



CHAPTER 12

Play to Promote Mental Health in Children and Youth

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After reading this chapter, the reader will:

- Identify the benefits of play in relation to mental health.
- Describe the effects of adversity and mental health conditions on play.
- Make play “just right” for children with mental health concerns.
- Manage barriers to implementing play-based interventions for children with mental health concerns.

When we treat children’s play as seriously as it deserves, we are helping them feel the joy that’s to be found in the creative spirit. It’s the things we play with and the people who help us play that make a great difference in our lives.

—Fred Rogers

Play contributes to the social emotional health of children (Ginsburg, 2007). Play is primarily a pleasurable experience that often results in positive emotions, which in turn, helps build a child’s resilience and sense of well-being (Donaldson et al., 2011; Fredrickson, 2004; Seligman & Csikszentmihalyi, 2000). In contrast, mental illness can disrupt occupations (Krupa et al., 2009), including the essential occupation of play. Mental health conditions may become a barrier to play and have a negative effect on participation in other occupations (Keyes, 2007; Passmore, 2003; Singh & Anekar, 2018; Zawadzki et al., 2015). The benefit of play for mental

health suggests that children and youth who have, or are at risk of, mental health conditions can benefit from a focus on play in occupational therapy. Occupational therapy practitioners therefore must understand the importance of play for children who experience trauma, adversity, and mental health conditions. This chapter presents play as a way to promote mental health and well-being as well as a desired outcome for children and youth with mental health conditions.

Mental Health

Mental health is the psychological foundation that supports all aspects of health and human development. Mental health is defined as a positive state of being and includes emotional, psychological, and social aspects of function (Galderisi et al., 2015). Mental health encompasses how one thinks and feels,

how one manages social interactions, and how one regulates emotions and behaviors (American Occupational Therapy Association [AOTA], 2016a, 2016b).

Development of Mental Health in Children and Youth

The mental health of children and youth is a dynamic state of flourishing and functioning that includes elements of coping and resilience and changes over time depending on relationships, life situations, or stressors (Keyes, 2007). Recent research has broadened our understanding of the complex interplay of the impact on mental health from biological, family, community, and societal levels (National Academies of Sciences, Engineering, and Medicine, 2019; Ungar & Theron, 2020). Science informs us that fetal and early childhood experiences shape brain architecture and can strengthen or disrupt a child's emotional and mental health well-being (National Scientific Council on the Developing Child, 2012; Zhang et al., 2021). Positive relationships with responsive, caring adults are an important foundation for mental health as well as an ongoing protective factor (Mikulincer & Shaver, 2012; Rutten et al., 2013; please see Chapter 11 for more detail). Over time, advantages such as strong families, communities, and full societal inclusion continue to encourage the development of a healthy mind and body (National Academies of Sciences, Engineering, and Medicine 2019; Silva, Loureiro, & Cardoso, 2016).

Youth mental health development similarly includes positive and caring family and peer relationships, as well as learning about how to cope with mild or moderate levels of stress (Gunnar & Quevedo, 2007; Patalay & Fitzsimons, 2018; Spencer, Chun, Hartsock, & Woodruff, 2020; Triana, Keliat, & Sulistiowati, 2019; Ungar & Theron, 2020). Inter-related brain circuits and hormone systems that are specifically designed for youth to adapt to situations or environmental challenges allow for managing and coping with stress (Loman & Gunnar, 2010; Lupian, 2017; Van Der Kolk, 2014). In adolescence, science demonstrates the importance and complexity of the interaction between risk factors and resilience in relation to mental health (Gore & Colten, 2017).

Mental Health Conditions in Children and Youth

The development of a mental health condition is the result of a complex interplay of multiple internal and external factors and exposures, time/age, and exposure to unpredictable life events. Although

they require a combination of biological, psychological, and environmental factors (Larson et al., 2017), in children and youth, mental health conditions are, however, quite common.

Prevalence of Pediatric Mental Health Conditions

In the United States, the prevalence of psychiatric conditions in youngsters has increased, now affecting 13–20% in a given year. Of children ages 2–17 years, 9.4 % have been diagnosed with ADHD, while 7.4% of children ages 3–17 years exhibit behavioral problems, 7.1% have been diagnosed with anxiety and 3.2% with depression. Anxiety, depression, and behavioral problems are even more common among children and adolescents living below the federal poverty level, affecting 22% of this population (Centers for Disease Control [CDC], 2019). These conditions often co-occur in the same child (CDC, 2020a). With this growing prevalence, researchers have become more interested in the factors leading to mental health conditions in children and youth.

