistic perspective strives to depersonalize potentially sensitive issues such as insider/outsider status, and to understand them within the context of cultural

norms. Deaf culture is only one of many cultures that observe strict boundaries (e.g. Barbopoulos, Fisharah, & El-Khatib, 2002).

It must also be noted that Deaf identity is a complex phenomenon influenced by many factors. Pamela Rohring, a respected Deaf teacher and language specialist, described Deaf identity as being “in constant flux within the process of enculturation. This enculturation changes as we see ourselves ‘fit in’ in the Deaf and Hearing worlds when we interact with our hearing and deaf counterparts in different ways in a variety of associations” (quoted in Lane & Rohring, 2004).

Once someone in a collectivist culture has been accepted, there are generally high expectations of the member (Hall, 1976). Deaf culture is no exception (Mindess, 1999). An example of these expectations in Deaf culture is reciprocity, which Smith (1996) described as a social system in which members give both concrete and intangible support to one another in the group, under the assumption that there will come a time when they will be at the receiving end. As might be expected, members of a collectivist culture are often more involved than individualists in the lives of other in-group members (Hui & Triandis, 1986), a phenomenon that has been observed in the Deaf community (Smith, 1996). Perhaps particularly for Deaf people, who live in a world in which information is hard to come by, there is a perceived obligation to share news with one another. As Mindess (1999) describes, this obligation applies to “practically everything from the latest news to one’s own and others’ medical conditions and marital problems” (p. 88). Another, related aspect of Deaf culture is the predilection for direct speech: information and clear communication are at such a premium that one is expected to speak as plainly as possible (Mindess, 1999). In fact, “hinting and vague talk in an effort to be polite are

inappropriate and even offensive (Lane, 1992, p. 16). The potentials for cross-cultural misunderstandings between Deaf and hearing are obvious.

### *Language use*

In recent years, sign language and deaf people received more exposure than ever before in the media, and sign language classes have grown in popularity. Consequently, it has become fairly common for hearing people to know at least a few signs. Despite this fact, or, ironically, perhaps because of it, many hearing people do not appreciate the complexity of the language. It is commonly believed that ASL is similar to English, that it is like mime, that it is an international language, and/or that it is easy to learn (Pollard, 2004). Jacobs (1996) noted that people frequently assume that knowing the signs of ASL and using them in the order in which English is spoken constitutes competency in the language: in fact, these skills, although they may allow a certain level of communication with deaf people, are not sufficient to convey or comprehend the many subtleties of ASL. Jacobs (1996) cited multiple factors that establish a convincing rationale for categorizing ASL as a “truly foreign language” from the perspective of English speakers.

The most obvious difference between ASL and English, perhaps, is the fact that the former makes use of the visual rather than the auditory channel (as described above). There are many implications of this; prime among them is the need to be able to see those who are talking, or what is referred to as line-of-sight. As one might guess, line-of-sight, and the use of a visual language in general, affect turn-taking and communication patterns (Spencer & Hafer, 1998). This creates some interesting advantages for deaf people, as line-of-sight can sometimes be established when speech is ineffective: through closed windows, for example, or in a noisy crowd. Line of sight also affects cultural norms of proximity, as communication is enhanced

when one steps a bit back from the distance normally assumed by mainstream hearing conversants in order to keep in view the whole upper body and arms of the person who is signing (Mindess, 1999).

Another implication of reliance on the visual channel has been called the issue of “divided attention” described by Lederberg (1993) as “the fact that deaf people have to shift their attention from the environment to the communicator” (p. 94). Adams & Rohring (2004) noted four effects of divided attention, particularly as hearing people are faced with the phenomenon (the first two of which were adapted from Lederberg [1993]): a) the amount of interaction and communication between deaf people and their communication partners is decreased for a given time period, b) hearing people are prone to be less responsive to the deaf person’s attentional focus, c) the amount of time it takes to communicate when competing with the environment is increased, and d) hearing people not used to the natural constraints on visual communication may often become frustrated (p. 66). A significant implication for therapists working with deaf people is the need to be sensitive to communication adaptations required by line of sight and divided attention considerations.

Although divided attention may extend the time needed for communication when there are environmental cues that vie for attention, this is not to say that, in general, ASL is a more time consuming language than English. It is true that individual signs, formed as they are by large limbs of the body, may take longer to articulate than words, which are formed by the relatively tiny articulators of the mouth and tongue. However, ASL takes advantage of the medium of space by layering information, compared to English, which presents information in a much more linear fashion (Lane, 1999). One way that this happens is through nonmanual facial markers. In ASL, nonmanuals are used not only to indicate emotion (as is common across

spoken languages), but also for grammatical purposes. These, as Jacobs (1996) described, are exceedingly difficult to master, as facial expressions in ASL are used in very subtle ways to mark such complex linguistic features as topic/comment structure, relative clauses, adjectives and adverbs, pronouns, and turn-taking. All of this is conveyed simultaneously with other grammatical information, as opposed to English, which frequently adds suffixes, prefixes, and/or additional words in a linear fashion to provide that kind of information.

Another particularly foreign feature of ASL is the part of speech that has been termed “classifiers.” Classifiers are a specific category of signs with no corollary in English; although they can serve as prepositions, adjectives, adverbs and/or nouns (Humphrey & Alcorn, 1994). Highly descriptive, classifiers are sophisticated devices that succinctly capture dense amounts of information. One classifier, for example, moved in a certain fashion and modulated by nonmanual grammar, can simultaneously convey the size of a person, his or her mood, and the speed, manner and direction of their ambulation. ASL relies heavily upon classifiers, and they comprise the most difficult aspect of ASL for English language users to master (Wilcox and Wilcox, quoted in Jacobs, 1996).

More broadly, the discourse of ASL differs significantly from that of English. That is to say, the ways that culturally Deaf people select and organize the elements of language to convey information, to make a point, to persuade, and to share feelings are in many ways foreign to English speakers. Humphrey & Alcorn (1994) described the discourse style of ASL as “narrative, descriptive, high context, and time-sequenced” (p. 35).

“Descriptive,” according to Humphrey & Alcorn (1994) indicates the degree to which Deaf discourse emphasizes the “visual and kinesthetic” aspects of a given event. The detailed description of people and objects is required for high-context language users (Humphrey &

Alcorn, 1994). In addition, these descriptions are often “time-sequenced,” meaning that the retelling of the events correlates to the sequence in which the events originally occurred. Thus, responses to questions often become long, involved stories that include description of events prior to or following the event in question, the familial relationships of all involved, and background information and physical descriptions of the players. This discourse style may try the patience of hearing listeners unaccustomed to listening to such detailed descriptions, or worse, lead to clinical suspicions of tangentiality or other thought disorders. However, for Deaf people, this degree of description is necessary to establish context, and it is “the context [which] is the point” (Smith, 1996, p. 307). Another difference between the discourse of ASL and that of English is the degree of repetition; in ASL, themes and opinions are frequently repeated many times, which “may appear suspect to a hearing clinician unfamiliar with Deaf usage” (Kitson & Thacker, p. 86).

The above description of ASL does not, of course, describe the language of all deaf people. As mentioned earlier, some deaf people primarily use ASL, while others speak and use speech-reading skills to communicate. Still others rely on sign systems invented by educators to teach English; these typically borrow most of their signs from ASL, and invent additional signs to represent English grammatical features (such as suffixes and prefixes), and combine them to follow the syntactic structure of English sentences (Humphrey & Alcorn, 1994). Additionally, users of ASL cannot help but come in to frequent contact with the English language, and depending on their educational experience and degree of enculturation, borrow more or less extensively from the syntax and vocabulary of English. Often, Deaf people who use ASL among themselves “code-switch” to more English-like signing when speaking with hearing people, a variety of sign language that has been termed Pidgin Signed English, or PSE (Woodward, 1982).

Code switching may occur for several reasons: a) to minimize misunderstandings between Deaf and hearing people not fluent in ASL, b) because certain topics are associated in the speaker's mind with the English language, c) because English is the language of power in the majority culture, and thus perceived as advantageous to use in certain contexts, and d) to protect ASL from being co-opted by the hearing majority (Woodward, 1982).

### *Minority status*

The Deaf community, newly defined as a legitimate minority group, has just begun to articulate for themselves issues that traditional minority groups have grappled with for years, including autonomy and power vis-à-vis the majority culture, self-definition, and conflicts about the desirability of enculturation (Pollard, 2004). Barnett (1999) has articulated the many similarities that the Deaf community shares with other linguistic minority groups:

#### Social Similarities:

1. Use of a non-English language,
2. Socialize and marry within their own communities, and
3. Subscribe to different cultural norms than those of majority culture.

#### Power Inequities:

1. Lower educational levels, socioeconomic status, and literacy levels,
2. Often encounter prejudices that limit opportunities,
3. Limited access to English-based information.

#### Health care:

1. Infrequently encounter a professional from their own cultural group, and
2. Language differences and health care knowledge are frequent barriers to appropriate

care (Barnett, 1999, Table 1).

These similarities do not imply, however, that the experiences of Deaf people correlate perfectly with those of other minority groups. Woodward (1982) pointed out that the Deaf community has had to suffer additional pressures not experienced by other minority groups: a) stereotyping has been reinforced by the professionals' view of deafness as a medical pathology, b) positive identification as a Deaf person has been made more difficult by the fact that the majority of Deaf children belong to a different cultural group than their parents, and c) the primary language of deaf people differs not only in code structure but in channel [as described above].

In 1973, legislation was passed that dramatically increased the number of programs and services accessible to all disabled people, including deaf people (Rehabilitation Act of 1973). The issue of whether or not deaf people are, in fact, disabled, is a highly sensitive one in the Deaf community; most individuals who identify themselves as culturally Deaf are offended at the label (Austen & Coleman, 2004). Be that as it may, the legislation on the whole has afforded deaf people a potential increase in access to mental health services.

#### *Implications for Mental Health Treatment*

Although, as noted above, there has been a historical tendency to confound hearing deficit with intellectual deficits and psychological pathology, it is now well recognized that the majority of deaf adults are mentally and emotionally healthy (Pollard, 1996). The actual prevalence of mental health problems in the deaf population is still under question. Some studies have indicated that the incidence of mental health problems in the deaf community may be larger than that in the larger majority culture (Vernon and Daigle, as cited in Pollard, 2003), while others (Kitson & Thacker, 2000) suggested that the numbers, at least for certain disorders, may be smaller.



More and more, professionals recognize that many deaf people are members of a cultural minority, and that there is positive value for Deaf individuals in their identification as members of that culture (Glickman, 1986; Glickman & Harvey, 1996; Lane, 1992; Pollard, 1992; Sacks, 1989). There is also a greater understanding of the multiple contexts that affect the psychological development of deaf individuals. Clark (1998), for example, has advocated for an ecological perspective, in which the deaf individual is understood within the context of various, interacting systems, namely, microsystems (including school, peer, and family systems), exosystems (including social and economic systems), and macrosystems (i.e. historic events and cultural beliefs). With recognition of all the variables that can affect deaf people comes the responsibility of providing sensitive, competent, and ethical assessments, programs, and treatments. This does not imply that a new psychology needs to be created specifically for deaf people (Sussman & Brauer, 1999), but rather that clinicians need to strengthen, adapt and expand their existing skills and knowledge base in order to serving deaf people well. Towards this end, Sussman & Brauer (1999) have identified ten qualifications that therapists must possess in order to work effectively with this unique population:

1. The ability to communicate
2. Therapist credibility
3. Belief in depathologizing deafness
4. Validating Deaf clients' experience
5. Refusal to label Deaf clients
6. Recognizing countertransference issues
7. Belief and faith in mode of therapy
8. Learning from failure

## 9. Empathy

## 10. Humor

The ability to work effectively with any population depends largely on one's success in gaining their trust and respect. The qualifications above are, for the most part, attitudes and skills that a therapist may develop in an effort to gain the trust and respect of the Deaf community, listed above as "therapist credibility." Credibility, however, is a complicated construct; it differs from the other qualifications in that it is not under the direct control of the therapist. Rather, credibility in this context is bestowed upon a professional by the deaf community. Pollard (1996) has coined the term "cross-cultural legitimacy" (p. 393) to describe this phenomenon.

*Cross-cultural legitimacy*

Cross-cultural legitimacy may be particularly important to the community of deaf people because they have suffered such a long history of oppression. For decades, they have been subject to psychological services administered by professionals who, though qualified in their fields, have been largely ignorant of the special issues pertinent to deafness, and even worse, unable to communicate effectively with deaf people. This has resulted in countless misdiagnoses over the years. The history of deaf people is rife with stories of deaf people who have been institutionalized for mental disorders when, in fact, the only thing that wasn't "normal" about them was their hearing (Lane, 1999). Current ethical standards have evolved out of the increasing acceptance of deaf people as members of a minority culture, and the pursuant application of cross-cultural ethics (Pollard, 1992). They encourage mental health practitioners to earn legitimacy from the deaf community through "consistent and culturally appropriate interaction with persons who are deaf" (Pollard, 1996, p. 393). The gifts of sign fluency and cultural legitimacy "constitute an investment" by the deaf community in the hearing practitioner,

who is expected to return these favors, in some measure, through the provision of competent and effective care (Pollard, 1996, p. 393). Adherence to this expectation is a sign of respect not only for professional standards of ethics, but also for the system of reciprocity described earlier, and thus respect for a core value of Deaf culture.

The ability to communicate with one's client, the first step in obtaining legitimacy, and the number one skill listed in Sussman & Brauer's (1999) list of qualifications, may seem to be an obvious requirement for any kind of therapy. As Harvey (1989) emphasized, in order to join with the client, the therapist must take care to use the same communication mode as the client uses (whether it be Signed English, PSE, or ASL). However, because of the scarcity of clinicians who can sign (Myers, 1995), deaf people often settle for services delivered by therapists who do not know their languages. Treatment in these cases is often facilitated by an interpreter, a practice which Sussman & Brauer, (1999) have argued "dilutes and distorts the usual one-to-one relationship" between therapist and client (p. 15), although it is admittedly far better than communicating through written notes (a practice which, disconcertingly, still occurs). The therapeutic relationship is disturbed on several counts, perhaps most obviously by the divided attention phenomenon discussed earlier. Divided attention in therapy drastically affects the amount of eye contact possible between therapist and client. Consequently, when communication is mediated through an interpreter, the therapist's ability to utilize personal characteristics and interpersonal techniques is significantly reduced (Sussman & Brauer, 1999).

Beyond the issues related to client's trust and comfort in the clinician, the use of an interpreter does not necessarily resolve the problem of communication between therapist and client. Despite interpreters' general commitment to interpret faithfully and accurately, Marcos (1979) identified three types of distortion that may occur in an interpreted psychiatric situation:

a) distortions associated with the interpreter's lack of language competence and translation skills, b) distortions associated with the interpreter's lack of psychiatric knowledge, and c) distortions associated with the interpreter's attitudes and opinions about the clinician's work. Identifying the potential problems of using an interpreter does not imply, however, that the practice completely invalidates therapy. Many deaf clients have undoubtedly benefited from interpreted treatment.

One way to mitigate the inherent problems is to ensure that therapists, interpreters, and consumers are aware of the possible pitfalls. To improve the quality of interpreted mental health care, there have been efforts to train interpreters in the special skills needed in the mental health setting, including topics such as transference, facilitating therapeutic alliance, and the challenges of translating the dysfluent utterances of clients with thought disorders (Harvey, 1997; Pollard, 1998). According to these models, therapy progresses most effectively when interpreters and therapists work closely as a team, each keeping the other informed of their respective areas of expertise as they relate to the case at hand.

Reports of the opinions of Deaf people have indicated that, when given the choice, they prefer direct communication with either a Deaf therapist or a hearing therapist fluent in sign language (Brauer, 1990). One study (Steinberg, Loew, & Sullivan) found that a majority felt that signing skills were more important than excellence in counseling skills, although the preference was not universal; a significant number stated that they would choose a counselor with specific skills related to their area of concern. In the reviews summarized by Brauer (1990), Deaf people ascribed fewer positive qualities to those hearing therapists who, though experienced working with Deaf people, still relied upon interpreters, than to less experienced therapists who used interpreters. Brauer (1990) attributed this finding to Deaf people's distrust of professionals who earn a living working with Deaf people, yet fail to make the effort to learn how to communicate

with them. It could be that cultural legitimacy is withheld in these cases because the practitioners are perceived to have violated the reciprocity norm.

Apart from the crucial issue of communication, the Deaf community's willingness to confer cultural legitimacy depends a great deal on what is often called "attitude," an overarching term that indicates the degree to which a hearing person is willing to validate and embrace the cultural norms of Deaf people. The qualifications enumerated above as "belief in depathologizing deafness, validating Deaf clients' experience, and a refusal to label Deaf clients," are descriptive of some of the elements of a good "attitude." They also refer to a therapist's understanding of how healthy Deaf people function, without which it is impossible to gauge a Deaf client's psychological health (Sussman & Brauer, 1999). Lacking such an understanding, hearing therapists may erroneously label "normally different" characteristics of deaf people as psychopathological (e.g. mistaking animated signing for affective lability, or dysfluent English writing for a sign of psychosis) (Pollard, 1998, p. 172).

Another aspect of "attitude" that has an impact on a clinician's legitimacy in the Deaf world has to do with the concept of insider/outsider status, as described previously. Deaf people are keenly aware of the degree to which individuals affiliate with the Deaf community: how often they attend Deaf events, support Deaf causes, and generally socialize with Deaf people. Trust is hampered when a professional is perceived as an outsider, with no connection or allegiance to the Deaf community. The importance of cultural affiliation is evidenced in a book on psychotherapy with culturally diverse Deaf clients edited by a Deaf psychologist and respected authority on deafness, who in the description of the contributors is careful to mention whether or not each is hearing or deaf, is the child of deaf parents, or even, as is the case with one author, has a hearing loss that "fluctuates" as a result of an illness (Leigh, 1999). The

obvious implication is that the number of authors with strong affiliations to the Deaf world lends legitimacy to the work.