Risk Factors

Structural brain abnormalities and/or chemical imbalances in the brain accompany most of the psychiatric conditions (American Psychiatric Association [APA], 2013; Bonder, 2015; CDC, 2021); however, biological vulnerabilities and genetic susceptibility interplay with other risk factors. Research suggests that many psychosocial vulnerabilities or stressors contribute to the development of psychopathology in children (Garfinkel et al., 1990; Meiser-Stedman et al., 2017). Maughan and Kim-Cohen (2015) describe epigenetic factors such as a child's stress response, individual vulnerabilities, and environmental or situational triggers. Some childhood psychiatric conditions are neurodevelopmental in nature, but other risk factors include parental and environmental stress and parental mental health conditions (Simmons et al., 2017; Yule, Houston, & Grych, 2019). Compromised early attachment patterns can negatively alter neural systems and neurodevelopment and contribute to neuropsychiatric problems, resulting in social and emotional difficulties later in life (Gaskill & Perry 2014). Intrinsic elements that influence the development of mental health conditions include temperament, insecure attachment, low self-esteem, shyness, and excessive worries or fears (Gartland, Riggs, Muyeen, et al., 2019). Extrinsic elements include poverty, deprivation, abuse, neglect, and exposure to other adverse childhood experiences (Basu & Banerjee, 2020).

Additional risk factors include adverse childhood experiences and trauma. The CDC (2020c) reports that one in seven children in the United States experience abuse, neglect, or adverse childhood experiences (ACEs). In the United States, approximately one million children are victims of maltreatment or trauma in any given year (National Child Traumatic Stress Network [NCTSN], 2020). Life events that cause adversity and traumatic stress in children and adolescents include physical, sexual, and emotional abuse and neglect; family dysfunction/mental illness or incarceration of a family member; institutional rearing; both community and domestic violence and/or substance abuse; human trafficking; natural disasters; mass shootings; terrorism and war/refugee experiences; life-changing accidents and illnesses; and losses of loved ones, such as sudden deaths or military deployment of family members, etc. (Cohen et al., 2010; NCTSN, 2020; Pizur-Barnekow, 2019).

Reactions to adverse events in children include negative emotional responses, attachment issues, developmental regression, behavioral changes/increased risk-taking and aggressiveness, disrupted sleeping and feeding patterns, and a variety of physical health problems (Felitti et al., 1998 as cited in Brown et al., 2019; NCTSN, 2020). Exposure to maltreatment, domestic violence, and other forms of adversity frequently results in developmental delays, trauma-and-stressor-related disorders, delinquency, or other mental health issues (APA, 2013; Cohen et al., 2010; Conrath et al., 2014; Enlow et al., 2013; Patterson et al., 2018; Sciaraffa et al., 2018). Psychiatric conditions in the trauma-and-stressor-related disorders category include reactive attachment and disinhibited social engagement disorders, adjustment disorder, acute stress disorder, posttraumatic stress disorder (PTSD), and persistent complex bereavement disorder, all of which are accompanied by disrupted play

patterns in children and adolescents (APA, 2013; Bonder, 2015; Champagne, 2019).

Relationship to Age and Developmental Stage

Across the life span, there are frequent changes in both mental health and mental illness (Westerhof & Keyes, 2010). Certain mental health concerns can be experienced at any stage of childhood or adolescence; however, other emotional problems, such as anxiety or depression, and behavioral disorders, such as self-injury, noncompliance, and significant aggressions (verbal or physical), tend to occur in later childhood. Still other conditions, such as schizophrenia, are more often diagnosed in late adolescence or early adulthood (Kessler et al., 2007).

Threshold to Diagnosis

While most children and youth experience some level of stress and adversity, or mental health challenge at some point in their lives, not all emotional or behavioral responses are indicative of a psychiatric condition (Ogundele, 2018). Some behaviors can be a transient reaction to external circumstances. As children and youth grow, many experience occasional fears, worries, or behaviors such as impulsivity or tantrums. Early childhood behavior difficulties, such as being defiant or impulsive from time to time, becoming aggressive or losing one's temper, having a tantrum, and being deceitful or stealing occasionally, are considered an aspect of typical development in very young children and preschoolers (**Figure 12.1**). However, severe problem behaviors and prolonged emotional distress are generally indicative of a mental health condition (Galderisi et al., 2015). The challenge for practitioners is to distinguish a possible mental illness, which requires referral and intervention, from typical child

Figure 12.1 Not all behavioral difficulties indicate a mental health condition, as they are an occasional part of typical development.

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development or transient situational crisis, which can be managed without additional support.