Personal involvement in the community, however, may become a double-edged sword, as professional ethics and the respect for Deaf clients' privacy dictate that confidentiality and professional boundaries be observed (Gutman, 2002). Deaf clients have been known to refuse to see Deaf therapists due to the fear that their privacy may be compromised when they inevitably encounter their therapist at Deaf social events (Sussman & Brauer, 1999). It can be challenging for therapists working in the Deaf community to achieve the delicate balance between status as a member of the community and professional boundaries. Multiple relationships within the small Deaf world are common, even unavoidable, and it is incumbent upon the professional to insure that the best interests of the client are maintained while navigating these relationships (Gutman, 2002).

The necessary qualifications for therapists working with deaf clients include an understanding of audiological, developmental, educational, vocational, and legal issues, as well as the linguistic and cultural norms of the deaf community discussed above (Pollard, 1996). Knowledge in all of these areas allows an appreciation for the ways in which mental, emotional, and behavioral pathologies can appear differently in deaf people. For example, O'Rourke & Beail (2004) mentioned that "a glance away in a hearing person may be of little significance, but, in a Deaf person, it means they are no longer 'listening' and are cutting themselves off," (p. 351) or possibly even responding to internal stimuli.

Sussman & Brauer (1999) also cautioned that therapists working with deaf people need to be sensitive to the special considerations of the various subcultures within the deaf community. Although these will not be covered in depth in this paper, suffice it to say that most of the

subcultures of the larger hearing community have their representatives in the deaf world, including ethnic minorities, gays and lesbians, the elderly, and people with multiple disabilities, each with their own concerns in addition to and often interacting with their identity as a deaf person.

### *Treatment, testing, and research*

#### *Treatment*

After a long history of limited treatment options, the scope of treatments seen as appropriate and efficacious for deaf people has finally begun to widen (Pollard, 1998; Sussman & Brauer, 1999). Attitudes informed by cultural relativism have allowed clinicians to see that the reasons for ruling out diverse treatments for deaf patients may have been due to their own lack of awareness, and that “the reported and observed difficulties and failures in psychotherapy with deaf clients often reflected the therapist’s skills and attitudes rather than the imputed or stereotyped limitations of the deaf client” (Sussman & Brauer, 1999, p. 5). As practitioners have embraced a cultural rather than a pathological perspective of deaf people, and as they have learned more about the ability of ASL to convey subtle and complex communication, they have begun to realize that previously discarded treatment modalities may in fact be singularly well-suited to the deaf population. Sussman & Brauer (1999), for example, concluded that, far from ruling out client-centered treatment for a deaf patient, the Rogerian approach is in many ways “made to order for ASL” (p. 4). To date, a wide range of psychotherapeutic methods have been demonstrated as not only possible, but effective, with deaf people, including psychoanalysis (Fernando, 2004; Levin, 1981), Adlerian therapy, cognitive therapy, and rational-emotive therapy (Anderson & Watson, 1985; Gough, 1990; Sussman, 1988), and family systems therapy (Crocker, 2004; Harvey, 1986). Much of the literature exploring the effectiveness of various

treatment options has consisted of case studies or reports of treatment programs with small patient numbers; to date there has been little empirical evidence of treatment outcomes (Pollard, 1998). One criticism that has been made of these studies is that they are largely adaptations of existing treatments, applied under the premise that deaf and hard of hearing individuals will benefit from treatments created for use with hearing people (Pollard, 1998). As the number of practitioners with expertise in the field of deafness slowly grows, especially those who are deaf themselves (Pollard, 1996), we may see new forms of treatment developed specifically for use with deaf clients begin to emerge.

One of the recent innovations in mental health care for the deaf community has been programs designed specifically for deaf people. Although there are clear advantages of such program in terms of cultural sensitivity and communication accessibility, these may come at a steep price. Program designers must balance these advantages with the risks of funneling deaf people of varying diagnoses into a one-size-fits-all treatment model (Pollard, 1994, 2003). Obviously, delivering appropriate, competent, and culturally sensitive treatment is a complicated endeavor, with many subtle and complicating issues to be addressed.

### *Testing and Research*

Practitioners must give careful thought to the appropriateness of assessment tools and administration if they are to avoid the rampant misdiagnoses of deaf people common in years past. Pollard (1992) has identified five factors that are important to consider when utilizing psychological measurements for deaf people: “purpose or goodness of fit to the evaluation question, the way the instructions are conveyed, the nature and content of the items or tasks, the response modality, and the scoring methods and norms” (p. 97). The difficulties these considerations raise for mental health practitioners has been aptly described by Lane (1999): “if



they change the procedures and language so that the deaf person understands the test, then they cannot compare the results to the norms obtained with hearing people and thereby evaluate their client. But if they do not adapt the test for their deaf client, the deaf person's scores do not represent a true picture of their knowledge or state of mind" (p. 52).

Cross-cultural practices also extend to research, in which professional standards dictate, among other things, that researchers work in collaboration with the host community and insure that the researchers' agenda, purpose, methodologies are in concordance with the values and best interests of the host community (Pollard, 1992). In concurrence, Clark (1998) suggested that research understood as for or about deaf people is inappropriate; current ethical practices demand research that is "in relation to the context in which specific deaf groups find themselves" (p. 306).

The issue of informed consent is one area of testing and research that is particularly sensitive when working cross-culturally with deaf people (Gutman, 2002; Pollard, 1992). Not only must the professional be able to communicate clearly the pertinent risks and benefits, but he or she also must consider that deaf people may be more vulnerable to exploitation because of the traditional power differentials that exist between the hearing majority culture and the deaf minority (Gutman, 2002).

The commitment to conducting appropriate research, providing the most effective and appropriate treatment, and making ethical decisions regarding assessments for a group that is culturally different from one's own may be best accomplished with an attitude of "cultural humility" (Tervalon & Murray-Garcia, 1997). The term captures the essence of what it means to work as partners with the client, being willing to engage in self-reflection and self-critique, and

to remain “flexible and humble enough to say that they do not know when they truly do not know (Tervalon & Murray-Garcia, 1997, p.119).

Although the last thirty years have seen significant advances, mental health services for the deaf community are still severely limited by the lack of hearing professionals with specialized training, as well as the lack of deaf professionals trained in the mental health field (Pollard, 1996). Although there has been some preliminary data gathered regarding the efficacy of specific treatments for deaf people, cross-culturally appropriate research in this area has just begun. These issues also affect the mental health care of deaf children, despite years of professional inquiry into the topic.

#### *Deaf Children.*

The tremendous amount of research in the field of social, emotional, psychological and cognitive development of deaf has yielded varying accounts of the incidence of disturbances among deaf children as compared to hearing children, ranging from rates two to five times greater in prevalence (Greenberg & Kusché, 1989; Hindley, 2000; van Eldik, Treffers, Veerman, & Verhulst, 2004). These discrepancies may be due in part to the methods of assessment; Hindley (1993) reported that measures sometimes included speech related items, rendering them unreliable for children who do not hear. Other research has been beset by methodological flaws. Lane (1999), for example, found that the numbers of hearing children used as a comparison group in an oft-quoted study by Meadow (1983) were artificially low. Lane (1999) also suggested that teacher reports, often used as assessment tools in studies of deaf children, may be too subjective to serve as accurate measures of children’s dysfunction, and also that the numbers of disturbed deaf children may be inflated because some school districts receive increased funding as the numbers of children with emotional and behavioral problems rise. Van Eldik,

et.al, (2004) argued that assessments of the mental health functioning of deaf children need to include a variety of informants, including deaf children themselves. The wisdom of this recommendation is reinforced by a review of the research by Hindley (2000), in which he found that studies using parent/teacher reports found a “preponderance of conduct disorders,” but when the children themselves were questioned, they reported anxiety as the primary problem. Greenberg & Kusché (1989) described another difficulty with interpreting research results conducted over the last thirty years: the characteristics and life experiences of deaf children have changed significantly during that time, and thus the cohort effect has a considerable impact on results, a serious problem when a limited number of research findings are generalized to the greater population of deaf children.

Although the exact numbers vary considerably, it is clear that, as a group, deaf children are at increased risk for social, behavioral, cognitive and/or emotional difficulties, although it is widely understood that deafness itself is not the cause (Bond, 2000; Greenberg & Kusché, 1989; Hindley, 2000). There are several reasons for the phenomenon. One is the higher incidence of multiple disabilities among those who are deaf than in the hearing population; some percentage of the numbers of disturbed deaf children are better explained by the secondary diagnosis (Bond, 2000). Also, the deaf child’s repeated exposure to negative and discriminatory attitudes towards Deaf people may lead to a lowered sense of self esteem, which in turn may set in motion other emotional and behavioral problems (Hindley, 2000). Additionally, deaf and hard of hearing children appear to be at greater risk for maltreatment and sexual abuse (Kennedy, 1990; Sullivan, P.M. & Knutson, J.F., 1998), which also increases the numbers of those who experience other difficulties. However, there is an abundance of evidence that the primary reason that deaf children may develop social, cognitive, emotional and behavior problems is related to

communication disturbances (Greenberg & Kusché, 1989), which might be considered the real disadvantage of being deaf. Deafness as a communication disorder resides not within the children who cannot hear, but in the impaired ability of the world around them to respond adequately to their communication, educational, and social needs.

### *Communication disturbances*

There are many areas where this mismatch of communication between the deaf child and his or her environment manifests, including: a) interactions with parents and siblings, b) educational environment, and c) access to incidental learning (Hindley, 2000; Greenberg & Kusché, 1989).

### *Parent/child interaction*

van Eldik, Treffers, Veerman, & Verhulst (2004) cited various research studies that have found correlations between emotional/behavioral problems in deaf children and parenting issues, including a) difficulties parents have in accepting their child's deafness, b) communication problems between parents and their deaf child, and c) family stress and mental health dysfunctions. Ninety percent of deaf children are born to hearing parents (Moore, D., 2001), a fact that creates a dilemma for many deaf children, in that their parents cannot be the ones to induct them into the linguistic and cultural minority of people who share their experiences of deafness (Calderon & Greenberg, 2003).

Hearing parents, when they find out that their child is deaf, typically enter a period of shock, disorientation, and grieving, and often feel a confused mix of emotions including anger, guilt, disappointment, which may translate to ambivalent, confused behavior towards the child (Mindel & Vernon, 1971; van Eldik, Treffers, Veerman, & Verhulst, 2004). Unfortunately, this parental crisis frequently coincides with the child's entry into the stage of separation-

individuation, making it difficult for the child to successfully transition through the stage (Altshuler, 1974). The inability to communicate with one's deaf child may continue for many years, even as the child reaches adolescence and adulthood. Lane, Hoffmeister, & Bahan (1996), for example, found in one school for the deaf that only one parent in ten could communicate well with his or her own child. The deaf child may also inadvertently serve as a screen for the projections of family or marital problems (Altshuler, 1974), a dynamic that potentially affects the deaf child in a multitude of detrimental ways.

For several reasons, Deaf parents commonly react differently than hearing parents do to the news of their child's deafness; a) they may have expected the diagnosis, and b) they tend to have a much better understanding of what deafness implies, including a schema for how one can achieve a successful life as a deaf person, and c) they may even be pleased to learn that their child will share identity as a deaf person and become a member of the same community. A deaf child born to Deaf parents has the tremendous advantage that the parent-child interaction is uninhibited by language differences (Schlesinger & Meadow, 1972). Deaf parents appear to instinctively take into account the potentially problematic phenomenon of divided attention, and use touch adaptations of sign language, including signing on their infant's body and shifting signs into a more visually accessible space, all accommodations that facilitate early parent-child interaction and attachment (Hindly, 2000). As a result of these advantages, there are likely to be less social-emotional-behavioral problems later on among those children: Bond (2000) cited a 1969 study by Vernon in which it was indicated that only 10% of deaf children of deaf parents exhibit behavioral problems, compared to 18-30% of deaf children of hearing parents.

Schlesinger & Meadow (1972) reported significant differences between the parenting practices of (hearing) mothers of deaf children as compared to mothers of hearing children; the

former tended to supervise their children more closely, were more didactic, less permissive and flexible, and demonstrated a restricted range of disciplinary methods. Also, these parents, due to communication difficulties, may more frequently “take on” their children’s problems, leaving the children with less opportunity to resolve their own issues (Calderon & Greenberg, 2003).

Hearing parents of deaf children also tended to expend more energy on establishing communication and teaching language (i.e. English/speechreading), rather than on simply talking or playing together, a pattern of interaction that “may tend to encourage dependency and inhibit independent thought (Altshuler, 1974). The concentration and stress on (English) language development does not, unfortunately, prove to effective for most deaf children. Sisco, Kranz, Lund, & Schwarz (1979) cited several studies that suggest “most deaf children begin school with little or no vocabulary or grasp of syntax” (p. 852).

In contrast, Greenberg & Kusché (1989) described a study that suggested that Deaf parents of deaf children treat their children very similarly to the ways that hearing parents treat their hearing children; their interactions were “complex and reciprocal,” suggesting again that “deafness per se does not lead to qualitatively poorer parent-child interaction” (p. 115).

### *Educational environment*

There has been longstanding controversy within the field of deaf education regarding the most appropriate and effective way to educate deaf children (Austen & Coleman, 2004; Lane, 1999; Lang, 2003; Pollard, Miner, & Cioffi, 2000). Currently, 7 out of 10 deaf children are placed in mainstream environments, where their teachers may not sign at all and often do not know much about the deaf experience (Lane, 1999). Using interpreters in the classroom does not resolve the problem, given “the known limitations of interpreting as a basis for full and equitable access to classroom communication” (quoted in Power & Leigh, 2003, p. 43). Many programs

for deaf education now ascribe to an approach called “Total Communication,” which ostensibly promotes the use of any and all forms of communication that work effectively for the child. In practice, however, total communication is often reduced to the use of manually coded English, invented sign systems that have been shown to be difficult for deaf children to decode for meaning, and ineffective, at any rate, for teaching the English language (Schick, 2003). Although there are few, if any appropriate language role models for children in the mainstream environment, self contained classrooms or specialized schools for the deaf, as they are currently configured, do not resolve the issue of providing a language-rich environment: most often, teachers of the deaf are not native signers and many are not proficient in ASL (Lane, 1999). Deaf children thus experience great difficulty gaining access to the school curriculum due to the emphasis placed on learning English, rather than on subject content, and because of the communication barriers when content is being discussed. The results of deaf education have been, by many measures, dismal; Karchmer & Mitchell (2003), in an extensive review of the research on deaf education, concluded the following: “the average performance of deaf and hard-of-hearing students is roughly six grade equivalents lower than their hearing peers (p. 27).

Interactions with hearing peers are an important part of the daily lives of most deaf children, especially given the numbers of deaf children in mainstreamed settings. Positive peer interaction has been shown to help advance negotiation, conflict management and other social skills, as well as improve the ability of children to understand multiple perspectives (Shirin & Kreimeyer, 2003). Research suggests that the overall amount and quality of peer interaction is deficient among deaf and hard-of-hearing children (Shirin & Kreimeyer, 2003). These negative experiences may affect self perception and the opportunity to establish positive self identity as well as the development of social skills, with potentially debilitating consequences, given recent

evidence suggesting that identity affiliations are associated with higher self-esteem and satisfaction with life (Maxwell-McCaw, 2001).

### *Access to incidental learning*

Incidental learning, defined by Calderon & Greenberg (2003) as “the process by which information is learned by passive exposure to events witnessed or overheard” (p. 178), is an important avenue for acquiring information about expectations for interpersonal interactions and problem solving techniques. Because most deaf children live in environments in which the communications of others are, for the most part, out of reach, they have little access to this type of learning, and thus miss out on important opportunities for gaining understanding and skills critical for living effectively. The lack of access to incidental learning is related to another artifact of deafness, a deficiency in what Pollard (1998) has termed “fund of information,” defined as “the number of facts which one knows” (p. 183). This limitation is difficult to overcome, given a deaf person’s lack of access to overheard conversations and radio, and, frequently, diminished access to printed materials due to limited English proficiency.

These challenges affect the amount of knowledge and understanding that deaf children can bring to bear on manipulating and gaining mastery over themselves and their environments, and cause difficulties in their emotional and behavioral regulation.

### *Resulting Problems*

#### *Delayed language development*

The lack of a good fit between the environment of most deaf children and their need for a visual form of communication frequently results in a significant delay in language acquisition, which in turn proves to be a serious obstacle to normal development in many areas. It has been hypothesized, for example, that language acquisition, by encouraging the internalization of



structure and symbols, serves as a mechanism for developing self-regulation and impulse control (Altshuler, 1974). The adults in a deaf child's family and school, even if they use sign language with the child, are frequently not proficient or fluent. Consequently, concerned that they will be misunderstood, parents and teachers may tend to simplify their signs in what Calderon & Greenberg (2003) have called "linguistic overprotection" (p. 179). The unintentional effect is that the child's opportunities to learn about sophisticated reasoning processes and emotional states are restricted (Calderon & Greenberg, 2003). Deficits in language input commonly lead to a limited range of vocabulary for expressing emotions; studies indicate that even when deaf children appear to know the names of feelings, they do not have a solid grasp of their conceptual meaning (Greenberg and Kusché, 1989). Also, the ability to use language effectively to influence the environment has been hypothesized as an important step in developing feelings of competency and self-worth (Sisco, Kranz, Lund, & Schwarz, 1979). It would stand to reason, then, that without early access to language, many deaf children would be delayed in developing emotional competency.

#### *Social/emotional/behavioral results*

Greenberg and Kusché (1989) cited several earlier studies that found that deaf children exhibited greater impulsivity and had poor ability to take the perspectives of others compared to hearing children. Upon examination, the studies were found to rely on measurements inappropriate to the deaf children's language; when assessments were corrected for language mismatch, deaf children performed comparably to their hearing peers (Greenberg and Kusché, 1989). However, there were convincing results that deaf children struggled with effective problem-solving and lacked motivation and initiative. The former may be related to the lack of access to direct communication and incidental learning; Meadow & Dyssegaard (1983) have

hypothesized that the latter may be due to the interactional effect of the highly directive approach often taken by teachers and parents of deaf children. Rieffe, Meerum Terwogt & Smit (2003) described the dilemma that children face in learning these skills:

“For example, deaf children in a hearing family will be poor at carrying out negotiations. On the one hand, they miss the advantage of overhearing discussions and negotiations among others, which teaches hearing children different strategies and different steps that can be taken in a negotiating process. On the other hand, deaf children will lack the opportunity to experiment with diverse negotiating strategies themselves. They might not even be aware of the possibility of negotiating” (p. 167).