Mental Health and Play

The Impact of Mental Health Conditions on Play

Mental health conditions and psychiatric conditions in childhood disrupt playfulness as well as the ability to participate and engage in the elements and patterns of play, both individually and with others (Pollack et al., 2016). Even though behavioral and emotional conditions in children are not always visible, how children with these conditions play and behave during play is observably different (Caprino & Stucci, 2017). For example, when a young child has a mental health condition, attunement play is disrupted (Whitcomb, 2012). The child may not have the capacity to effectively connect and engage with others. A child with a mental health condition may have difficulties deciding what to play, with whom, or how (Remsetter et al., 2010). As a result, object play, social play, and transformative-integrative and creative play patterns are altered. The form, function, and meaning of the play is different. Elements of playfulness, such as internal control, internal motivation, and the ability to suspend reality, may be disrupted (Bundy, 1997). If a child or adolescent is not feeling mentally well or in a “just right” emotional state, it can be difficult to be playful or to engage in play. Therefore, there will be observable altered play behaviors and patterns that result from mental ill-health such as refusal to participate in play, lack of spontaneity, persistent boredom, frequent temper tantrums/explosive behaviors, seeking to have his/her “own way” all the time, excessive need for reassurance, or difficulty taking turns or following the rules. Each mental health condition can negatively influence children’s and adolescents’ engagement, performance, and satisfaction across all areas of occupation, including play, in varied ways.

Neurodevelopmental Disorders and Play

There are a variety of neurodevelopmental disorders and each may impact play slightly differently. A child with an intellectual impairment might have a hard time participating in play activities due to cognitive and communication deficits, sensory processing issues, clumsiness, and social isolation. Children with intellectual impairments, although spontaneous and curious during play, may show less enjoyment of challenges presented in play activities (Messier, Ferland, & Majnemer, 2008). Multiple studies have documented

the way in which autism spectrum disorder (ASD) impacts play (Hobson, Lee, & Hobson, 2009; Jarrold, 2003). A child with ASD might exhibit restricted play preferences and repertoire due to difficulty with transitioning to novel situations (APA, 2013; Bonder, 2015; Tanner et al., 2015). In contrast, youngsters with a developmental coordination disorder (DCD) participate less in and are sometimes left out of team play and sport activities because of their clumsiness and inability to catch up with typically developing peers (APA, 2013; Bonder, 2015; Izadi-Najafabadia, 2019). Their play differs in other ways than merely motor skill (Rosenblum, Waissman, & Diamond, 2017), as they have fewer friends, less enjoyment in their play, and fewer play choices and opportunities. Preliminary evidence also shows that young children with DCD might be more prone than their typically developing peers to take part in aggressive play, both as victims and perpetrators (Kennedy-Behr et al., 2013). Children and adolescents affected by attention-deficit/hyperactivity disorder (ADHD) may struggle with sustaining attention and sequencing tasks, noticing details, following instructions, and controlling impulses. They often lose belongings, fidget during quiet tasks and seek movement excessively, present as more talkative than others, and intrude on conversations (APA, 2013; Bonder, 2015). Additionally, young people affected by ADHD demonstrate deficient social skills and less empathy for others when compared to their typically developing peers (Wilkes-Gillan et al., 2016). Studies of the play of those with ADHD suggest they are less likely to participate in cooperative play and may have more conflict, lack empathy, and be more likely to play indoors on the computer (Cordier, Bundy, Hocking, & Einfeld, 2010; Jasem & Delpont, 2019; Normand et al., 2019).

Disruptive, Impulse-Control, and Conduct Disorders and Play

Issues with impulse control and lack of empathy are common among young individuals with oppositional defiant and conduct disorders, which are often characterized by poor social skills and hostility toward others. For example, a child with oppositional defiant behaviors might frequently bully peers, while an adolescent with conduct issues might violate rules, initiate physical altercations, show cruelty toward animals, and purposefully destroy property owned by others. Such behaviors can subsequently lead to social isolation and limited opportunities for age-appropriate play activities (APA, 2013; Bonder, 2015; Pollack et al., 2016). Compromised social skills are even more evident in children with complex symptomatology,

such as ADHD combined with oppositional defiant disorder and higher levels of anxiety (Pollack et al., 2016). Moreover, behavioral problems in youngsters might eventually result in their placement in foster care or encounters with the juvenile forensic system (Engler, Sarpong, Van Horne, Greeley, & Keefe, 2020; Islam et al., 2020), which in turn might further decrease opportunities for developing healthy play/leisure habits.

Anxiety Disorders and Play

Anxiety can also impede play participation. For instance, a child diagnosed with separation anxiety might be able to play successfully in the presence of a trusted caregiver, yet refrain from any forms of play when feeling overwhelmed by the caregiver's absence, even if it is brief. An adolescent affected by social phobia might experience a similar discomfort when attempting to join play activities that involve peer interaction. Additionally, inflexible play patterns (e.g., unnecessarily repeating game steps or reordering toys or game parts) or compulsive cleaning up of toys may occur with obsessive-compulsive disorder (Brezinka, Mailänder, & Walitza, 2020). Research suggests that children with higher anxiety play less imaginatively, engage in more solitary play, express less positive affect in play, and demonstrate decreased organization in their play than those with less anxiety (Barnett, 1984; Christian, Russ, & Short, 2011).

Mood Disorders and Play

Play participation is often negatively influenced by affective symptoms, such as depression or mania. Unstable mood, anger, and irritability along with impulsive behaviors characterize young individuals diagnosed with disruptive mood dysregulation disorder and can be even more pronounced in those diagnosed with bipolar illness, often resulting in these youngsters being excluded from social play. Depression, on the other hand, often comes with diminished energy, impaired concentration, psychomotor retardation, poor self-esteem, and decreased ability to experience pleasure, all of which inevitably could limit a child's ability to enjoy playing (APA, 2013; Bonder, 2015). Children with depression play less and may engage in more nonplay than children without depression (Lous, de Wit, de Bruyn, Riksen-Walraven, & Rost, 2000).

Psychosis and Play

Psychosis is characterized by hallucinations (altered perceptions), delusions (fixed, unsubstantiated

beliefs), distorted thought process, grossly disorganized speech and behavior, and negative symptoms, such as restricted emotional expression, diminished motivation, and diminished ability to enjoy daily activities. Psychosis can occur in children and adolescents as a result of different psychiatric conditions, such as schizophrenia spectrum disorders (SSD), bipolar illness, major depression and OCD, or due to exposure to trauma (APA, 2013; Green et al., 2015). Although less common than other mental health problems in pediatrics, when present, psychosis can challenge children's engagement in play by negatively affecting their cognition, language, imagination, and spontaneity during play (Green et al., 2015). Additionally, it is important to mention that children who are later diagnosed with SSD are also likely to demonstrate mild motor delays (APA, 2013; Hans et al., 2005), which further complicates their play participation.

Feeding and Eating Disorders and Play

Some of the childhood/adolescence psychiatric conditions impact play adversely because of the amount of time and energy the affected young individuals spend on the maladaptive routines that accompany their conditions. For example, an adolescent affected by anorexia nervosa or bulimia nervosa might be consumed by bingeing, purging, and exercising excessively, leaving little time for healthy leisure and socialization. In contrast, a child with pica may attempt to eat nonfood substances that are used in play (e.g., chalk, paint, strings, and pebbles) instead of playing with them (APA, 2013; Bonder, 2015; National Eating Disorders Association, 2020). Little research exists examining the relationships between these conditions and play or leisure specifically; however, one study identified restrictions in social leisure as the area of greatest perceived impairment reported by a group of individuals with anorexia (Tchanturia et al., 2013).

Substance-Related Disorders and Play

There is a relationship between leisure and substance use (Caldwell & Faulk, 2013; Sharp et al., 2011). Substance use can have a detrimental effect on play/leisure participation in young people. For instance, one of the symptoms of inhalant use disorder, which is more common in children ages 12–17 years than adults, is reducing or giving up social and recreational activities for the sake of using inhalant substances (APA, 2013; Bonder, 2015). Similarly, experimenting with other types of substances might have a negative

impact on the developmental trajectory of children and adolescents, subsequently reducing their play/leisure opportunities and negatively affecting their quality. Engagement in healthy leisure, however, can be preventative (Caldwell & Faulk, 2013; Sharp et al., 2011). Occupational therapy practitioners may be able to assist youth in developing healthy leisure to prevent or reduce substance use.

Excessive substance use in adults can compromise children's play participation indirectly. For instance, children born to mothers who abuse alcohol might present with fetal alcohol spectrum disorders (FASD), which result in an array of sensory, motor, cognitive, social, and emotional deficits (CDC, 2020b), inevitably disrupting play skill acquisition in these children and their sense of mastery over play. Children with FASD have been shown to be less playful than those without the disorder (Pearson, Ramugondo, Cloete, & Cordier, 2014).

Gaming Addiction and Play

The era of technological advancements and social media has provided children and adolescents with augmented virtual opportunities, but has also created new mental health challenges for this population. Gaming addiction is now included in both the DSM-5 and the ICD-11 and is considered a significant public health concern that requires more research (APA, 2013; Kwak et al., 2020; Rumpf et al., 2018). While Internet gaming offers certain cognitive, motor, emotional, and even social benefits to young people and can be used therapeutically, when excessive, it is associated with disrupted daily routines, impulsivity, and poor behavioral control, especially in the absence of proper social supports (Kwak et al., 2020). Moreover, even though active video games might be less harmful than sedentary video games, when they replace active outdoor play, the effects on youths' mental health are still

detrimental (Janssen, 2016; Montag & Elhai, 2020; Moore et al., 2020). On the other hand, decreased screen time (including video games) might be associated with lower rates of depressive symptoms in adolescents, while physical activity appears to improve attention in those affected by ADHD (Moore et al., 2020; Wagner, 2015). Occupational therapy practitioners are well positioned to help young clients plan their daily routines in a way that makes a balanced use of the virtual environments available to them (see Chapter 16 for details).