The finding that deaf children are poorer at emotional regulation (Greenberg and Kusché, 1989) is not surprising given the discussion of communication difficulties described above. Rieffe, Meerum Terwogt & Smit (2003), for example, found that deaf children focus on desires as an explanation for emotions, and hypothesized that the children’s reasoning might stem from a long history of communication failures. Consequently, deaf children may often be relatively unaware of the reasons behind the actions of others, and may become conditioned to try to get what they want while avoiding communication frustration. This has deleterious effects: “concentrating more on the result—fulfillment of desire—than on possible factors that cause this outcome, will affect deaf children’s emotional competence” (Rieffe, Meerum Terwogt & Smit, 2003).

Deaf children, then, appear to lag behind their hearing peers in the development of language and in many important social and emotional skills (Calderon & Greenberg, 2003). The lack of a linguistic match between most deaf children and the environment in which they are raised makes it difficult for them to communicate easily or interact socially, which

understandably lead to difficulties in behavior (Greenberg & Kusché, 1989). Other issues frequently ignored by developmental theories based on the experiences of hearing children are “the multigenerational identity gap and the visual orientation of deaf children” (Sheridan, 2001, p. 35). These issues appear to result in fewer opportunities afforded to deaf children for taking risks, assuming responsibility, and initiating action on their own behalf, increasing the likelihood of developmental delays and consequent social/emotional/behavioral problems.

### *Types of interventions*

Many interventions aimed at helping deaf children with behavioral and interpersonal problems have been curriculum-based programs utilizing behavioral, cognitive-behavioral, and psycho-educational approaches (Naiman, Schein, & Stewart, 1973; Greenberg & Calderon, 2003). However, treatment options for deaf children are best kept open, particularly given the imperative for culturally sensitive practices and the history of paternalistic treatment practiced on, rather than with, the deaf community. As with all populations, interventions for deaf children are best selected with careful consideration of the client’s needs. Given that it has been speculated that directive approaches in parenting and education may be causally linked to deaf children’s lack of initiative and underdeveloped sense of self-efficacy, interventions with a theoretical underpinning that emphasize the value of a nondirective approach may, at least in some cases, be indicated as a treatment of choice. Play therapy, and specifically, child-centered play therapy, may be an advantageous option.

### *Play Therapy*

Play has long been understood as a vitally important mechanism for children’s growth and development: it “alone is the free expression of what is in the child’s soul. . . It is full of meaning and import (Froebel, 1903, quoted in Landreth, 2002, p. 28). Play therapy is uniquely

suited for children because it them the opportunity to the child to "play out" [their] feelings and problems in the same way that certain types of adult therapy allow an individual to "talk out" his [or her] difficulties (Axline, 1947, p. 9). Landreth (2002) described play as the "symbolic language of self-expression" (p. 18) and listed the aspects of the child's inner state that it reveals, including what the child has experienced and his or her reactions to and feelings about that experience, as well as the child's wishes and needs, and his or her perception of self (Landreth, 2002, p. 18). Although child-centered play therapy shares some of the same basic goals and premises as other popular play therapies, a belief, for example, in the effectiveness of play as a means of communication (Knell, 1994), it differs markedly in emphasis and methodology. Brief overviews of Adlerian, time-limited play therapy, and cognitive behavioral play therapy are offered as bases for comparison.

#### *Adlerian play therapy*

Kottman (1994) described Adlerian play therapy in the following ways; it encourages social interest, and will even invite others important to the child into the therapy session. Adlerian play therapy "uses play to understand clients' lifestyles, mistaken beliefs, and private logic" (Kottman, 1994, p. 5). Adlerian play therapists understand the child's play as goal directed towards one of "four primary goals: attention, power, revenge, and the display of inadequacy" (Kottman, 1994, p. 6). According to Kottman (1994) the Adlerian therapist structures the therapy in such a way as to insure that the major themes are addressed, taking both a reflective and problem focused approach, and utilizes positive transference, confrontation, interpretation at carefully chosen junctures in therapy. Kottman (1994) described seven fundamental Adlerian assumptions about children: a) children are unique and creative, b) children have a natural tendency to connect with others, c) all children have a need to belong and

will satisfy this need in any way they can, d) children can make conscious decisions about themselves and others, e) children's behavior always has a purpose, f) all children have some feelings of inferiority, and g) children who have problems may be discouraged, but are not mentally ill.

### *Time-limited play therapy*

Sloves and Belinger Peterlin (1994) described time-limited play therapy (TLPT) as a "highly structured, aggressively managed, interactive" modality "for children who have experience that put a strain on their development but do not require extensive psychotherapeutic or major structural change to move forward" (p. 29). They were careful to emphasize that TLPT is not simply "an abridged form of long-term therapy," and that it is neither superficial nor "second-best" (p. 34). The goal is to enable the children to gain a more objective view of themselves, to accept responsibility for their part in the difficulties they experience, and increased abilities to cope with problems and conflicts. Sloves and Belinger described the unique characteristics of time-limited play therapy as the following:

TLPT focuses on resolving one theme or dynamic that is understood as underlying the child's problems.

TLPT focuses on resolving one theme or dynamic that is understood as underlying the child's problems.

The theme is symbolic of the separation-individuation process and represents the child's struggle to gain mastery over the environment.

The therapist is highly involved, which serves to encourage positive transference.

Play is structured, in order to avoid regression and helplessness.

The therapist uses time as a construct to serve the therapeutic momentum.

Therapists working in the TLPT model, according to Sloves and Belinger Peterlin (1994), view much of treatment as happening outside the therapy hour. They emphasize strengths rather than presenting problems, and are much more active in the therapy than traditional long-term therapists.

#### *Cognitive-behavioral play therapy*

According to Knell (1994), most of the principles of cognitive-behavioral therapy (CBT) are applicable to therapy with children, despite arguments made by other authors to the contrary. The adaptive interplay of cognition, emotions, behavior, and physiology, Knell (1994) argued, is as critical for children's optimal functioning as it is for adults. However, certain CBT principles may need to be adapted to play therapy with children in order to take into consideration their stage of development. For example, for children at the preoperational or concrete-operational stage, CBT can be adapted to focus on behaviors, with interventions focused on ameliorating cognitive deficits (lack of understanding and knowledge) and cognitive distortions (errors and misunderstandings) (Knell, 1994). Other key attributes of the CBT model, according to Knell, are well suited to the child's needs, including its emphasis on remaining time-limited and problem focused, structuring and directing therapy, and engendering a warm, therapeutic relationship based on trust and acceptance. Knell argued that the educational approach of CBT is particularly effective with children because, as a teacher, the therapist can instruct

Table 2  
Comparison of CBPT and Traditional Play Therapies

	Psychoanalytic	Nondirective Axlinian	CBPT
<b>Differences:</b>			
Direction and Goals	Direction does not come from therapist	Direction is not accepted because it imposes on child; does not accept child as he/she is	Therapeutic goals are established; direction of goals is basis of intervention
Play Materials and Activities	Therapist is “participant observer” not playmate Therapist does not suggest any materials or activities	Play materials, activities, direction of play <i>always</i> selected by child	Both child and therapist select materials and activities
Play as Education	Play is not used to educate; education is not the goal of therapy	Education is not appropriate because it is a form of direction	Play is used to teach skills and alternative behaviors
Interpretations Connections	Interpretation as ultimate tool	Not made by the therapist unless child introduces them first, therapist communicates unconditional acceptance, not interpretation of symbolic play	Introduced by therapist, therapist brings conflict into verbal expression for child
Praise	Not considered appropriate	Praise should not be used by therapist; praise communicates acceptance of child	Praise is crucial component, communicates appropriate behaviors and reinforces child
<b>Similarities:</b>			
Therapeutic Relationship	Establish contact with child Engage child in treatment Engender child’s trust		
Play as Communication	Play is treatment modality as well as means to communicate		
Therapy as a Safe Place	Provide child with a sense of security and safety		

Note: Adapted from Knell (1994)

the child in positive coping skills and alternative behaviors, given that “children cannot generate alternatives and test them out” (p. 115). Knell provided a table comparing psychoanalytic, child-centered, and cognitive behavioral play therapy (see Table 2).

### *CCPT*

#### *Theory*

Child-centered play therapy differs from other play therapies primarily in the degree to which it allows the child to direct the content and progress of therapy (Axline, 1947). It is based on Carl Rogers’ belief in the human being’s motivation to achieve self-actualization (Guernsey, 1983), or what O’Connor (2000) described as “the drive to maintain and enhance growth” (p. 28). Everything that the therapist does in CCPT is directly connected to this belief in the ability of the child’s capacity for positive development, and is done in the service of facilitating that growth. Guernsey (2001) emphasized that the therapist practicing CCPT must follow the system in its totality; “deviations from the system make the therapy something else, not CCPT” (p. 19). Child-centered play therapy, thus, requires the therapist to fundamentally adhere to the following guidelines:

The therapist must develop a warm, friendly atmosphere with the child. Good rapport should be established as soon as possible.

The therapist accepts the child exactly as he or she is.

The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back in such a manner that the child gains insight into his [or her] behavior.



The therapist maintains a deep respect for the child's ability to solve his [or her] own problems if given an opportunity to do so. The responsibility to make choices and institute change is the child's.

The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way, the therapist follows.

The therapist does not attempt to hurry the therapy along. It is a gradual process and must be recognized as such by the therapist.

The therapist only establishes those limitations necessary to anchor the therapy in the world of reality and to make the child aware of his [or her] responsibility in the relationship (Axline, 1947, pp. 73-74).

More generally, the qualities required to be a good child therapist are simply "liking children, playfulness, respect, and the ability to set limits" (Kissel, 1997, p.2). The CCPT therapist's commitment to accepting the child exactly as the child is may be disconcerting to parents or teachers who refer a child concerned about problematic behaviors, and hoping for change as soon as possible. The CCPT stance assumes, however, that real change cannot occur without empathy and absolute acceptance, although, and this does not imply that the therapist agrees with a child's distorted or unrealistic perceptions (Guerney, 2001).

CCPT assumes the same goal for all clients, namely replacing symptoms of maladjustment with behaviors that indicate a growing independence, acceptance of self, and acceptance of others (O'Connor, 1983). Typically, no specific goals are established for individual children, since the therapist assumes that all maladjustments are simply various forms of attempts to express the frustrated expression of the self, and the therapist behaves similarly regardless of the presenting problem (O'Connor, 1983).

*Processes of child-centered play therapy*

Virginia Axline, the innovator of child-centered play therapy (CCPT) described the process as one in which the child can experience “self-exploration, self-in-relation-to-others, self-expansion, and self-expression,” and thus learns “to accept and respect not only himself but others as well” (1947, p. 13). The general approach of the therapist is to convey positive regard and help the child understand him or herself by reflecting the child’s feelings and tracking the child’s behavior by stating what it is that he or she is choosing to do at any given moment. An important part of the process of facilitating the child’s process is that of providing limits on the child’s behavior, in order to structure the development of the therapeutic relationship and to help ground the experience in the real world (Landreth, 2002). Landreth (2002) described limit-setting as providing children with an opportunities to “learn self-control, that they have choices, what making choices feels like, and how responsibility feels” (p. 246). Limits in CCPT are always paired with an empathic statement, communicating to the child that the therapist both understands the child’s wish to break a limit and will not allow him or her to do so (Guernsey, 2001, Landreth, 2002). Landreth (2002) stated seven reasons for setting a limit with a child in CCPT:

- to provide physical and emotional security and safety for children
- to protect the physical well-being of the therapist and facilitate acceptance of the child
- to facilitate the development of decision-making, self-control, and self-responsibility of children
- to anchor the session to reality and to emphasize the here and now
- to promote consistency in the playroom environment

to preserve the professional, ethical, and socially acceptability of the relationship and to protect the play therapy materials and room (pp. 250-258).

Guernsey (2001) has identified several stages that typically occur during the process of CCPT. Although the length and sequence of stages may vary from child to child, and children may progress to a subsequent stage only to revert to a previous one at any time during therapy, generally children progress through four identifiable stages. These are a) the “warm-up,” stage in which the child becomes oriented to the therapist and the process, b) the “aggressive” stage, in which the child begins to deal with the problematic issues which brought him or her into therapy, c) the “regressive” stage, in which the child works through issues of dependency, nurturance, and attachment, and d) the “mastery” stage, in which the child demonstrates adaptive behavior and competency in areas that formerly were problematic.

#### *Research problems*

In general, it is challenging to empirically demonstrate the efficacy of any specific therapeutic intervention. Many researchers have found that there is no convincing evidence that any particular type of therapy is more or less effective than another, although therapy in general has been demonstrated as helpful (Reisman J.M. & Ribordy, S., 1993). Studies of CCPT have not been any more convincing; research has indicated that the core conditions may be the agent of change, rather than the specific techniques of CCPT (Truax , C.B. & Mitchell, K.M. (1971). One of the most difficult aspects of conducting solid research is the challenge of controlling for possible variables. Studies of interventions for children may be confounded by multiple intervening variables, including behavioral symptoms and social, cultural, gender variables; the apparent failure of a given therapy to achieve positive outcomes, for example, may be due to persistent difficulties in home life and family instability, rather than the inefficacy of the

treatment itself (Carroll, 2000). A particularly challenging intervening variable in child therapy is that of developmental maturation (Carroll, 2000); rigorous controls are needed to tease out behavioral changes in children due to therapeutic interventions from those due to the natural process of growing emotionally and cognitively more mature.

Although there is great deal of clinical experience that attests to the effectiveness of CCPT for children with a variety of behavioral problems, research has not empirically validated those assertions (Phillips, 1985). In addition to the difficulty of accounting for all the relevant variables, comparing the results of one child-centered play therapist with another may be problematic, as each may use different techniques (Carroll, 2000), and their way of using the relationship in the service of the therapeutic goals may be qualitatively different. Also, play therapy that purports to adhere to the principles of CCPT may, in fact, not do so; Russ (1995), for example, described the limitation of one study that found positive effects: the procedure was not limited to a specific theoretical approach, and included information giving, play, and verbal support, making it impossible to know which procedure caused the positive effect.

The difficulty of taking the effectiveness of play therapy at face value has been stated by Carroll (2000): “many practitioners of non-directive play therapy believe that all children who are exhibiting symptoms can benefit...yet with no unequivocal outcome research to support or contradict this view, the reader has no evidence with which to question such assertions” Carroll, 2000.

Phillips (1985) suggested five reasons that may explain why there has been such difficulty in obtaining empirical evidence for the efficacy of a therapy that has received such positive responses from clinicians: a) the unconvincing data that exists to date, and the relatively rudimentary research methods used in the early studies, do not inspire new research, b) the

conceptual models of play therapy have not generated testable hypotheses, c) the face validity of using play as a therapeutic method for children may have precluded it as a subject for serious scrutiny, d) since most play therapists are clinicians with little time or inclination for empirical research, the majority of research has been qualitative, and e) play is viewed as frivolous, and by many academicians, unworthy of scientific study.

Recent suggestions for strengthening the empirical basis of play therapy may be viewed as antithetical for CCPT practitioners. For example, Phillips (1985) reported that the data that appears most promising for play therapy incorporates cognitive behavioral techniques, and suggested that modality as a fruitful direction for future research. Also, Russ (1995) described a growing consensus in the literature that calls for play therapy that clearly links to specific treatment goals, focusing on the specific processes in play therapy for particular problems of specific populations of children. As noted above, CCPT, as a matter of principle, does not identify specific treatment goals, other than the development of a positive sense of self and self-efficacy; the emphasis is on the child, not the presenting problem (Sweeney & Landreth, 2003). Phillips (1985) advocated for carefully controlled, rigorous empirical research of play therapy, and particularly, for carefully detailed descriptions of the procedures. The “procedures” of CCPT, however, are very difficult to detail, as they are constituted by the therapist’s every verbal and nonverbal expression of the principles of CCPT, within the myriad of idiosyncratic opportunities presented in a play session. A single glance, to the degree that it does or does not embody the spirit of CCPT, may evidence adherence, or a lapse of adherence, to the “procedure” in any given moment in a CCPT session.

*Supporting evidence*

Despite criticisms that play therapy lacks empirical support, there have been many studies that have achieved positive outcomes. A meta-analysis conducted by Ray, Bratton, Rhine, & Jones (2001) of 94 play therapy outcome research studies found a “large positive effect across modality, gender, clinical vs. non-clinical populations, setting, and theoretical schools of thought” (p. 85). There are fewer studies, however, that specifically measure the outcome of the CCPT modality, and even fewer using controlled scientific conditions, perhaps for the reasons listed above. There is, however, enough empirical evidence of positive outcomes to warrant continued investigation (i.e. Crow, 1989; Elliot & Pumfrey, 1972; Fall, 1999; Fall, Balvanz, Johnson, & Nelson, 1995; Herd, 1969; Landreth, 2002). This evidence is given a considerable boost in the eyes of many clinicians by the strong positive effects that they observe in their practice (Landreth, 2002).

Qualitative studies, more than rigorously controlled quantitative research, appear to have been a more popular method of inquiry among CCPT investigators over the years since Axline first described the approach (Phillips, 1985). Perhaps this has been due as much to the predilections of the kinds of clinicians who are drawn to CCPT as to the common obstacles of time and money. Carroll (2000) has identified two types of narrative case studies: those that focus on the details of a case, and those that describe an overview of the therapeutic process. The former was used by Ryan & Wilson (1996) in describing the processes involved in CCPT with a young child with limited verbal skills who discloses abuse during play therapy. The description illuminated the issues that arose as the therapist CCPT theory to the specific problems brought by the child into the relationship.

There has been criticism of the narrative approach for its focus on an understanding and discussion of the process, with “little analysis of the applicability of a given approach” (Carroll, p. 17). Goods & Watts (1989) argued that practitioners cannot assume generalizability from narrative studies of specific cases. Studying the idiosyncrasies of one subject would seem to...lead to the discovery of laws that are applicable only to that one individual” (Barlow and Harlen, 1984, p. 49). However, this problem is not resolved with all the rigors of quantitative research; there is never any guarantee that what has been found to be true for one subject, or even many subjects, will be true for the next individual. The narrative method does not claim to demonstrate outcomes of a preferred therapeutic approach for a given population problem, but it may be a rich resource for exploring the issues and raising important considerations important when applying theory to specific populations.