Gender Dysphoria and Play

Gender dysphoria refers to distress resulting from a discrepancy between one's gender identity and assigned gender. Gender-nonconforming choices may occur as early as preschool and may be associated with later gender dysphoria (Koehler et al., 2017; Roshan et al., 2019). Children may experience strong preferences for cross-dressing as well as for spending time with playmates of the opposite gender and choose play activities/objects and make-believe play roles that are typically assumed by the other gender. When the social environment does not accept an individual's gender identity, they can experience significant distress (Galupo, Pulice-Farrow, & Lindley, 2020; Syed, Afridi, & Dars, 2019). However, distress can be mitigated by the contexts that support children's desire to embrace the role of the other gender (Kimberly et al., 2018). It is, therefore, crucial for parents, caregivers, educators, health providers, and others to remain child-centered and to respect children's choices pertaining to play partners, roles, and objects. Occupational therapy practitioners may assist children and youth to engage in meaningful play and leisure occupations that fit their preferences, while educating others about the importance of such engagement for mental health (**Figure 12.2**).

Figure 12.2 Occupational therapy practitioners should assist children to play in ways that fit their preferences to support children's health.

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Additional Psychiatric Disorders and Play

Some psychiatric conditions in children impact their play participation indirectly. For example, elimination disorders, such as enuresis and encopresis (intentional or unintentional elimination of urine and feces into bed or clothing items) often contribute to a diminished self-esteem and social rejection and isolation of the affected child, perhaps eventually limiting their social play experiences (Lang et al., 2017). Similarly, sleep-wake disorders, which cause, among other symptoms, nightmares and sleepwalking in children, can create a significant distress for the child and their family (Gruber et al., 2014; Owens, 2007) eventually compromising their performance in all areas of occupation, including play.

Play in Twice-Exceptional Children and Adolescents

The term *twice-exceptional* refers to youngsters with disabilities who possess above-average intellectual ability. This phenomenon has been observed among young people with learning, communication, and autism spectrum disorders; ADHD; and emotional and behavioral issues. (National Association for Gifted Children [NAGC], 2020). These youngsters often demonstrate special talents and interests, as well as unusually high levels of curiosity, knowledge, creativity, imagination, and problem-solving and verbal abilities, while at the same time exhibiting motor,

cognitive, emotional, and social deficits. As a result, they often display atypical play patterns, have difficulty forming friendships, and have a difficult time relating to and joining their peers during play, often seeking out older children or adults (**Figure 12.3**) (Bildiren, 2018; Chamberlin et al., 2007; Demina & Trubitsyna, 2016; NAGC, 2020; Sankar-DeLeeuw, 1999; Shechtman & Silektor, 2012.)

The Impact of Adversity on Play

Understanding play in children who have been exposed to traumatic events and other forms of adversity is of critical importance. The experience of significant adversity affects the developing brain and can have a negative impact on learning, social-emotional development, and emotional regulation (McKelvey et al., 2017; Nelson & Gabard-Durnam, 2020). Because younger children with a history of trauma cannot rely on the use of language to express their distress the way older children and adults do, they often exhibit posttraumatic play (PTP). PTP is characterized by inhibited or negative affect, rigid rituals that recreate traumatic events and utilize trauma-resembling objects, higher than usual presence of morbid themes, and increased levels of acting out/aggressivity (APA, 2013; Cohen & Gadassi, 2018; Cohen et al., 2010; Dripchak, 2007; NCTSN, 2020). While in certain contexts children may be asked to alter their play themes to those that are more acceptable, occupational therapy practitioners with additional play therapy training are well suited



Figure 12.3 Some children with above-average intelligence may prefer to play with adults rather than other children.

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to support children and youth engaging in posttraumatic play to work through their distress with their play activities (Blunden, 2001; Cohen & Gadassi, 2018; Humble et al., 2019; Parker, Hergenrather, Smelser, & Kelly, 2021). By using trauma-informed approaches, practitioners help children build regulation through play (Fette, Lambdin-Pattavina, & Weaver, 2019).

The Reciprocal Relationship Between Mental Health and Play

As demonstrated earlier, mental health conditions impact one's play, but there is a reciprocal relationship between play and mental health. Play can also influence one's mental health. Research has demonstrated the importance of play in facilitating mental and social well-being. Engaged parenting and nurturing relationships, as they promote learning and adaptive behaviors, facilitate emotional regulation and provide an experience of joy (Bratton et al., 2005; Bratton et al., 2013). Understanding how mental well-being and play patterns interact in young individuals is crucially important for occupational therapy practitioners who work with the pediatric population.