#### *Deaf Children and CCPT*

As stated above, one of the major concerns for deaf children are the obstacles they face in developing a strong identity and a sense of self-determination. Given that CCPT theoretically targets a person’s sense of self, and that it has been indicated as effective in improving children’s sense of self-efficacy (Fall, Balvanz, Johnson, & Nelson, 1999), CCPT may be uniquely suited as an intervention for the particular needs of deaf children.

#### *Cross cultural applications of play therapy*

Studies have suggested that CCPT is amenable to children from different cultural backgrounds (Cochran, 1996; Costantino, Malgady, & Rogler, 1986; Trostle, 1988; Wakaba, 1983). Cochran (1996) observed that CCPT’s practice of labeling feelings, done primarily to help children gain insight into their own feelings, has an auxiliary benefit particularly beneficial for culturally different students, that of increasing their vocabulary of emotions. Kunkle-Miller

(1990) stressed the benefits for deaf children of therapeutic interventions that utilize nonverbal communication (which may reasonably include CCPT, inasmuch as play is nonverbal), within comprehensive mental health programs, reasoning that the communication and expression available through the arts build upon the assets of children who are hearing impaired while “minimizing their verbal limitations” (p. 35).

As advantageous as CCPT may be for cross-cultural work, the assumption that it is the best intervention for deaf children on the basis of their perceived lack of verbal skills is ill founded. Although it may be true that deaf children frequently lag behind in emotional vocabulary (Calderon & Greenberg, 2003), the most empathetic way to introduce them to that vocabulary is through a visual form of communication. Even therapies which rely heavily on nonverbal means of communication, including play therapy, are critically informed by verbal exchanges, and, if therapist and client do not share the same language, significant problems may arise “when the therapist and the child attempt to translate the meaning of the verbal and body language being used” (O’Connor, 2000, p. 68). Deaf children who use some form of sign language are best served by therapists who are proficient in sign, and able to both understand the child’s signs and reflect back the children’s utterances in ways that the children can understand and apply towards gaining insight into their behavior, thus remaining true to a fundamental principle of CCPT as described above. Native signers serendipitously provide a language model, while those who are at least proficient in sign demonstrate, by matching the child’s language, empathy and acceptance. An important potential benefit in using the language most accessible to the child may be an increase in the child’s confidence in his or her ability to communicate successfully, an effect which may be all the more powerful for deaf children who frequently find themselves in environments where they have difficulty making themselves understood. This



point was emphasized by O'Connor (2000): "play therapy is not necessarily free from problems should there be language differences between the therapist and the child. Both persons may have difficulty translating verbal and non-verbal behavior" (p. 69).

The particular advantages of CCPT for deaf children may lie in its focus on responsibility, identity development, and self-efficacy, as well as in its attention to effective communication. These emphases appear to coincide with the qualities suggested by Greenberg & Kuché (1989) as those that increase social and emotional competence, including, among others, good communication skills, the capacity to think independently, and the capacity for self-direction and self-control. Given the challenges of growing up in environments that are (frequently) poor matches, these are precisely the skills that many deaf children struggle to master.

Erikson and others (cited in Sisco, et. al., 1979) have demonstrated that play fulfills an important role for children in providing them with a vehicle for rehearsing social, interpersonal, and cognitive roles. In other words, it allows children to play out, in their imaginations, the developmental issues that lie before them. CCPT may be beneficial for deaf children given the findings of Singer & Lenahan (1976) that the play of deaf children typically was less imaginative and involved less fantasy than that of their hearing counterparts, and their recommendation that "the children should be encouraged to explore their inner lives and feelings in order to tap the potential for imagination... (p. 48).

#### *Previous studies*

Four previous studies of non-directive play therapy with deaf children have been discussed in the literature: Oulline, (1975), Sisco, Kranz, Lund, & Schwarz (1979) Troester,

(1996), and Smith & Landreth (2004) Each of these will be described in turn, in order of year published, to form a context for the current study.

Oulline (1975) undertook a study of short-term play therapy in which a group of 24 profoundly deaf children ages four through six were divided into an experimental and a control group. The groups were referred from what were described as “classes for the deaf.” No data was included regarding the percentages of children referred from public schools vs. schools for the deaf, numbers of children with deaf vs. hearing parents, or mode of communication preferred by the children.

The experimental group received approximately ten sessions of individual, non-directive play therapy following the principles developed by Axline (1947). Results gathered via the Vineland Social Maturity Scale indicated significant improvement in mature behavior patterns. Analyses of other measures did not support the author’s hypothesis that the therapy would result in significant improvements in personality adjustment or manifest behavior. However, narrative responses to questions posed to teachers and parents of the children described positive changes in the children over the course of therapy, including characterizations of individual children as “more mature,” “more grown up,” and “more independent” (p. 130).

At the time of Oulline’s study (1976), research validating ASL as a legitimate language was very new, and it was still the largely uncontested norm that teachers, counselors, and therapists working with deaf children were hearing professionals with very little or no proficiency in sign language. Communication was largely dependent upon the professional’s natural ability to “mouth” English clearly and gesture effectively, and the deaf child’s skill in speech reading. This appears to be the case in Oulline’s research, as she described the difficulties of communicating important messages to the children in her study: “through facial expression

and gestures, the therapist attempted to reflect [the child's] feelings of anger," and "it was difficult to explain to [the child] that this was his last session" (p. 106). Although Outline apparently did her best to understand the children and to reflect their feelings as accurately as possible in ways that they could understand, assumptions reported in the discussion were biased by prevailing attitudes that laid the onus of communication on the deaf children: "it is difficult for deaf children to understand why they must wait" (p. 107). Yet, despite the differences in language between therapist and child, results of her study of CCPT were promising.

Sisco, Kranz, Lund, & Schwarz (1979) described a study that continued over the course of three years, in which a total of ten students at a residential school for deaf and blind students, age 4 through 13, were seen for a minimum of ten sessions. Although the therapy was not labeled "non-directive," guidelines described were basically commensurate with the child-centered principles of Axline, including therapist emphasis on observation, in order to "avoid the adult control issues which usually confront the deaf child," and limits, stated as rules, confined to matters of safety, such as "you must not hurt anyone" (p. 854). Teachers and supervisors of the children reported improvements in behavior, including "a) an increase in appropriate interpersonal behaviors, b) increased competency in interpersonal relationships, c) increased communication skills, and d) a marked decrease in aggressive behavior on the part of the deaf students toward other students" (p. 855).

Sisco et.al. asserted that rules "were communicated to the child using the communication most suitable to the child's acquisition and mastery of the language" (p. 854); it was not specified whether the language referred to was ASL or English. The therapists made several important observations about the process of play therapy with the deaf children, including a) deaf children's response to therapy was similar to hearing children's, and included work on important

developmental issues such as trust vs. mistrust, aggression, and attachment, b) consistency was very important for establishing trust, c) the children especially seemed to enjoy adult-child role reversals, i.e. “controlling” the therapist, d) deaf children’s play followed the same developmental trajectory as that of hearing children, although two to four years behind (an observation consistent with the findings of Darbyshire [1977]) and 6) introduction of new language provided the children labels for feelings and emotions, and improved communication and rapport (p. 856). The authors emphasized the importance of the consistency of sessions, and stated that keeping scheduled appointments, and personally informing the children when an appointment had to be missed, facilitated “basic trust, security, and ‘therapist-child attachment’ ” (p. 855).

Troester’s 1996 study consisted of a three-year, ongoing group of three severely to profoundly deaf boys, beginning when the boys were eight years old. Troester apparently was not proficient in sign language, as he mentioned that he depended upon one of the boys who was described as “both verbal and proficient in sign language” to serve as interpreter “when verbal communication was necessary” (p. 103). Observations made of the boys’ progress over the three years included academic improvements and psychosocial development such as developing more “sensitivity,” and becoming “more independent,” and more “confident and assertive” (p. 107). Troester emphasized the therapeutic benefits of the group process, particularly when the therapist took a “hands off” approach, and noted how the boys became a cohesive group over time and developed pro-social interpersonal relationships. Of course, with no control group, developmental maturation may be a significant confounding variable in a study that followed boys as they aged from eight to eleven years old.

Smith & Landreth (2004) adapted Landreth's (2002) filial therapy for teachers of deaf and hard of hearing children age 2 to 6.11 years old in a preschool program that specialized in offering special deaf education services while integrating the deaf and hard of hearing children into classrooms with hearing children. The experimental group consisted of one auditory class (in which students and teachers communicated through speaking and speech-reading) class and three "total communication" classes (in which teachers and students spoke and signed English simultaneously). In order to keep the ages of the children comparable, researchers had to arrange the control group in the reverse combination (i.e. one "total communication" class and three oral classes). Students in both groups were evenly matched for gender and ethnicity.

Smith & Landreth's study indicated that children whose teachers demonstrated an increase in empathizing skills exhibited a decrease in overall behavior problems, as well as a significant decrease in internalizing behaviors that may lead to the development of depression, anxiety and emotional withdrawal. These results cannot be directly correlated with results that might be accomplished by CCPT sessions with an individual therapist, as the empathic and validating behaviors that the teachers learned to apply in one to one sessions were shown to carry over to their relationship with the children throughout the week, whereas contact with a CCPT therapist would be limited to one or two sessions a week. Nevertheless, results were promising, and Smith & Landreth speculated that "child-directed play and the accepting, empathic presence of the teacher provided the students with an avenue of relief for the ongoing frustration of not hearing, thus allowing them to be more trusting, [and] reducing the need to internalize stress" (p. 27). No note was made as to any differences found between the groups in which a teacher used oral communication compared to those groups that utilized "total communication."

Although Smith & Landreth addressed the important issues of language and communication with more sensitivity and care than the previous studies, they made an observation regarding linguistic “modifications” made to CCPT that is at odds with current understanding of the differences between ASL and English. Smith & Landreth stated that the teachers and researchers made modifications to the language typically used in child-centered play therapy in order that it might better “fit American Sign Language” (p. 23). Although translation issues are a real concern when a theoretical model, originally conceived in one language, is adapted for use with a population of a different language, the description above appears to indicate a misunderstanding or obfuscation of the linguistic differences under discussion. The communication mode of the participants was described as “total communication,” which, by definition, is not American Sign Language, given that in “total communication” (defined by experts as a system, not a language [Lane, 1999]) signs are produced simultaneously with spoken English, thereby prohibiting the inclusion of many key grammatical features of ASL. It may, in fact, be the case that the young students in Smith & Landreth’s study lacked “the fundamental language ability to understand [the] hypothetical kind of logic or language” inherent in a sentence such as “if you throw the sand out of the box, there will be no more playing with the sand today.” However, restructuring the sentence in the way described by Smith & Landreth constitutes a simplification of the English structure, and not an “adaptation to fit ASL.” Although it is true that “there is not a sign for every word” in English, ASL makes use of complex non-manual features and differing syntactic structures that are quite capable of conveying hypothetical propositions. If the sentence under discussion were translated, rather than modified, as described, it would look quite different from the original English version. Although it is impossible to predict, it may be that some students would have been

capable of understanding the language typically used in the CCPT model, even the hypothetical logic used when setting limits, if the teachers and therapists used ASL. The distinctions between the terms “modification” and “translation,” and “ASL” and “total communication,” may appear to be arguments over mere semantics, however, given the history of education for deaf children and the legacy of oppression of sign language, they carry significant implications for those who care about access to communication and effective demonstration of empathy to deaf children.

The studies described above found significant benefits of CCPT for deaf children, despite the fact that the researchers, for the most part, overlooked key differences between the language and culture of the deaf children and the therapists. Perhaps this is indicative of the robust nature of the CCPT model. Nevertheless, it is incumbent upon contemporary clinicians to be as culturally sensitive as possible, whether providing counseling or conducting research.

*Cultural and linguistic considerations of CCPT with Deaf children*

As may be seen by the discussion above, there are very specific issues inherent in translating the language and practice of CCPT into an intervention treatment that is effective for deaf children. A culturally sensitive study of CCPT with deaf children in the context of the Deaf community needs to consider cultural issues such as the potential impact of collectivist values placed on insider/outsider status and reciprocity. The establishment of cultural legitimacy depends upon an awareness and sensitivity to issues such as these. Also, linguistic and communication concerns need to be thoughtfully considered in order not to unwittingly perpetuate the patronizing stance pervasive in the history of mental health care for deaf people. The most basic implication of the culturally sensitive perspective, as described above, is to use the language that the child may most readily understand.

As described earlier, line of sight has a profound impact on turn-taking patterns (Spencer, E.P., & Hafer, J.C., 1998). This will inevitably affect the interactions during a CCPT session, given that deaf children must choose at any given moment where they will direct their visual attention. The simple and yet easily overlooked fact is that initiating conversation in a visual language necessitates breaking the child's attention away from his or her engagement with toys or other types of independent activity. Learning how Deaf mothers interact with their children may be instructive in helping CCPT therapists adapt the ways that they track and reflect deaf children's emotions and play.

E.P. Spencer & J.C. Hafer (1998) found that Deaf mothers adapt their communication with their children in ways “specific to visual communication: (a) modifying signs to attract attention to them by signing slowly, rhythmically, with large movements and many repetitions; (b) modifying the location of signs to produce them on or near an object to which the child is already attending; (c) using attention-directing signals including tapping on the child and waving in the visual field; and (d) waiting to allow the child to attend sequentially to an object or event and then to the communication partner” (p. 147). The attention getting signals referred to in “c” have been described by Mather (1996) as the “visual and tactile initiation regulators” of usual deaf discourse. Mather expanded on the ways that deaf people gain their “listener's” attention, adding that deaf people may also wave a hand in the person's peripheral line of view, or visually create “sharp movements in body or hand motion” (Mather, 1996, p. 115). These methods are modulated in size, frequency, and intensity, according to the tone of the intended message (Mather, 1996). Mather (1996) also stressed the importance of making sure that eye contact is established before communication is initiated, and that the “addressee” indicates readiness to listen.



Child play therapists working with deaf children might do well to consider how to use these conversation regulators in the service of the overall goals of CCPT. In CCPT with hearing children, for example, the therapist would not typically ensure that he or she had the child's full attention before making a statement that tracked the child's play. The lack of eye contact in casual conversation is congruent with norms in mainstream hearing culture (although in disciplinary situations, adult interactions with children, and in various hearing subcultures, it may be common to demand attention from the listener, i.e. "look at me when I'm speaking to you!"). In CCPT, the lack of a demand upon the listener to pay attention allows the child to decide whether or not to ignore or pretend to ignore the speaker. A CCPT therapist working with deaf children may regulate the number of times or manner in which he or she uses traditional deaf "visual and tactile initiation regulators" to track the child's play in order to give the deaf child the same freedom to direct his or her attention as afforded the hearing child.

ASL may be uniquely suited in some ways for use in tracking the child's play. Classifiers, described earlier, quickly and efficiently describe the size and shape of an object, its location, and its movement, including speed and direction and manner of motion (i.e. abrupt, smooth, jerky, etc.) Thus, classifiers as linguistic devices unique to signed languages, can accurately and succinctly describe a child's play, with out ascribing any intention or emotion on the part of the child.

The present study was undertaken to explore the ways in which the complex social and linguistic issues described above might impact the application of CCPT with deaf children who are experiencing social, emotional, and/or behavioral problems. CCPT was chosen as the modality because it has been shown to target the problems of self-esteem and self-direction that research indicates might lie at the center of deaf children's difficulties. The central question was

whether or not a treatment that took those issues in to consideration would prove efficacious, or at least helpful in informing future practice regarding the salient variables of providing a culturally sensitive CCPT.

### Methods

A small program of CCPT offered by the graduate intern for deaf children in a local school for the deaf was determined to be the most practical method to initiate the inquiry under discussion. Both qualitative and quantitative measures were chosen to gather data, in order to objectively assess the effectiveness of the program while allowing subjective investigation of the more subtle issues at hand. Two instruments, a well-researched objective measure of behavior and a projective apperception test, were used to collect data on the children's behavior and on their unique personality characteristics, and to assess changes made over the six months of therapy. These were the Behavior Assessment System for Children (BASC) rating scales (both teacher and parent versions) (Reynolds and Kamphaus, 1992), and the Roberts Apperception Test for Children (RATC) (McArthur & Roberts, 1982). These tools were selected on the basis of cultural sensitivity, ability to elucidate individual differences among the deaf children and in comparison to hearing population norms, ability to provide comparisons of pre- and post-treatment behaviors, and external validity. In addition, therapist progress notes and videotapes of the individual sessions were used to examine interpersonal dynamics and cultural/linguistic phenomena.

### *Participants*

Subjects for the study were recruited from a school for the deaf located in a large metropolitan area in New York State. The school was founded in the late 1800's, and has a well-

established place in the history of the education of deaf children. The communication policy requires that all staff sign at all times; practically, this results in the majority of the staff (who are hearing) speaking and signing at the same time, a mode described earlier as “simultaneous communication.”

The school currently serves over one hundred children, from pre-school to 12<sup>th</sup> grade, who are bussed in from surrounding school districts; a small percentage of the children come from neighboring counties, and live during the school week in dormitories on the campus. Admission requirements for the school are a hearing loss in excess of 80 decibels (db) in the better ear, or documented evidence that the child is “functionally profoundly deaf.” The ethnic diversity in the school is more homogenous than the greater population, with 90% Caucasian students. The school states that, in addition to following New York State curriculum for individual subjects, its mission is to “provide a rich introduction to Deaf Cultural studies,” and it offers a variety of after school sports and social clubs, as well as special programs, towards that end.

The first step in the recruitment process was to describe the project and get approval for it from the social worker at the school, who is Deaf and an active member of the Deaf community. This was deemed important as a part of the process of securing cultural legitimacy from deaf parents and other community members who might hear of the study. The social worker agreed to help, and introduced this researcher to the teachers of the second and third grade classes. Both teachers were hearing. The teachers were asked if they would allow children who might benefit from individual play therapy sessions to be excused from regular class time to attend the sessions once a week for forty-five minutes. Upon receiving permission, letters (see Appendix A) were sent home to the parents of all the children (approximately six in each class). Signed permission

letters were received from the parents of four students, three boys and one girl. There were no criteria for selection other than the willingness of the parent, the child, and the teacher to allow participation.