Participation in play is fundamental to healthy cognitive, physical, social, and emotional development in childhood and adolescence (Ginsburg, 2007; Gray, 2011; Polatajko & Mandich, 2004). Play is also vital to the experience of positive mental health in children, which is essential to their overall well-being (Ginsberg, 2007; Zawadzki et al., 2015). The belief about play's influence on health and well-being is a basic tenet of occupational therapy practice (AOTA, 2020). Engagement in play contributes to flourishing, which refers to the experience of life going well, a combination of

feeling good, participating, and functioning effectively in life (AOTA, 2011; Ginsburg, 2007; Huppert & So, 2013; Keyes, 2007; Nijhof et al., 2018). The amount of play and the type of play a child engages in may also signal the child's positive affect and general level of well-being (Ahloy-Dallaire, Espinosa, & Mason, 2018).

Spontaneous free play builds flexibility, coping skills, and resilience in emotional and social responses (Goldstein & Lerner, 2018; Slot, Mulder, Verhagen, & Leseman, 2017; Thibodeau, Gilpin, Brown, & Meyer, 2016). Through play, children can explore the social and emotional world and become comfortable with uncertainty and unpredictability. Play interactions with others afford the child opportunities to share, negotiate, cooperate, problem-solve, and self-manage emotions and behaviors. Pretend play fosters creativity and emotion regulation (**Figure 12.4**) (Goldstein & Lerner, 2018; Hofman & Russ, 2012). Free, unstructured play is also essential to acquiring social skills and empathy. Moreover, for younger boys in particular, rough play affords opportunities to learn how to manage one's anger and aggressivity (LaFreniere, 2011). As a child develops and grows through play, so too does their sense of relationship, identity, and feelings of belonging.

When young people are deprived of play, especially active outdoor play, they are essentially stripped of the opportunities to develop intrinsic interests and competencies; to learn how to regulate emotions, control behaviors, follow rules, and problem-solve; and restricted in their ability to make friends (Gray, 2011). All of these issues may contribute to the increase of psychiatric diagnoses, such as depression, anxiety, and ADHD, in this population (Belknap & Hazler, 2014; Chen et al., 2020; Gray, 2011; Montag & Elhai, 2020; Moore et al., 2020).

Figure 12.4 Pretend play fosters creativity and emotion regulation.

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Addressing Mental Health with Play in Occupational Therapy

Given the impact of play on mental health and the impact of mental health conditions and adversity on play, it is clear why play is at the heart of occupational therapy practice in mental health settings. Occupational therapy practitioners serving youth with mental health conditions value and utilize play-based interventions in their practice (Halperin, 2020). An online survey of 31 therapist respondents who were working with youth with psychiatric diagnoses in 20 different states found that 77.42% rated the utilization of play-based interventions for pediatric populations with behavioral issues/psychiatric diagnoses as “extremely important.” More than half (61.29%) of the therapists indicated that they incorporated play into their work daily, and they emphasized the role of play as an outlet for a young person’s emotional distress. One of the therapists commented, “Play is a way to engage with traumatized or introverted kids.”

Play, especially when child-driven, can significantly enhance the child’s motor, cognitive, social and language development, self-esteem, coping skills, and ability to self-soothe. Productive play with parents or caregivers fosters a healthy attachment while at the same time promoting a sense of autonomy and self-control, and overall behavioral health (Cohen et al., 2010; Green et al., 2015; Haertl, 2019; Kjorstad et al., 2005; Patterson et al., 2018; Sigafos et al., 1999; Waldman-Levi & Weintraub, 2015; Wilkes-Gillan et al., 2016). When channeled properly, play enables children to express their hidden thoughts and emotions and, by doing so, to accept their anxiety-provoking and even traumatizing experiences. Engaging in therapeutic play experiences can help children process the traumatic event, reduce stress, and facilitate coping (Cohen & Gadassi, 2018). Promoting playfulness in our clients may also be a way to facilitate better coping (Hess & Bundy, 2003; Magnuson & Barnett, 2013). Children can realize their strengths, hopes, and opportunities and problem-solve through play, all of which can have a healing effect (Dripchak, 2007). Moreover, play allows for interactions with typically developing peers and practice of social skills, while also fostering empathy for others (Rizk & Howells, 2019; Wilkes-Gillan et al., 2016).