All of the children were Caucasian, as was the therapist, the teachers, and parents. All of the children had been assessed at average or above average intelligence. Descriptions of hearing loss, and family and school communication profiles (per school records and report of the school social worker) are as follows (names have been changed):

John had a hearing loss of 90 db in his better ear, meaning that he was classified as profoundly deaf. His parents were both deaf, sign-fluent, well educated, and socialized in the deaf community. John used sign language exclusively to communicate with peers and teachers in the school, and likewise used sign with the therapist in CCPT.

Adam had a moderate to profound hearing loss (83 db loss in his right ear, and 113 in his left). His biological father was deaf and sign fluent, although he had been absent from the family since Adam was an infant. Adam's mother, per social worker report, signed well. Adam used sign and speech with his peers and teachers, and used sign exclusively with the therapist in CCPT.

Caitlin had a profound hearing loss (120 db bilaterally) and used sign language exclusively to communicate. Per social worker report, her mother could sign well; information about her father's sign ability was unknown. Caitlin's parents were divorced, and she lived primarily with her mother, although visited her father on a regular basis.

Eric's hearing loss was classified as moderate (63db) but was admitted to the school on the basis of his family's status as "deaf." Both parents were deaf/hard of hearing, and used both sign language and speech to communicate. Eric used sign and/or speech to communicate with his

peers and teachers, and used primarily speech to talk during CCPT. The therapist primarily used “sign supported speech,” (signing in English word order while speaking) to assure Eric understood her spoken communication.

### *Researcher Description*

If this study is to help inform the practice of culturally sensitive therapy for deaf children, it is important to understand who I am, as researcher and therapist, and where I stand in relation to the Deaf community. I am hearing, and have worked as a sign language interpreter for twenty years in the community in which the project was undertaken. If the Deaf community is understood as a series of concentric circles, interpreters have been described as inhabiting one of the circles outside the core of the Deaf community (Boylor, 1998, personal communication). The proximity of interpreters to the Deaf core depends upon the extent to which their lives outside of work revolve around socializing with Deaf people and attending Deaf events. Deaf people may take a dim view of interpreters whose affiliation with the deaf community is restricted to the time they spend earning a living, as reflected in the pejorative term describing such an interpreter as a “nine-to-fiver.” Other interpreters are perceived as closely connected to the deaf community, for example, those who have many deaf friends, frequently attend Deaf events, and/or example, marry a Deaf person. Perhaps because I have interpreted for so many years, and because I have a solid reputation as an effective interpreter, I have been told by Deaf people that I am a member of the community. However, due to my family life and other constraints, I have at the present time very few close deaf friends, and attend deaf community events only sporadically. I would place myself at a mid-range distance from the core of the deaf community, somewhere between hearing people who are totally immersed in the deaf world, and the “nine-to-fivers.”

### *Instruments*

#### *The RATC*

The RATC is a picture thematic apperception test designed specifically for children ages 6 through 15 (McArthur & Roberts, 1982). It is based on a theoretical assumption, common to projective measures, that “children when presented with ambiguous drawings of children and adults in everyday interaction, will project their characteristics thoughts, concerns, conflicts, and coping styles into the stories they create” (McArthur & Roberts, 1982, p. 2). The RATC, as a projective test, is qualitative, in that it allows freedom of response to the test-taker and relies upon the judgment of the scorer to determine ratings, and quantitative, in that the scores, once obtained, may be used to compare results with a normative sample.

The RATC was chosen for the present investigation for several reasons. Firstly, it appears to be appropriate as a cross-cultural measure: several studies, cited in Barbopoulos, Fisharah, & El-Khatib (2002), have shown that non-verbal tests, including the RATC, are less sensitive to cultural bias than verbal instruments. Barbopoulos, et. al. (2002) successfully used the RATC to compare cultural traits relevant to the populations they were studying, namely, collectivism vs. individualism in Egyptian children and Canadian children, respectively. Their study confirmed the hypothesis that children in each culture would rate higher on scales that correlated with their cultural norms. Qualitative methods have been suggested as helpful in avoiding stereotypes and biases when studying minorities, and specifically deaf children, in that they allow the researcher “to identify common themes while appreciating the uniqueness of the individual child” (Sheridan, 2001, p. 32), making the RATC, specifically designed as a tool to help describe the unique personality profiles of children studied, an appropriate choice. Finally, the RATC includes scales that measure constructs suggested in the literature as frequently problematic for

deaf children, i.e. the children's relative "self-sufficiency and maturity as indicated by assertiveness or the experience of positive emotions," and the children's ability to generate resolutions for problems in constructive and positive ways.

The RATC makes use of 8 adaptive, 5 clinical, and 3 indicator scales. The adaptive scales include the following:

Reliance on Others, which measures the child's adaptive capacity to use outside help to overcome a problem" (p. 12),

Support-Other, which indicates a propensity to support others by "giving assistance, emotional support, or material objects" (p. 12),

Support-child, which measures "self-sufficiency and maturity as indicated by assertiveness or the experience of positive emotions," (p. 13)

Limit Setting, which measures "the extent to which parents or other authority figures in the story place reasonable and appropriate limits on the child in response to a perceived violation of rules or expectations" (p. 13),

Problem Identification, which "indicates the child's ability to formulate concepts beyond the nature of the card" (p. 14),

Resolution 1, which "reflect a child's tendency to seek easy or unrealistic solutions to problems" (p. 14)

Resolution 2, which indicates an ability to find a constructive resolution to either external or intrapsychic problems,

And Resolution 3, indicates the child's ability to create a solution that has implications beyond the immediate conflict.

The clinical scales include:

Anxiety, which assesses anxiety or apprehension expressed by characters in the story, or themes of guilt or remorse,

Aggression, which measures anger and physical or verbal aggression

Depression, which measures affective responses such as sadness and despair, or physical symptoms such as fatigue, sleeplessness, or fatigue, and

Rejection, which indicates themes of separation, jealousy, discrimination, or feelings of being left out.

There are three clinical indicator scales that have not been standardized, because they were lacking in the normative sample, but may be clinically useful. They include Atypical responses, Maladaptive responses, and Refusal. In addition, there are three supplementary measures (Ego functioning, Aggression, and Levels of Projection) as well as an Interpersonal Matrix that indicates the degree and types of interpersonal interactions that may be rated on the RATC.

The RATC's objective measures were standardized on a sample of 200 "well-adjusted" children, stratified to provide an equal number of children in each age group and of both sexes. The sample was not stratified according to ethnic groups or socioeconomic status, but "an effort was made to select children from lower, middle, and upper middle class family backgrounds" (McArthur & Roberts, 1982, p. 73). Interrater agreement on the 16 different profile scales and indicators was generally good, ranging from the relatively low average level of agreement (80.0%) found among masters level students on the more difficult protocols to an average of 92.8% for doctoral students on the less difficult protocols (p. 76). Split-half reliability of the RATC was variable, ranging from .44 for the scale measuring "reliance on others" to .86 and .85 for the scales measuring "limit setting" and problems that were left "unresolved," respectively.



The split-half reliability mean was .62, which indicates that the scores “reflect true personality differences, not just stereotyped predictable responses which are determined by idiosyncratic characteristics of the cards” (p. 77).

Examinations of the validity of the RATC have been conducted along several dimensions. Intercorrelational studies indicated that several of the scales correlate with one another at a level of significance that indicates that the individual scales measure they purport to measure, i.e., Limit-setting was found to be positively correlated with five adaptive scales and one clinical scale (aggression), indicating that “Limit setting may identify children who adhere to social rules ...as well as children who may be particularly concerned with punishment because of their preoccupation with aggressive themes” (p. 77). Studies were also conducted to assess the power of the RATC to predict clinical vs. nonclinical groups of children, resulting in a finding that “62% of the variance in group membership [i.e. clinic vs. nonclinic] was accounted for” in the RATC scales (p. 81). In comparisons with other projective tests, the RATC was found to elicit significantly less stereotyped responses. The RATC was also compared to the Behavior Problems Checklist (BPC) (Quay, 1977) on two important factors of the BPC and two key scales of the RATC (Resolution ration and Level of projection) and found to have a moderate correlation (-.50 and .41). The authors of the RATC suggest that this finding is “reasonable assurance that the tests measure shared variance, especially given that the two tests, a projective measure based on stories and a behavioral checklist, are so diverse” (p. 90). The RATC was also determined to be a valid indicator of overall success, as measured against other standardized tests, including the BPC and three other unpublished rating scales. However, the results of the outcome study did not find significant correlations between the RATC and the other ratings in regard to the “children’s severity of presenting problems at intake, or the direction and

magnitude of changes in individual children as a result of therapy” (p. 91). McArthur and Roberts (1982) suggested that the mixed results on the outcome study might have been partially due to the limitations of the other scales.

Test results of the RATC must be considered with caution, as the test administrator did not follow standard protocols as described by McArthur and Roberts (1982). The RATC instructions state clearly that administrators of the test may prompt a child to respond more completely to the test stimuli by asking follow-up questions such “What happened before?” and “What are they feeling?” when administering the first two cards. After that, the authors (McArthur and Roberts, 1982) advise, the child’s lack of a complete response is a clinically relevant observation, and continued prompts constitute a deviation from the standard procedure. Such deviations indicate that the norms and interpretive guidelines may not apply (McArthur and Roberts, 1982). The test administrator for this project prompted all of the children throughout the RATC administration, thus, any observations or interpretations must be considered with some skepticism.

### *The BASC*

According to Reynolds and Kamphaus (1992), the BASC is “multidimensional, in that it measures numerous aspects of behavior and personality, including positive (adaptive) as well as negative (clinical) dimensions” (p. 1). It consists of several different methods of evaluation, including teacher and parent report forms, both of which were used in the current study. Other measurements in the multimethod BASC system were not used in this study due to either time constraints or the youth of the subjects. The Teacher Rating Scale (TRS) and the Parent Rating Scale (PRS) are comprehensive measures of adaptive and problem behaviors in the school and home environments, respectively. Each has three forms targeted towards three age levels: the

child forms, designed for children age 6-11, were used in the project under discussion. The PRS assesses behavior on twelve different scales, which are grouped into three composite measures, including Internalizing problems, Externalizing problems, and Adaptive skills. The Adaptive composite includes four individual scales: Adaptability, Social skills, Leadership, and Study Skills. The externalizing problems composite includes Hyperactivity, Aggression, and Conduct Problems scales. The internalizing composite includes Anxiety, Somatization, and Depression scales, and there is an additional clinical scales composite that includes Atypicality and Withdrawal. The TRS adds Learning Problems and Study Skills to the scales used in the PRS for a total of fourteen scales, and adds another composite measure, "School Problems," to those in the PRS, for a total of four composites. Both the PRS and the TRS scores also yield a behavioral symptoms index (BSI).

The BASC was normed against a general sample of children in each age range, with gender and ethnicity evenly distributed to reflect U.S. population figures. In the child age range, the TRS sample included 1,259 children while the PRS included 2,084. Children with behavioral-emotional problems were proportionally represented, but those with learning disabilities were underrepresented in the PRS, and children with speech and language disabilities were underrepresented in all the BASC measures.

Reliability of the TRS rating scales and composites are high; internal consistency of the child age-level form for ages 6-7, for example, was found to have a median of .88. Test-retest correlations were determined to have a median correlation of .92 at the child level, and interrater reliability ranged from .63 to .83, depending upon the number of children rated. Validity of the BASC also appears to be strong, correlations between the BASC and other similar measures of child behavior have been found to be substantial at both the scale and composite levels. The PRS

has been shown to have similarly high levels of reliability, with overall averages in the mid to upper .70s, with some variability noted for individual scales: the most reliable were determined to be Social Skills and Leadership, and the least reliable Atypicality and Conduct Problems. Test-retest reliability was found to be .88 at the child level, indicating that parents are consistent in their interpretations of the items. The number of high correlations of individual scales indicate that the BASC PRS has good construct validity in general. Correlations of the PRS with other behavior checklists were found to range from moderate to high; with the measurements of externalizing behaviors appearing to be more consistent across instruments than either internalizing or adaptive behaviors. However, correlations between the teacher and parent ratings have been reported as low to medium (median of .37), a complicating factor when trying to analyze data retrieved from both sets of respondents.

#### *Test Administration*

Once the four children were designated as participants in the program, parent versions of the BASC were sent home to each of their parents to be filled out as soon as possible. All four were returned within two weeks. The two teachers filled out and returned teacher versions of the BASC the same week it was given to them. Therapy sessions were scheduled for Friday mornings, beginning at 8:30. Each session lasted nearly the full period, forty-five minutes, leaving five minutes in between each session to return and pick up the next child. All sessions were videotaped. The first scheduled session was slotted for administration of the RATC.

On the day of that first session, only two of the four children were in school. Test administration was conducted in the room in which play therapy was to commence the following week, but the room was not set up at the time with play materials, other than a small portable sandbox and some small vehicles to use in it. This therapist attempted to administer the RATC to

to Eric and Caitlin in turn, with limited success. Eric reluctantly responded to ten of the sixteen cards of the RATC, and then played with the sandbox for the rest of the session. Caitlin refused to respond to any of the cards. Arrangements were made for the social worker to administer the test several weeks later, on the assumption that his prior relationship with the children and his position of authority in the school would serve as encouragements to the children to respond to the test stimuli. Accordingly, three weeks later (as soon as the social worker's schedule permitted) he administered the RATC. Under his administration, all of the children responded to all sixteen cards. Meanwhile, CCPT was begun the following Friday.

#### *Procedure*

The children came at regularly scheduled times that corresponded to periods of class time. Each child spent about thirty-five minutes in the playroom for approximately fifteen weeks, from the first week of December to the last week of April. Sessions were missed when children were absent from school on the scheduled day, or when there were school holidays. Introductions on the first day generally followed standard CCPT protocol, as described by Cochran (August, 2004, personal communication), i.e. "This is special play time: you can say anything you want, and do almost anything you want. When you come to something you can't do, I'll let you know." Translation of this message into ASL rendered an introduction that would be more literally translated as: "Here is special play time. You can say or sign anything you want- that's up to you. You can play at anything you want, that's up to you. If something is not permitted, I'll tell you." The sign here translated as "up-to-you," is comprised of the signs "think-yourself," and is common ASL vernacular for the concept that something is "your decision." At times, when conveying the idea of "something you can't do," the therapist used the sign commonly translated as "forbidden," or "against the law." This sign carries a stronger connotation than the signs

indicating “not-permitted,” but is very commonly used in ASL, and is generally understood clearly by children.

In addition, the therapist introduced the idea of confidentiality, explaining that the specifics of the child’s play would not be shared with anyone, unless there was something said or done that indicated that the child was in danger, in which case we would ask for help.

Following this introduction, the therapist sat in a neutral location on the floor and watched the child. Reflections and tracking responses, typically fairly frequent in CCPT, were greatly constrained by the divided attention phenomenon described earlier. Thus, therapist’s responses to independent play were relatively infrequent. On rare occasions, the therapist interrupted the child’s play to respond to a feeling or activity, i.e., “you’re really looking hard for something in particular,” or “you’re very frustrated with that.” When a child chose to directly engage the therapist, the divided attention phenomenon was reduced, and reflection and tracking responses became much more frequent.

### *Play Therapy Materials*

The play therapy room was originally set up in a classroom normally used for computer technology classes, which was available during the semester that CCPT was begun. Computer tables were pushed to one end of the room and covered with sheets, leaving a play area approximately twelve by fourteen feet. A large round table, originally used in a kindergarten class, and two chairs were brought in, as well as free-standing shelves, a beanbag chair and an easel. The shelves were filled with various toys appropriate for imaginative play, including action figures (notably Spiderman) and Bonicle© figures that transform into monster-type animals as their parts are manipulated, and a basket of plastic “food” and a set of dishes with plastic utensils and cups. There were also a toy revolver, a foam dart gun, and working handcuffs

with a hand release as well as a key, a foam ball, and about ten small Matchbox© type racecars. A dollhouse with a small family of dolls was set up, and a basket with baby dolls, a blanket, and a bottle was placed on the floor, along with a large container of Legos© and a small portable sandbox with construction-type trucks. A “dress-up” basket was also provided, filled with large pieces of colored fabric, a plastic fireman’s and army helmet, a flower crown, play high heels, and sunglasses, and a jump rope. Art supplies included paint and paint brushes, construction paper, markers, scissors, tape, and glue.

Halfway through the program the room was reclaimed by the computer teacher, and the play area was moved to a corner of the social worker’s office. The new space was about half the size of the former area, although all the toys and materials were retained, with the exception of the table.

### Results

Each child responded very differently to the therapist, the CCPT process, and the measures. Synopses of the course of therapy with each child, including the therapist’s impressions of the child’s therapeutic issues, developmental progress, and the therapist-child relationship, including any cross-cultural issues that arose, are included below, along with the treatment results as indicated by the BASC and the RATC. Descriptions of individual results will be followed by a more general discussion of the effectiveness of the treatment for all four children. It should be noted that the results reported here did not represent the final analysis of treatment progress, as play therapy sessions were continued for three more weeks after this thesis was presented.

*Eric**Treatment process*

Eric entered the playroom for the first time talking animatedly, asking questions, and actively exploring the environment. In his case, the word “talking” is meant literally; Eric’s speech is quite understandable most of the time and he seems to feel very comfortable using it. He asserted his identification as a Deaf person, however, in the first session, in which he told the therapist, “I am not hard of hearing; I’m Deaf.” Nevertheless, that first day he also suggested a point of connection with the therapist along the lines of communication, despite her hearing status, as he told her “You talk funny; you talk like a deaf person.” The pattern of interaction continued throughout the rest of the sessions; amount of communication, involvement with the therapist and intensity of activity was consistently high.

Themes frequently revolved around power, which was introduced the first session when Eric pointed a toy gun at the therapist and ordered her to go to jail, “or I’ll shoot you.” Typically, this play involved using action figures to combat one another, with Eric relating in detail the special powers and relative strength of each combatant. Usually, his action figure bested the therapist’s. Often, the therapist was criticized for not using the figure’s special powers to best advantage, or for otherwise not playing “the right way.” Once, Eric told the therapist that if she did not do what he had ordered her to, he would “kill her,” although this was quickly followed by the question, “Is there a rule about killing?”