Choosing Your Style as a Therapist

The importance of therapeutic use of self during play interventions is explained in Chapter 6 but

therapeutic style is an important consideration. Ideally, the way in which therapists facilitate therapeutic activities should match the client’s needs, developmental level, and therapy goals, as well as the stage the client(s) and the therapist have reached together in terms of their therapeutic rapport and alliance. A facilitative style, defined as helping clients choose the activity and then guiding the process as needed, is frequently used (Halperin, 2020). The facilitative style is used especially with clients who are able to attend to a task and need less assistance, when working on making choices and fostering independence, and during pretend play. Another frequently used style is the directive style (“choosing the activity and providing ongoing instructions and guidance”), which is used more when working with clients on certain skills or novel activities, when addressing motor or cognitive delays, to help the client focus, to set limits, and “to help a child better understand their emotions.” A third frequently chosen style is the advisory style, whereby clients choose/structure the play activity and engage in it independently, while the therapist stands by and intervenes only if necessary. An advisory style is used to assist young clients with developing social skills, such as collaboration and negotiation; with sequencing a task; and to ease the transition out of session. Although a facilitative style during play might be preferred by many therapists, both directive and advisory styles also offer benefits in certain situations.

Mental Health Settings

Occupational therapy practitioners work with children and youth with mental health conditions in many settings. Information on school-based practice and adolescent leisure intervention is provided in Chapters 10 and 13. In this chapter we focus more heavily on psychiatric hospitals, residential treatment centers, juvenile forensic centers, and group homes, which are the facilities where children and adolescents with more serious and complex mental health disorders receive care.

Assessment of and Through Play in Children with Mental Health Conditions

Assessment of play is described in Chapters 3 and 4 of this text, and the same general methods and tools can be used with children with mental health conditions. Here we discuss how we can use play to assess aspects of a child’s or youth’s social-emotional functioning, mental health, and well-being. So, this is a discussion of assessment *through* play.

Occupational therapists have unique knowledge, skills, and capacities to assess psychosocial and mental health issues in children and adolescents through play (Cahill & Bazyk, 2019; Champagne, 2019; Lane & Bundy 2011; Polatajko & Mandich, 2004). A mental health evaluation for a child emphasizes the barriers to a child's success, internal or external barriers, risk and protective factors and determines the challenges for the child that contribute to diminished emotional, social, cognitive, and behavioral engagement and participation. The occupational therapist often uses informal assessments such as activity analysis and observation (please see Chapter 4 for more guidance on informal assessment). The therapist may also evaluate the child through formal play assessment tools, such as the Parent Child Interaction Play Assessment Method (Smith, 2000) or the Test of Playfulness (Skard & Bundy, 2008).

Assessment through play can be more tolerable for the client, feel safer for the client, and allow the occupational therapist to see the client's strengths and weaknesses through the lens of a typical childhood activity. Play-based assessments are particularly valuable for children who are less verbal and expressive. Through play, the occupational therapist observes the child's ability to self-regulate with and without others. The therapist determines the child's preferences and motivations in play. The occupational therapist evaluates psychosocial behaviors and considers the child's sensorimotor performance. Somatosensory aspects of play afford the therapist an opportunity to evaluate a child's *window of tolerance* (Siegel, 1999) and consider the neurological foundations of social and emotional challenges. Through play assessment, the therapist might observe clumsiness and/or excessive fidgeting; overresponsiveness to touch or excessive seeking of a sensory input (e.g., an older child mouthing their toys); difficulty understanding/following directions; rigid play patterns (such as ordering toys excessively or resisting unfamiliar play objects/environments); limited ability to express thoughts and emotions about the play activity; hesitant or isolative play; restricted affect and limited engagement during play; difficulty taking turns; temper tantrums and explosive behavior toward peers or play objects; and play with "scary" themes. **Box 12.1** highlights some specific considerations in assessment through play for children and youth with mental health conditions.

Occupational therapy practitioners who address the needs of children and adolescents with mental

Box 12.1 Specific Play Assessment Considerations for Children and Youth with Mental Health Conditions

- Careful examination of child preferences and how they exacerbate or mitigate mental health conditions.
- Creation of boundaries and sense of safety, recognizing the child's prior trauma and potential fear(s).
- Resist feeling offended by defiant or aggressive behaviors, but be prepared for them.
- Examine and consider frustration tolerance and regulation during play activities.
- Identify potential triggers for problematic behaviors in play.
- Be prepared to provide comforting if needed.

health issues are likely to witness disruptive behaviors, aggression, inattention, dysregulation, unusual play behaviors, meltdowns, and a range of social-emotional behaviors among their clients. The occupational therapist needs to recognize that certain situations during the assessment can be traumatizing for a child. The therapist must be fully open to the child, in tune and calm with the child, and not be offended by defiant or aggressive behaviors.