The freedom to say anything he wanted appeared to foment an existential concern; in one of the last sessions, when the therapist affirmed that he could say anything he wanted, he asked, “What kind of an adult are you, anyway?” possibly indicating anxiety about the life task of taking responsible for himself. Ambivalence about this concern was also indicated in another



session when he asked why grown-ups are alive, and “what would happen if there were no grown-ups?” When the therapist reflected that sometimes maybe he wished that there were no grown-ups, Eric yelled angrily, “I didn’t say that!”

Eric consistently demonstrated a desire for connection with the therapist. During the first few sessions, when the therapist sat observing, tracking and reflecting, he complained, “Why aren’t you playing with me?” Subsequently, Eric explicitly described how he wanted her to join his play. Rarely did he play more than two feet away from her, and typically play involved physical contact. He frequently expressed a desire for the therapist to show him special favor, as demonstrated by repeated requests that she bring him a toy or gift. When the therapist reflected his desire, but did not promise to comply with his requests, Eric often threatened her with physical violence or other punishments. Towards the end of the sessions, these requests for special favors were followed by rather plaintive-sounding acknowledgements that he, in fact, knew that they would not be granted.

After about three sessions, Eric’s teacher informed the therapist that Eric appeared “wound up” upon his return from play therapy each week, and that it was difficult for him to control his behavior and get back into the routine of the classroom. Consequently, his time slot in play therapy was moved to the last session of the morning, which fell right before lunch. Eric accepted the change without complaint, and the solution was apparently effective, making for an easier transition for him to the school routine. Eric’s struggle with transitions became apparent when the switch to the new play space was made; he said several times that he didn’t like it, and then talked about how much he missed his old house, and that he didn’t like his Mom’s new baby.

Early on, Eric displayed power and exerted his independence from the therapist by calling her derogatory names, most frequently “stupid” and “idiot.” Sometimes these were delivered in a rather jovial fashion, as if he quite enjoyed having the freedom to talk in such a way; at other times he appeared quite angry. Often, Eric apologized afterwards, said that he “didn’t mean it,” or asked, “Did that hurt your feelings?”

During early sessions, Eric often asked if he had to clean up the toys he had gotten out. When told he could choose, he voiced concern about “getting in trouble,” and talked about the difference between special play time and other environments such as school or home. Once, Eric arrived after another child had thrown nearly every object in the playroom onto the floor (most of which was still there, due to the limited time allowed between sessions for clean up). Eric appeared shocked, and then bemused by the therapist’s response as she chuckled at the mess. That session he went to the easel for the first time, painted washes of color, and talked about how he would get in trouble if he got paint on himself. He added a figure to his picture with features resembling the therapist’s, then quickly added, “That’s not you.”

During the last third of the program, Eric began each session by emptying the contents of every container all over the room, and sweeping every toy off the shelves. In the midst of this activity, however, he was meticulous to follow the rule about not making a mess in the social worker’s part of the room, and if anything inadvertently was tossed into that area, he immediately apologized and retrieved it. In one of the last sessions, Eric made his usual mess, and then sat amongst the toys littering the floor and sang an invented song with the refrain, “I love you,” and then asked, “Did you like that song?” He then decided to leave the session about ten minutes early, because, he said, he wanted give the therapist time to clean up.

Eric's play throughout the program progressed from following rules that appeared to have been imposed upon him by figures of authority in his life, to experimenting with breaking those rules, to discovering for himself whether or not the natural consequences of those rules were acceptable to him. His relationship with the therapist appeared to be an exercise in exploring the power dynamics in relationships and how to balance an adversarial stance with intimacy. Eric seemed to work very hard in play therapy to find out for himself how he wanted to behave in a relationship in which he was given the freedom of control (within established parameters).

### *Test results*

#### *RATC*

Eric's RATC scores were very similar pre- and post-treatment (See Appendix B). His mean adaptive score pre-treatment was  $T= 55$ ; post-treatment  $T= 57$ . His clinical score was exactly the same pre and post:  $T= 59$ . These fairly high mean scores on the adaptive scales (compared to the  $T$  average of 50) likely indicated that Eric had average to high adaptive functioning. His relatively high average scores on both pre- and post-treatment clinical scales (just one point below a  $T$ -score of 60, the cut-off for a statistically significant finding) suggested that there were likely areas of conflict or psychological difficulty, and that treatment had not diminished his overall experience of conflict. It was interesting to note, however, that Eric's clinical scores on the individual profiles of Depression and Aggression changed significantly: on the pre-test, his clinical scores were highest on the Aggression profile (nearly one and a half standard deviations [SDs] above the mean norm), and his Depression score was just barely above clinical significance (at a  $T$ -score of 62) but, in the post-test, his score for Aggression dropped to the mean for the standardized non-clinical sample, while his profile score for Depression rose significantly: over one and a half SDs above the mean. The fact that Eric appeared more

depressed than aggressive in the RATC post-test may have indicated some progress in therapy, as anger has been described as a secondary emotion that may mask primary feelings of sadness and hurt (Linehan, 1993).

Eric's pre-and post scores on both the adaptive and the clinical profile scales showed a high degree of variability, referred to as "high scatter" in the RATC manual (McArthur & Roberts, 1982, p. 25). According to McArthur & Roberts (1982), high scatter in the clinical scale may indicate that the child was experiencing a distressing situation of recent onset, "marked by volatile behaviors and emotions," while the spikes in the adaptive scale suggest that he possessed important "compensatory resources" (p. 25). This interpretation may be accurate in Eric's case, given that his mother had recently gave birth to a new baby, and that the family had also recently moved to a new home (according to Eric's report). The social worker, as well as school assessments, indicated that Eric is of exceptionally high intelligence, which may have accounted for the spikes in the adaptive scale.

### *BASC*

David's scores on the pre and post-treatment BASC were difficult to interpret; Overall, the results from the parent and teacher pre-treatment BASC scores were not well correlated. The Behavioral Symptom Index on the parent's form yielded a T score of 67, suggesting that he was, at risk for clinical behaviors, while his teacher's rating yielded a clinical score of 57, which, comparatively high, is within the average range. There was some agreement between the two ratings. Most notably, both mother's and teacher's ratings for depression were in the "at-risk" range. Parent and teacher were also in near agreement in rating Eric low on the Adaptability scale, which measures ability on several variables correlated with early school school success, including ability to adjust to changes, to transition easily, and to share possessions. However,

there was significant difference between the two raters' perspectives concerning conduct problems; his mother's ratings placed Eric in the "at-risk" range, while his teacher's ratings were indicated that he was within normal limits. Another significant difference between the raters was seen on the Atypicality scale. This scale measures behavior that could have several interpretations, among them disruptive behavior disorders and psychotic disorders (the latter of which, in Eric's case was not indicated). Eric's teacher's rating yielded an atypicality score in the average range, while his mother's yielded a score that was clinically significant, which, according to Reynolds and Kamphaus (1992), is suggestive of a high level of maladjustment.

Some of the discrepancies between mother and teacher scores noted may be due to a lack of consistency in the teacher's ratings; a comparison of key item pairs yielded a score that suggested caution when interpreting her assessment. Also, Eric might well have demonstrated different behaviors at home than at school, however, given his parent's deafness, these differences were likely not as significant as in home where the parents were not able to communicate with their deaf child.

On the post-treatment assessment, the pattern of ratings between mother and teacher was reversed; Eric's mother's ratings on the Behavioral Symptom index clinical scales yielded a T score of 52, while teacher ratings were at 63T, in the at-risk range. On these scales, both parent and teacher scores on matched pair items yielded acceptable levels of consistency. However, the teacher rated Eric's depression, hyperactivity, aggression, anxiety and depression within the at-risk range, while his mother rated all of these scales within normal limits. Another striking discrepancy was the difference on the Atypicality scale. In a reversal of pre-treatment scores, the teacher's rating yielded a score which placed Eric in the "at-risk" range, while his mother's rating indicated that he was within average limits.

Overall, although the mother's ratings indicated that Eric had improved over the course of treatment, that finding was disputed by the teacher's ratings. Also, both pre- and post-treatment findings of the RATC showed a high scatter, suggesting that Eric was grappling throughout with significant life stressors. The pre/post treatment analysis of RATC profiles indicating a shift from aggressive behaviors to depressive symptoms was not corroborated by results of the BASC. Results of the two quantitative measures used were thus not consistent with one another, nor was the BASC consistent between raters. There was also inconsistency found within the scores of an individual rater. These results indicate that Eric's behavior appeared to be highly variable, although there is considerable evidence that he demonstrated difficulties with aggression, depression, and difficulties with transitions, at least at certain times, but with no obvious decline in problematic behaviors during the play therapy program. The findings suggest that Eric is still struggling with the issues that he had as treatment began, and that his process is highly dynamic and susceptible to intervention, as well as other intervening variables.

#### *Treatment Summary*

Although objective measures did not provide evidence that there was significant improvement in Eric's behavior after fifteen weeks of the CCPT program, changes in the profile on the RATC gave some indication that there were significant shifts in intrapersonal dynamics. This correlated with the therapist's observations of changes in Eric's behavior within the therapeutic relationship. Additionally, a subjective report from the teacher's aide indicated that Eric's behavior in the classroom had changed; she observed that Eric had less tantrums and was more "easy-going." There were likely multiple variables that contributed to this outcome, including, of course, developmental gains as a natural result of maturation. However, the CCPT process appeared to have been an effective modality for facilitating Eric's efforts to integrate the

seemingly dichotomous desires for intimacy and power, and to help him internalize a stronger sense of responsibility for his own decisions.

### *Caitlin*

#### *Treatment process*

During the first meeting with Caitlin, the therapist attempted to administer the RATC, and, as noted above, she refused to respond. When it became apparent that this was the case, the therapist invited her to play with the sandbox, the only toy that had been placed in the playroom at that point. Caitlin refused that as well. She spent the period lying on the floor and dragging her shoes along the wall, making a series of black marks on the white paint, and looking over to the therapist often, apparently to gauge the therapist's reaction. The therapist reflected what appeared to be Caitlin's intention ("maybe you think I'm going to get mad," etc.) and reflected her movements nonverbally. When the session was over, Caitlin ran back to the classroom and immediately told another child what she had done in what appeared to be a spirit of "telling on" the therapist.

Following this beginning, Caitlin came readily to therapy. Subsequent sessions typically followed a pattern; she frequently spent the first ten to fifteen minutes talking, with great attention to detail, about a topic of her choice. The conversation generally centered on objects she had grabbed from her backpack on the way to the playroom: a set of cards, Barbie dolls, etc., or about computer games or her favorite movies. After talking for some time, Caitlin usually began to interact with the therapist in symbolic play. One of the first activities consisted of hiding objects in the sandbox for the therapist to find, an activity tentatively interpreted as regressive. However, there were also elements of power in the game, as Caitlin was very

directive, telling the therapist exactly how to search the sand. When time was up, she threw sand at the therapist. She appeared both angry and thrilled as she ran back up to class.

Middle sessions of the program often bypassed the talking activity. Caitlin played the sand-search game a couple more times, and then began series of sessions in which the main activity was to order the therapist to eat pretend concoctions made from the plastic foods, and then order her to “throw up.” This was often done at (pretend) gunpoint, with Caitlin taking on the role of master, and labeling the therapist as “slave.” Multiple limits were often set in a single session, including limits: for throwing water at the therapist, leaving the room, shooting the dart gun at the therapist’s face, and systematically overturning the baskets and sweeping the toys off the shelves onto the floor at the end of the session (a limit was set on the last activity because there was very little time allotted for clean up before the next session). For the most part, these limits were ignored, except, notably, when the therapist told her that if she left the room, that would be the end of special playtime for that day, at which point Caitlin immediately returned to the room.

Another favorite activity was handcuffing the therapist. During one session she pocketed the handcuff key and then, when told the rule about taking things from the room, denied that she had it. She then ran up to the children’s closet, and displayed the key briefly to the therapist before slipping it into her backpack. The manner and consistency with which these activities were conducted appeared to indicate pervasive feelings of anger and, perhaps, an urge to reject the therapist before the therapist could reject her.

For several sessions Caitlin dressed up the therapist in play clothes. As Caitlin arranged the clothing and straightened the various headdresses, she seemed to be nurturing the therapist, engaging in regressive play. However, her primary affect when the costume was completed



appeared aggressive, as she taunted and ridiculed the therapist's appearance. Caitlin also presented this mixture of regressive nurturing and angry aggression at other times; one session she began to gently create a design on the therapist's hand with crayons, and then began to push the crayons hard against the skin, until the therapist set a limit. During this stage of the therapy Caitlin indicated self-control by respecting certain limits set, including the one just described, as well as a limit the therapist set stating that that any costume arrangement did not cover the therapist's eyes (an important rule to assure safety and continued communication accessibility when the language used is visual).

During one session, however, midway through the program, after Caitlin threw all the play materials onto the play space floor, she ventured into the social worker's office space, looking as if she would sweep the phone off his desk. The therapist set a limit but, because Caitlin appeared to be mid-action, and as her face was turned away so that she could not see that a limit was set, the therapist took her by the arm to physically restrain her from throwing the phone. At that point, Caitlin began to thrash vehemently, and the therapist, concerned for her safety, brought her into a basket hold. Communication was visually restricted while holding the child in such a way; consequently, the therapist attempted to convey acceptance and assurance by rocking gently side to side. At first, the tension in Caitlin's body indicated agitation, and she tried (and sometimes succeeded) to scratch and kick the therapist. There came a time when, although Caitlin did not relax completely, she appeared calmer. When the therapist released the hold, Caitlin ran out of the room and back to class. Concerns that Caitlin would test the limit even more vociferously after the restraining incident were unfounded. The next session, she appeared calm, and resumed playing with the dress-up clothes.

Caitlin continued to test limits in different ways in subsequent sessions: once, in defiance of a rule, she mixed the paints together in their containers. Another time, in the last half of the program, she threw play-dough at the therapist's head. After the last incident, when the therapist stated the rule, she quickly responded, "That was not me, that was my doll," which she was holding in her hand.

In one of the last sessions, Caitlin again played the game in which she hid an object in the sand; this time, it was a plastic knife, and when it was found she said, "It will cut you!" Later in that same session, she again played the game in which she ordered the therapist to eat the pretend food; this time, however, she gave the therapist the option of deciding whether or not the food would be tasteful; no "vomiting" demanded. She also was very careful to follow the "sand stays in the sandbox" rule, although it had not been stated that session. It appeared as if, although she still harbored some violent fantasies, they may have been beginning to subside, and that perhaps Caitlin was beginning to internalize some rules, and to feel more comfortable accepting the therapist's autonomy.

Apparently, by the time this paper was presented, Caitlin was beginning to internalize limits, and although she was not willing to restrain herself from breaking them all together, she was beginning to distance herself from maladaptive behavior. Her responses also suggested, however, that she was not yet willing to accept responsibility for limit breaking. Her propensity to talk in the beginning of the program appeared to indicate that she was anxious about risking a relationship with the therapist, while her repeated actions aimed at directly engaging the therapist as the sessions progressed provided some evidence that she was becoming willing to risk a relationship. Her play at the end of the program indicated that Caitlin was not at mastery stage. Her behavior was still volatile, and the relationship with the therapist often still adversarial.

When she was reminded that there were only three sessions left, Caitlin reversed her earlier careful adherence to the rule, and dumped a plateful of sand onto the floor. She also attempted to push over the four-foot high toy shelves. In another child, these behaviors might have been simply a way to recapture for a moment the intense dynamics of earlier sessions, or a last exuberant reminder of the power of her presence; for Caitlin, however, it felt more like a statement that she was not yet done with her work in the play room.

### *Test results*

#### *RATC*

Although Caitlin responded to all sixteen of the RATC cards on the pre-test, her results on the post-test were skewed by the fact that, due to her absence from school on the day scheduled and other logistical constraints, the post-test was administered by someone other than the original examiner. The substitute examiner, another school social worker who was also Deaf, described her relationship with Caitlin as recently strained due to an incident that had occurred when she had visited Caitlin's classroom two weeks prior to the assessment. At that time, when the social worker was not looking, Caitlin called her "fat," and was subsequently severely reprimanded by her teacher (out of sight of the social worker). Despite the possibility of a negative response to the examiner, testing proceeded, with the result that Caitlin refused to respond to all but one card in the stimulus set. Due to the special circumstance, Caitlin's extraordinarily high number of refusals on the second administration of the RATC could not be fairly interpreted in comparison to the standardized scores. However, the extreme antipathy towards the examiner, apparently resulting from an incident two weeks prior (in which the examiner was, for the most, uninvolved), gave indication that Caitlin may have had patterns of perseverating and of ascribing negative and inaccurate interpretations to events. Also, her refusal

was congruent with themes of power and control that were evident during many of her sessions with the play therapist.

An analysis of Caitlin's first RATC (see Appendix #) may still be helpful in understanding relevant themes and indications. Although Caitlin's REL (Reliance on Others) score was in the normal range, her score of 0 on "Support others" (T-score= 0) suggested that she did not identify herself or others as commonly offering emotional support or helping others in any way. Likewise, her 0 score on "Support child" (T-score =36) indicated that Caitlin may not have been skilled in asserting herself in positive ways, and that she may not have experienced pleasant emotions very frequently. It appeared that she perceived the world around her as unfriendly, perhaps even malevolent. Caitlin's very low score on the Aggression scale was interesting given her frequent displays of aggression towards this therapist during play therapy sessions. It may have been that the low aggression score indicated that Caitlin was defended against angry feelings, and that she denied and/or avoided aggressive feelings. This might have caused particular difficulties for Caitlin, given that her high score on Problem Identification suggested that, along with well-developed verbal abilities, she possessed the capacity to perceive complex interactions and conflicts. Perhaps Caitlin was adroit at perceiving problems, and, not knowing how to cope with or resolve them easily, she constricted the angry feelings they engendered. Her score on the Anxiety scale lent additional support point to that interpretation.

Caitlin's low scores on the resolution scale, along with the very high score on the unresolved scale (over three SDs above the standardized mean, even when given multiple prompts by the examiner) suggested that the issues that gave rise to her overt behavior of noncompliance in school and her difficulties at home remained unresolved and troublesome to her.

*BASC*

Interpretations of the BASC results pre- and post treatment were again difficult to analyze because of differences between parent and teacher ratings. The parent ratings in the Clinical Scales Overview indicated an increase of over one SD in clinically significant behaviors: scores rose from T= 62, indicating that Caitlin was in the “at-risk” range, to T= 76, which ranked her in the 99<sup>th</sup> percentile and in the “clinically significant” range. Specifically, Hyperactivity, Aggression, Depression, Atypicality, and Withdrawal all increased by at least one SD, pushing all of these scales at least into the “at risk” range, and pushing the aggression score into the “clinically significant” range. The mother’s ratings yielded an overall Behavioral Symptoms Index (BSI) score on the 99<sup>th</sup> percentile (T= 76).

Ratings by Caitlin’s mother indicated particular difficulty on the Aggression scale; her scores suggested that aggression was a problem in the beginning of treatment and that it became significantly worse by the end of the program (from T=67, in “at-risk range” to T= 76, rated as “clinically significant”). The parent ratings also indicated that Caitlin had difficulties with withdrawal, defined by Reynolds and Kamphaus (1992) as a “tendency to avoid others to avoid social contact,” (which the authors add may be an indication of depression) while the teacher rating for withdrawal was well within normal range.

Conversely, teacher ratings on the Clinical Scales Overview were well within “average range” and nearly identical at T= 55 pre- and T= 56 post-treatment. Teacher ratings for the Internalizing Problems Composite yielded very consistent scores that, overall, indicated Caitlin’s functioning as well within average range pre- and post-treatment. However, she rated Anxiety T= 62 on both pre- and post assessments, indicating Caitlin was within the “at-risk” range on that scale. Scores on the Externalizing Composite changed very little pre and post, and were well

within “average range.” For comparison purposes, it should be noted that the Aggression scale in particular was very similar pre- and post-treatment (T= 55 and T= 56), with no clinical indications.

There was much greater agreement between parent and teacher ratings on the adaptive scales. Both teacher and parent scores indicated that Caitlin’s adaptive skills were well below the normal range, although, once again, parent perceptions appeared much more negative. sTeacher ratings suggested that Caitlin’s adaptability, social skills, and leadership ability remained the same at about 40T pre- and post-treatment. Parent ratings, however, indicated that these skills degenerated from 32T to 29T, or from a percentile rank of 4 to a percentile rank of 2.

### *Treatment Summary*

Caitlin appeared to be young girl who was often angry, likely struggling with not liking herself, and not trusting that others would like her. Objective measures appeared to indicate that, at least in the perspective of her mother, Caitlin’s maladaptive behaviors became significantly worse over the course of treatment, particularly her aggressive behavior and her propensity to withdraw from others. Differences between teacher and parent ratings may have suggested that the child felt safer to display aggressive behaviors at home than at school, where uncomfortable feelings were internalized due to perceived teacher authority or peer pressure.

Therapist observations corroborated that relationships posed significant difficulties for her. A hypothesis was formulated that Caitlin’s apparent efforts to push the therapist away may have been her way of protecting herself from the rejection that she feared was inevitable. No apparent issues related to hearing status or cultural differences arose during therapy with Caitlin.

Given that there were many interruptions to therapy over the course of the program, due to school vacations and to Caitlin's frequent absences, treatment was still very much in the working stage, where behaviors frequently become worse before they become better. Caitlin had obviously not achieved mastery by the end of the program. Given the observations above, particularly the mother's clinically significant ratings of her daughter on the BASC, recommendations were made that she seek further treatment for Caitlin.

### *Adam*

#### *Treatment process*

Adam presented as a very anxious child. The first time the therapist went to get him for play therapy, he appeared reluctant to come with the therapist, and his teacher (who was hearing) urged him along. He then stated bluntly, by way of explanation for his reluctance, that the therapist was hearing and he was deaf. When he came to session, he played very tentatively with the toys, and appeared nearly listless. The therapist sat several feet from him, and left the door open, to help allay his apparent fears. By the end of the period, he was playing more actively with the toy cars, although he stated that the session seemed to be lasting a long time. When it was time to leave, Adam asked if he could take a marble with him. His feelings were reflected, and then a rule stated which denied his request, at which Adam repeated his request, with arguments such as, "No one will miss it," "I'd bring it back." The rule stood, however, and Adam left, apparently sad. This pattern was repeated a couple of other times in following sessions. Conversation was conducted in ASL that first meeting, and in every subsequent session, although Adam frequently used his voice in the classroom.

Adam was usually sitting on a bench in the hall when the therapist went to pick him up. Although very serious, he appeared eager to come to "special play time." There was very little

communication, other than occasionally some words exchanged outside of the playroom; for example, when the therapist was a minute or two late to pick him up, Adam solemnly informed her of the fact. Another conversation revolved around a box purporting to contain “Puxatawney Phil” that stood in the hall on the way to the playroom. A stuffed animal had been placed inside, and Adam asked several times with a worried expression if it was real. He was visibly relieved when a passing teacher showed him that it was not.

Adam continued to play with the toy cars continued for several sessions, and then he switched to the action figures, pretending to have them battle one another. Interaction with the therapist was minimal. In some sessions, Adam looked up frequently after a “kill,” had been made, apparently to check the therapist’s reaction. No response was made to the therapist’s reflection of this. Adam never made any battle sounds, and there was no apparent emotion when a figure was victorious or suffered defeat. He never narrated his play or commented on it in any way. His face most frequently appeared somewhat sad, or serious, and almost always intent on whatever he was doing. Another common activity at this time was play with the Legos®. Adam spent the greater portion of three sessions attempting, with some difficulty but great perseverance, to arrange the Legos® pieces on their base so that they formed a solid block, fitting them next to another like a puzzle.

As sessions progressed, Adam appeared to play with more conviction. For many sessions in a row, he got down the dollhouse, and arranged Transformer® action figures so that they appeared to be climbing up over the roof, while others hid within. Once, when he used the toy gun to “shoot” an intruder, he looked up at the therapist with a mischievous glimmer in his eye, the most animated expression he had shown. Around that time Adam began to occasionally lock



the handcuffs around one of the action figures. He also used the shark, and stuffed as many figures into its mouth as could fit.

When Adam was told that there were four sessions left, he appeared somewhat unhappy, but gave only a slight nod when it was reflected back to him. At the next scheduled session, a school-wide activity conflicted with the scheduled for play therapy, and Adam was given a choice as to which he would rather do. He unhesitatingly chose to join the school activity.

Adam played independently throughout the program of play therapy. He never invited the therapist to join him in play, or otherwise involved her in his play, other than the occasional glances up as described above. He played symbolically on his own, with very little facial expression, although as time went on, he physically demonstrated increasing (although relatively mild) enthusiasm. At the time this report was completed, he appeared to have grown more comfortable with the playroom, and freer in his play.

### *Test results*

#### *RATC*

Adam's RATC test scores suggested, overall, very little change in adaptive functioning: the mean on the adaptive scale dropped from 44.6 to 42, and on the clinical scale rose from 53 to 55.6. Individual scale scores indicated, however, that there were some disturbing shifts. The average T score of 57 on the Support Child scale achieved on the first administration, which indicated positive emotions and an ability to assert himself, dropped to a raw score of 0 (T=35) on the second administration. Nearly all of the other adaptive scores dropped as well. The one positive change was indicated on his Problem Identification response, which rose by two SDs on the post-test, suggesting that over the period of treatment Adam not only increased his ability to recognize problems, but also developed his ego-integrity to the point that he was able to talk

about and perhaps accept them more easily. However, the overall mean score on the clinical profile rose from a score close to the standard mean to one and a half SDs above the standard. All of the clinical scales increased except Aggression. The change in the Anxiety scale was particularly surprising, in that it rose two and a half SDs on the post-test. This may have been because his original score, which was well below the standard mean, was artificially depressed; given Adam's anxious presentation and reports by the teacher that changes in routine generally upset him, it seemed likely that Adam's expressions of anxiety were restricted during the first administration. The same phenomenon may have accounted for the rise in Adam's Rejection score.

The dramatic rise in his Depression score was more difficult to understand, however, as his original score was not unusually low. Unknown confounding variables may have played a part; given Adam's low scores on Reliance on Others and Support Others scales (raw scores of 0 on both pre- and post-tests), he appeared to have limited ability to ask for or receive help, which may have made him particularly vulnerable to the effects of conflicts. Also, Adam scored unusually high on the Unresolved scale on both pre- and post-test, a fact that suggested that he was struggling with underlying, unresolved issues throughout the treatment.

The consistently high scatter of both clinical and adaptive profiles indicated that Adam was possibly contending with an acute situation of recent onset, marked by variable emotions and behaviors. Since the mean of his adaptive scores were, however, within the range of normal responses, there was reason to believe that Adam generally functioned in adaptive ways, and had resources that he could utilize to cope with the stressors he was experiencing.

*BASC*

Adam's post-treatment parent rating scales for the BASC were never received, so there was limited opportunity to compare teacher and parent reports. Interpretations of treatment progress were tentative, particularly because the pre-treatment parent rater form yielded a false negative (F) score that warranted an "extreme caution" rating. Seven items were flagged, and although one of the items (a "never" response to the item, "Adjusts well to changes in routine") appeared to be a reasonable response to Adam's behavior, given therapist observation and teacher report, other responses seemed to indicate that the parent had adopted a negative response set, or misunderstood the questions. Particular items that appear to contradict teacher reports are as follows (Parent Rating Scale = PRS, Teacher Rating Scale= TRS):

Hits others: PRS= almost always, TRS (both pre and post)= sometimes,

Refuses to join group activities: PRS= almost always, TRS (both pre- and post) = sometimes,

Complains about rules: PRS= almost always, TRS, pre= never, post= sometimes,

Shows interest in other's ideas= PRS= never, TRS= sometimes.

Other flagged items were not present in the TRS, however, a perusal of the teacher ratings as a whole indicated that teacher responses for the remaining items would also have contradicted the parent's negative ratings. It was striking that every scale marked by the parent was either clinically significant or in the "at-risk" range. Several clinical scales were extremely high, including Hyperactivity (T= 87), Aggression (T=92, Conduct Problems (83), Atypicality (114), and Withdrawal (98). The excessive negativity of these responses indicated that parent ratings may have been invalid, and were therefore not included in this analysis.

Teacher ratings, however, also yielded above average scores in both Externalizing Problems (composite score of T= 68) and Internalizing Problems (composite score of T= 66). The Anxiety scale was rated highest, in the “clinically significant” range, and the Hyperactivity, Aggression, Depression, and Atypicality scales were all rated in the “at risk” range. The Atypicality score was not judged to be indication of psychosis, but more likely developmental delays, although continued attention was recommended. These scores improved somewhat, although not significantly, on the post-treatment assessment. Notably, Depression and Atypicality dropped to the “average range.” The Anxiety score, however, remained “clinically significant.”

Adaptive skills were apparently perceived by the teacher to be consistently below average, as the composite yielded a score in the ‘at-risk range’ both pre- and post-treatment. Adaptability and Social Skills were the two scales indicated as problematic, and remained in “the at-risk” range for both assessments.

#### *Treatment Summary*

Adam’s behavior did not appear to change significantly over the course of play therapy. Given reports of anxiety from his teacher, and his general anxious presentation, Adam may have been particularly sensitive to the impact of missed sessions due to school vacations and to the change in the playroom location. The excessively negative reports from his mother (assuming she did not misunderstand the rating form), and the rise in Adam’s RATC on the depression and anxiety scales, may indicate that there were variables at home that impacted his functioning over the course of treatment. There were some positive signs, however, as the therapist noticed a subtle shift towards greater freedom of expression in his play. Also, his teacher remarked in a short interview at the end of the treatment, that Adam had “gotten very funny all of the sudden,”

and that his appreciation of humor was helping him deal with stressors in the classroom better. However, Adam's consistently high scores on measures of anxiety and his mother's excessively negative ratings of Adam's behaviors, appeared to indicate that the family was in need of support. Consequently, a referral was made at the end of treatment for further services.

### *John*

#### *Treatment process*

John came to play therapy the first time quite willingly. He seemed surprised to see that there was a playroom in the school, and had questions about how they got there, and remarked that there were a lot of toys. When the structure of play therapy was introduced to him, he asked, with an expression of mild surprise, "Are there **any** rules here?" John communicated in ASL, producing his signs casually and using very little mouth movement (perhaps a common style among children whose parents are deaf, as his were). At times, the therapist had difficulty understanding him, and asked him to repeat what he had just said. John repeated himself with evidence of some irritation, and then acknowledged with a slight smile that this was the case when the therapist reflected that feeling back to him. Occasionally, when the therapist had understood and responded to his statement with a reflection, John repeated himself as if she had not. This was also reflected to him, which John then affirmed. There appeared to be a dynamic related to deafness and language use, the nature of which was difficult to determine precisely, between therapist and child.

For the most part, John used the time in play therapy to play independently, in the beginning almost exclusively with the Legos©, spending most of his time constructing buildings and vehicles. In the beginning of some sessions, and, occasionally in the middle of one, John struck up a casual conversation with the therapist, for example, letting her know, often with some

enthusiasm, what he had done over vacation or what he was going to do that weekend. After a brief exchange, he began his independent play. Like Adam, John never invited the therapist to join him, nor did he narrate his play or make comments on it. His play appeared very focused, and extremely patient as he fit the small pieces together, took them apart, and refit them in new configurations. Often, he looked up at the clock; when the therapist reflected that maybe he was hoping that time was up (a possible projection of her own lack of confidence in the play therapy process), John clearly denied that that was the case.

When the switch was made to the new play area, John looked as if he were slightly surprised, but went immediately to the Legos®. Soon, however, his play shifted to play with the Transformer action figures. He spent a great deal of time changing the fixing them into one shape or another, and then changing them again. His play appeared flat, with little symbolic representation, and the therapist at this time surmised that John was not interested in using the play therapy to process feelings. The next session, she told him that it looked as if he was not interested in play therapy, and that he could choose to stop coming if he wanted to do so, in which case he would return for two more sessions, to say good-bye, and then play time would conclude. He emphatically replied that he wanted to continue. In later sessions, John played more with the sand, frequently burying toy vehicles in it and then pointing small planes towards the hidden vehicles and “destroying” them. Once, when the therapist attempted to track this play by describing the action as rockets hitting the sand, John firmly corrected her, saying that they were not rockets, but airplanes.

Near the end of the play therapy program, John said, when the therapist went to get him to play therapy, that he was expecting his mother to bring him something, and that he did not want to miss her. The therapist asked him to come briefly to the play area, which he willingly

did. At that point, the therapist again showed John the calendar demonstrating that there were two more play times left after that day. John seemed to find that agreeable. He played for a few minutes, and then left to go back to the playroom to meet his mother, an event that the teacher indicated had not, in fact, been arranged.

Play therapy obviously held some attraction for John, as he chose to keep coming. There were some subtle changes in the nature of his play, as it became somewhat more symbolic toward the end of the sessions. Although there was little interaction with the therapist during play, the nature of their communication and of their relationship appeared to be of some importance to John's sense of himself and his relationship with others. It was not clear to this therapist whether the salient factor was her position as an adult and thus a possible figure of authority, or whether it was her status as a hearing person, and thus representative of the greater hearing community.

### *Test results*

#### *RATC*

John's overall means pre- and post treatment did not change significantly on the RATC; the mean on the adaptive scale improved 3 T points and decreased by 7 T points on the clinical scale. His scores in the Reliance on Others scale were consistently low, (raw score= 0, or T= 38) which suggested that he did not typically consider applying for external help to resolve his difficulties. Scores on the Support Others and Support Child scales both dropped by approximately one and a half SDs, which indicated, that for some reason, he became less inclined to help others or offer emotional support, and also that he felt more negative about himself, and less able to delay gratification or assert himself. The Anxiety score remained exactly the same, right at the standardized mean. The Aggression and Depression scores also did

not change significantly, however, both were above the average range, and depression climbed five points on the post-test to two SDs above the standard mean, while the Rejection score dropped by one SD. On the other hand, the higher post-test score on Resolution-2 and the significant drop (2 SDs) in the number of stories that were left unresolved, indicated that John became more adept at resolving issues in constructive ways. The similarities of the scores pre- and post-test are consistent with this therapist's observations of the course of treatment as described earlier, in which very little change was noted.

McArthur & Roberts (1982), as mentioned earlier, described high scatter, such as seen on John's profile, as indication of an acute issue that involves dramatic shifts in emotions and behaviors. The school social worker informed this researcher that John's parents had recently begun the divorce process, which may well have affected at least some of John's scores.

### *BASC*

As with Adam's BASC, John's post-treatment parent rating scales for the BASC were never received; and therefore there was again limited opportunity to compare teacher and parent reports. However, the consistency of the parent report that was received was rated as acceptable, as was the post-treatment report from the teacher. The teacher's pre-treatment report, however, had several inconsistent ratings on matched pairs, thus, that report was interpreted with caution.

Teacher ratings placed John within the "average" range on the Clinical Scales Overview, and on the Internalizing Problems Composite both pre- and post-treatment. However, the post-treatment teacher rating placed John in the "at-risk" range for Aggression, with a relatively high score of T= 75. The parent rating form, completed by John's mother, placed him in the "average" range on the Clinical Scales overview, and on the Externalizing Composite. However, John's mother rated him yielded a score within the "low" range on the Internalizing Problems



Composite because her rating of her son on the Anxiety scale was very low, affecting the overall average.

John's Adaptability scores were consistently within the average range on the TRS pre- and post-treatment, as well as on the PRS pre-treatment. Notably, all three forms rated John as "high" on the "Leadership" scale, a result consistent with literature that has found that Deaf children of Deaf parents frequently become leaders in the community (Hindley, 2000).

### *Treatment Summary*

John's behaviors did not appear to change significantly over the period of play therapy. It proved to be difficult for the therapist to establish an environment in which John felt ready to explore play in symbolic ways, although by the end of the treatment program there were some indications that play had shifted in that direction. It may have been that the therapeutic relationship was affected by insecurities on the part of the therapist in her own ability to understand and communicate effectively. A brief interview with the teacher's aide in the classroom, as well as the teacher's BASC report, indicated that John became increasingly aggressive over the course of treatment. As always, this may have been affected by intermediating variables, one of which, in this case, may have been his parents' divorce process. John's reactions to that event may have been exacerbated by a reluctance to ask for help, as indicated by results of the RATC. However, John's strengths appeared to have been sufficient to help him to maintain generally adaptive coping skills. No further treatment at this time was recommended.

### *Overall results*

Overall, pre and post treatment measures did not provide statistically significant evidence that the children in this study improved over the course of treatment. Careful attention to the

process of CCPT, however, revealed that the degree of child-therapist interaction was correlated with the child's progress. The play of the children who engaged frequently with the therapist, Eric and Caitlin, progressed through at least three of the stages of play. A variety of themes were evident in their play, and their relationship with the therapist went through several transitions. However, Adam and John, who played almost exclusively on their own, appeared to make less progress through the stages of play. The themes of play remained fairly consistent, and their relationships with the therapist did not noticeably change over the weeks of therapy. Results of this study, then, are mixed, and appear to be affected by cultural and linguistic factors that may impact future cross-cultural studies of CCPT with deaf children.

### Discussion

There are likely many factors contributing to the lack of statistically significant changes in the children. Some of these are related to structural problems with the treatment delivery, including scheduling consistency and lack of parent and teacher involvement with the program. Also, consideration of cohort differences between the populations studied helps to explain the discrepancies between the outcomes of the present study and studies in the past. Finally, this study revealed the importance of certain linguistic and cultural factors that significantly affect the delivery of CCPT to Deaf children, including the impact of the divided attention phenomenon and deaf norms of conversational regulators. These issues, and implications for further research, are discussed below

### *Consistency*

One of the variables that likely impeded the effectiveness of the treatment was the lack of consistency in the sessions. Given that the treatment was offered in the school, the program was subject to the school schedule. Fridays, the day chosen for regularly scheduled sessions, turned

out to be a particularly inauspicious day for consistency. Aside from the weeklong holidays (two weeks off during the Christmas holidays, and an additional week off each for the winter and spring breaks), school was cancelled on three additional Fridays for various reasons. At one time, the school schedule resulted in three missed sessions in a row, meaning that there were four weeks between sessions. The therapist attempted to reduce the amount of time missed by rescheduling a session for a Thursday. This seemed to help reconnect the children somewhat to the process and to the therapist, but it did not help to establish consistency, as the make-up session was not on the regularly scheduled day.

Several authors (Landreth, 2002; Troester, 1996) emphasize the importance of consistency. It seemed to this researcher, upon reflection of the course of the program, a valid concern. Other lapses in consistency and structure also appeared to affect the children. For example, although the children were given warning that the room would be changed, the relocation of the play space mid-program, seemed to cause some disorientation, concern and perhaps anxiety.

Another inconsistency resulted from an oversight in planning; the schedule of sessions did not allow adequate time for clean up. Thus, if a child left the playroom a mess, the therapist was left with a dilemma: either spend the time to clean up thoroughly, and be late to pick up the next child, or leave the room untidy, with the result that the next child not only saw what the previous one had done, but also had to begin his or her play in an cluttered space. Neither solution was ideal, and although the therapist became adept at cleaning up very quickly, there were still times when she was late for the next child. Although this circumstance did not happen often, when it did, the child waiting was affected by the unreliability of the start time of his or her session. This scheduling detail also left the therapist more vulnerable to lack of empathy and

congruence as a child began to mess the playroom near the end of the session. Eventually, sessions were cut back by five minutes, an imperfect solution. This seemingly simple scheduling error likely impacted the children's sense of safety and trust in the therapist, and consequently the course of therapy as a whole.

#### *Parent/teacher involvement*

Previous studies of CCPT have indicated that the process is much more effective when parents are involved in the treatment (Ray, Bratton, Rhine, & Jones, 2001). Also, Smith and Landreth's (2004) research with teacher filial therapy found that involving the teachers in the CCPT process was very successful. The current study, to its detriment, did not make an effort to involve the parents or the teachers.

Although signed consent was obtained from the parents, and a brief description of CCPT provided, there was no further contact between therapist and parents other than a progress update midway through the program. It is likely that treatment would have proved more effective had the therapist spent time with the parents, explaining further the CCPT process and theory, and providing education for the parents regarding the ways that they might incorporate some of the basic methods of CCPT, i.e. feelings reflection, in their relationship with their children. That kind of time investment would also have likely improved the parent's confidence in the treatment and in the therapist, which may well have affected the children's feelings of trust.

Similarly, taking the time to describe more completely the CCPT process with the teachers of the children involved would likely have instilled more confidence, and perhaps translated to the children a greater expectation of success. Future studies would benefit from more careful consideration of the other significant adults in the lives of the children coming for treatment.

### *Measurements*

As described in the narrative reports of each child's course treatment, changes did occur for all of them. These changes, however, were not apparently measurable by the instruments chosen, and might, in fact, be difficult to measure by any instrument, other than the human heart and eye. It is inherently difficult to measure the results of a therapy that regards the identification of specific treatment goals, other than the development of a positive sense of self and self-efficacy, as antithetical to the unconditional positive regard that lies at the core of its theory.

Another difficulty in evaluating children's progress is, as Hindley (2001) suggested, that parent and teacher reports often represent children's problems very differently from the ways that the children themselves see their issues. Of course, the observable behavior of children (as well as that of adults) may appear to be at odds with their internal struggle; that paradox is the very nature of a behavioral problem. Still, in order to help the child resolve maladaptive behaviors, it is probably most effective to address the issues as the children themselves experience them.

An attempt was made to understand the children's perspectives through use of a projective instrument, the RATC, however, there were administration difficulties with the measurement that led to problems in interpretation. The test administrator deviated from standard procedures (i.e. prompting the children throughout the assessment, rather than only on the first two cards, as is standard procedure). This was likely due to lack of training on the instrument; he was (rather unfairly) asked to administer the assessment after only several minutes of instruction, and with virtually no practice. There may also have been a cultural influence on the process, however. Typical ASL discourse structure is even more reliant on back and forth exchanges than

is English, and it may have felt to the Deaf administrator that inhibiting that exchange was uncomfortably deviant from those norms. Of course, psychological testing often creates an unusual circumstance; however, it may have been that much more unusual in the context of Deaf culture.

Nevertheless, the RATC pointed to internal struggles the children were experiencing that were not always captured by the parent and teacher behavioral checklists. The instrument seemed to be more sensitive to the varying internal dynamics of the children, although at the time of this report, those changes had not appeared, at least for most of the children studied, to resolve into positive behavioral changes.

### *Cohort Effects*

An obvious limitation of the current study was its size; it is very difficult to generalize from an N of four. Nevertheless, some of the differences between the results of the current treatment program and those found in Oulline's (1975) study, for example, are likely impacted by cohort differences. As mentioned by Greenberg and Kusché (1989), the characteristics and life experiences of deaf children have changed significantly over the last thirty years. Although, as mentioned earlier, Oulline did not describe the educational or family environment of the children in her study, it is likely, given the date of her research, that communication was not accessible to the children in any of their environments. This was made poignantly clear by the struggles that the therapist herself had in communicating with her clients. That circumstance was remarkably different from the lives of the children in the current study. The school attended by the children in this study maintained policies to provide full access to communication, and required the consistent use of sign language in the entire school environment, as well as in the classroom. The school also encouraged positive Deaf identity by providing Deaf role models and

incorporating Deaf cultural, historical references into the regular curriculum, by providing regular instruction in and modeling of ASL.

The extreme differences in the accessibility of daily communication for children in the Outline study compared to the opportunities afforded the children in the current investigation may have affected the outcomes of each. It is likely that children accustomed to an impoverished communication environment would respond very favorably to the sustained attention and positive regard of a CCPT therapist, even considering the fact that they shared no common language.

In fact, research quoted earlier that suggested that deaf children in general suffer from deficient peer interactions, have negative self perceptions, lack the opportunity to establish positive self identity and social skills, and have difficulty understanding the causes of emotions (Calderon & Greenberg, 2003; Rieffe, Meerum Terwogt & Smit, 2003; Shirin & Kreimeyer, 2003) may not apply to a cohort of children educated in a school for the deaf where access to communication is policy and raised in families that consistently use sign language. Of course, this is not to say that individual Deaf children may not struggle with such issues, or that CCPT could not be effective with children regardless of usual communication access. However, given that issues of positive identity and self esteem may not be as pervasive as they might have been in a cohort of thirty years ago, assumptions about the issues affecting contemporary deaf children should not be made based on studies conducted in a different era or with children in very different life circumstances..

This implies the obvious, that a given treatment is not necessarily indicated for all children in a population, and that interventions for Deaf children, as for all children, should be selected on an individual basis, with consideration for cultural and linguistic applicability.

*Cultural, Linguistic, and Cross-cultural Issues*

Several hypotheses regarding cultural, linguistic, and cross-cultural issues were formulated as the results of the treatment were analyzed. One was that CCPT does not translate well into the discourse of ASL. It was reasoned that the particular vernacular of CCPT practitioners, a way of speaking that emphasizes tracking the children's play, reflecting their feelings, and resisting giving answers to certain questions (in order to encourage self-discovery), was contrary to the norms of ASL. Although the therapist recognized that the "CCPT way" of talking is often perceived, at least initially, as odd by many English-speaking children, she became concerned, as therapy progressed, that it was prohibitively so with Deaf children. It was observed, for example, that the therapist's interactions with Eric, in sign-supported speech, and her interactions with John, in ASL, were markedly different. With Eric, the therapist tracked play and reflected often, and continued to do so, sometimes despite Eric's protestations. Their relationship from the beginning was intense, and apparently therapeutic, as Eric's progress through the stages of CCPT could be readily seen. However, the therapist found that she was reluctant to track John's play or to reflect his feelings, and thus speculated that the difficulty was possibly a function of the language and/or culture.

As described earlier, an important feature of ASL is its assumption of shared context. In fact, one of the indications of a person's relative affiliation with the Deaf community is the extent to which he or she understands the context without needing to have it stated explicitly. It appears that awareness of this norm influenced the therapist's discomfort in speaking with ASL-using clients in the ways suggested by CCPT theory. Reflecting, and even tracking, seemed to violate the norm that the obvious does not have to be stated, and to risk positioning herself as "outsider." This dynamic was exacerbated by John's reaction when the therapist tracking or



reflecting types of statements: he typically looked at her with an expression of mild amusement, or repeated himself as if the therapist had misunderstood him.

Upon further analysis, and discussion with Deaf consultants, however, it was determined that John's reaction was likely illustrative of his lack of interest in, or resistance to, engaging in a therapeutic relationship, rather than an indication that the language of CCPT was inappropriate for use with Deaf children. Of course, John's resistance to the therapist may have been influenced by her status as a hearing person, but in the hands of a more experienced therapist, that dynamic could have been simply "grist for the (therapeutic) mill." An important lesson was learned about the temptation to ascribe interpersonal issues with cultural ones, particularly for a therapist working in her second language.

Further evidence that the high context aspect of ASL did not necessarily proscribe the use of CCPT was found in the relationship between the therapist and Caitlin. Although Caitlin used ASL exclusively, the therapist felt comfortable and facile with tracking and reflecting her actions and feelings. Caitlin, as opposed to John, interacted almost constantly with the therapist, and was obviously very interested in establishing a relationship, as antagonistic as it might, at times, have appeared. The comfort level of the therapist in using the language of CCPT was clearly, then, not so much a function of Deaf cultural norms as a result of the degree to which child and therapist interacted.

A more legitimate concern for the applicability of CCPT with Deaf children appears to be the issue of "divided attention," as described above. It remained true that when children were immersed within their own play, as John and Adam often were, it was problematic for the therapist to establish contact and gain entrée to a relationship. This is a very different dynamic from the one that occurs between in CCPT when both child and therapist are hearing.

When a hearing child plays independently, even with his or her back turned to the therapist, contact can be maintained through the auditory channel, i.e. when the therapist reflects, tracks or otherwise demonstrates empathy. The child may choose to respond in any way, including ignoring the therapist. A spoken comment does not demand attention; there is no commitment to communicate, listen, or even acknowledge the therapist required. The choice is left entirely to the child, and yet, even if the child pretends that nothing was said, he or she has access to the words, knows that a relationship was broached, and, hopefully, is aware that someone was attempting empathy. A therapist could reflect throughout an entire session without a hearing child ever acknowledging a word, and yet be assured that the child had at least heard the therapist's attempts to connect.

However, with a deaf child whose gaze is averted from the therapist, such undemanding communication is very difficult to achieve. How can a therapist allow a deaf child to play independently while still offering consistent empathy? To leave the child to play alone without reflecting and tracking his or her play seems to neglect the relationship, even if using body language that communicates focused attention. However, interrupting the child in order to secure visual attention so that empathic statements may be made appears to violate the spirit of CCPT, which is to allow the child to choose where to give his or her attention, it seems, in fact, unempathic. Thus, the divided attention phenomenon is very challenging when working with children who prefer to play alone. Of course, with children who spontaneously choose to interact with the therapist, there is no difficulty; the child is already looking at the therapist, and no division of attention is required. This may well be part of the reason why the relationship with Caitlin and Eric was so much stronger than it was with Adam and John. It is strikingly easier to

reflect the statements of deaf children, and thereby make a connection with them, when they are already looking at the therapist.

However, divided attention does not necessarily prohibit therapeutic connection. One of the Deaf social workers noted that, if the CCPT therapist waits for the child to look up before venturing a reflection to him or her, it is comparable to asking permission. That type of exchange may create an uneven power dynamic in favor of the child, a dynamic that is likely to be uncomfortable for the child, as well as inappropriate. A more effective way to approach the divided attention phenomenon may be to take a position within the peripheral view of the child, and then go ahead and make comments to the child even when he or she is not looking. This does, in fact, violate Deaf social norms of turn-taking, which may feel awkward or uncomfortable, but therapy is not, after all, a normal situation. The tactic recommended has the advantage of giving the child an additional opportunity to make a choice, that of whether or not he or she wants to engage with the therapist at any given moment.

### *Conclusion*

This study indicated that CCPT may be effective as a cross-cultural intervention with Deaf children, although statistically significant positive changes in the children studied were not obtained with the measures used. However, the subjective experience of the therapist, observations of videotapes of the progression of children through the stages of therapy, informal subjective reports from school personnel, as well as shifts in individual scales on a projective measure, suggest that some positive changes occurred that were apparently resistant to measurement.

Comparisons of the literature on deaf children with the life experiences and presenting problems of the children studied in this program indicate that there is a significant cohort effect

impacting studies of this population. Future research of the emotional and behavioral characteristics of deaf children needs to carefully describe the social context of the children studied, particularly their access to communication, and readers need to consider these factors when ascertaining whether or not research findings are likely to generalize to any other group of children.

Consideration of the possible mediating variables impacting the current study appeared to corroborate the findings of previous research indicating that a program of CCPT is strengthened when parents and teachers of the children are included in treatment planning. This recommendation supports the findings of Calderon and Greenberg (2000) who referred to several studies suggesting that person-centered approaches “must be integrated with ecological models that examine how development is affected by systems-level factors” (p. 185).

Another significant variable indicated by this study is the structure of treatment; it appears important to plan the program carefully to maximize consistency. It is recommended that CCPT therapists take care to schedule sessions so that very few, if any, are missed, to ensure that the time of the play therapy is consistent, and to try to secure a play therapy location that can remain consistent for the duration of the treatment.

Perhaps the most important finding of this project was the challenge of providing effective CCPT with deaf children who preferred to play independently, because of the complicating factor of the divided attention phenomenon. This author feels it may be possible to overcome the challenge, however, the problem demands careful consideration and consultation with experts in CCPT as well as in Deaf culture and ASL. Another conclusion drawn from the study is that it is not enough for therapists working cross-culturally in the Deaf community to understand the language and culture of their clients. They must also examine their own

relationship to that community, and balance the need to obtain what Pollard (1996) termed “cultural legitimacy,” with their responsibility to provide unbiased psychological care. That is to say, it is incumbent upon hearing therapists working in the Deaf world to see their clients as humans first, and to avoid confusing psychological dynamics with cultural ones. One of the most effective ways to achieve this balance is to maintain a spirit of “cultural humility” (Tervalon & Murray-Garcia, 1997), in which, recognizing that he or she will never completely understand what life is like as a deaf person, the therapist seeks to work in active partnership with the deaf community, in order to provide the best possible services for their clients.

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Appendix:

Initial Recruitment Letter to Parents

“Special Play Time” Program

We are sending you this letter to ask your permission for your child to come once a week to play therapy. This invitation does not mean that there is anything “wrong” with your child. Play therapy, or “special play time,” is an opportunity for children to have some individual time with a counselor in a safe, supportive setting where they can feel free to express themselves through play. Play is the natural way that children communicate, and a comfortable way for them to learn about themselves and their world. Children often find that this kind of special play time helps them to learn more about how they feel, what they want, and the natural consequences of the choices that they make.

Benefits of play therapy may include an increase in the child’s sense of him or herself as likable and capable, a stronger sense of self-responsibility, and an increased ability to form positive relationships with others.

Play therapy will be once a week for forty-five minutes, and will continue for fifteen weeks. Your child’s teacher has agreed that your child may be released for that time. This is a special program provided by Susan Chapel, a counseling education graduate student trained in play therapy, to give children the opportunity to express their feelings and learn about themselves. She will be under the supervision of the social worker at the school, and Jeff Cochran, counseling education faculty at SUNY Brockport, who is also a trainer in play therapy. The play sessions with your child will be videotaped only for the purpose of supervision. No one other than Susan or her supervisors will see them. Susan has been an interpreter for many years before beginning her studies in counseling, and is fluent in ASL, and so will communicate directly with your child in whatever communication method he or she prefers.

Susan will be assessing the program to determine if it helps children to understand their feelings better, increase their ability to make positive choices, and develop more positive relationships with others. In order to do that, you and your child’s teacher will be asked to fill out

a form that asks questions about your child's current behavior before we start play therapy. The form takes between ten to twenty minutes to fill out. Also, your child will be shown some pictures of children and adults in typical scenes from everyday life and asked to describe what they think is happening. This process will take about forty-five minutes. These assessment tools will be given again at the end of the special play time program. There are no risks associated with either the measurement tools or the play therapy. If you like, the information gathered from the assessment tools will be shared with you at the end of the play therapy program.

Thank you for taking the time to read this. Please feel free to call Susan at 755-0798 (voice only), or e-mail her at [schapel@netacc.net](mailto:schapel@netacc.net) if you have any further questions. If you would like to give your permission for your child to come to special play time, please sign below, and return by **Wednesday, November 3<sup>rd</sup>**.

I understand the above information about the play therapy program. I give my permission for my child, \_\_\_\_\_, to participate.

Signed, \_\_\_\_\_