Types of Interventions Using Play in Occupational Therapy

Occupational therapy practitioners select and design interventions to target mental health issues using play within occupation-based models of practice and frames of reference. Direct interventions with children and adolescents utilize play activities and promote capacities for occupational engagement. Examples of the types of play activities that may be used with children and youth with mental health conditions are provided in **Table 12.1**. Modifying play materials and environments, modeling for and imitating the child during play, creating "just right challenge," as well as therapeutic use of self/nurturing interactions with the child, and parent/caregiver education on play are all important strategies in this area of pediatric occupational therapy practice (Halperin, 2020). Interventions may be utilized in individual or group sessions. Therapists also adjust their style for clients and activities when delivering play-based intervention. See **Practice Example 12.1** for an example of the occupational therapy process in a mental health setting using play interventions.

Table 12.1 Common Play Activities Used in Occupational Therapy for Children and Adolescents with Psychiatric Diagnoses

Category of Play	Examples of Activities, Equipment, Supplies
Gross-motor/sensorimotor play	Obstacle courses, gym and sports-based play, outdoor and playground activities, challenge games, hide-and-seek, and yoga moves
Object play involving toys and sensory items	Small stretchy manipulatives, bubbles, kinetic sand, and cause-and-effect/exploratory toys
Social and team-based play	Peer interactions involving negotiation and collaboration
Pretend play	Pretend meal planning and preparation; playing “school” with focus on fine-motor tasks and relaxation strategies
Sensory integration-based/multisensory play	Suspended equipment; other vestibular and proprioceptive input
Play combined with storytelling/social stories	Storytelling using stuffed animals, dolls, toy houses, magnetic board/magnets
Expressive media-based play	Moving to music; drama play; drawings and arts and crafts
Board games	Both regular and therapeutic tabletop games
Play with symbolic themes	Puppets and popular movie/cartoon characters chosen by the child
Virtual reality-based play	Video and phone application-based games

Note: As reported by occupational therapy practitioners working in pediatric mental health (Halperin, 2020).

Data from Halperin, L. (2020). *Play-based occupational therapy in pediatric mental health: Therapists' perspective* (Unpublished manuscript). Graduate Program in Occupational Therapy, Sacred Heart University, Fairfield, CT.

Practice Example 12.1 Rohit and Play Within and Beyond a Psychiatric Facility

Rohit is an 8-year-old boy, who lives at home with his parents and three older siblings. Rohit's family immigrated to the United States from India a few months before he was born. When Rohit was 2.5 years old, he was diagnosed with an autism spectrum disorder (ASD). Rohit attends a special education school and receives outpatient treatment at a Child Guidance Center. Rohit frequently gets in trouble both at home and in school because of his out-of-control behaviors (screaming, hitting, biting, etc.). A week ago, during his visit to the Child Guidance Center, Rohit physically attacked his counselor and, as a result, was brought to the children's unit at the local inpatient psychiatric facility, where he is currently receiving medications, individual therapy with his social worker, and milieu and group occupational therapy.

On the unit, Rohit often giggles inappropriately and makes offensive comments toward his peers and some of the staff members. The charge nurse reports in the team meeting that Rohit comes across as “seeking negative attention and needing frequent redirection.” Rohit's social worker at the hospital has been in touch with the Child Guidance Center. According to Rohit's counselor there, the father tends to use corporal punishment to discipline his children, despite her attempts to educate him about more appropriate parenting strategies. The social worker is considering referring Rohit to a residential program for children with behavioral problems.

You are an occupational therapist working at the hospital and running groups on the children's unit. You notice that during groups, Rohit presents with poor balance, bilateral coordination, and motor planning. For instance, he has difficulty throwing and catching balls and frequently bumps into people and objects around him. In addition, Rohit rarely establishes eye contact, often misses out on verbal directions provided to him, and frequently seeks tactile stimulation by touching peers, staff members, and various objects on the unit (such as the rug and the couch in the TV room).

You look through Rohit's chart and find a note indicating that Rohit had received an occupational therapy evaluation as a toddler (through the Birth-to-Three services), and that a home program was recommended to boost Rohit's sensorimotor development and to decrease his tantrums. The program consisted of vestibular and proprioceptive activities, including “rough play” with the father. There is no documentation in the chart indicating that Rohit has received any occupational therapy follow-up evaluation or treatment.

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PRACTICE EXAMPLE 12.1 Rohit and Play Within and Beyond a Psychiatric Facility*(continued)*

How can you best help Rohit? As an occupational therapist situated in an acute setting, you can be instrumental with improving Rohit's quality of life during his short hospital stay; teaching him coping skills for dealing with his daily stressors; educating staff about the unique needs Rohit may have; and participating in monitoring his progress and planning his discharge in a way that will benefit him in the long run.

Play-based interventions, carried out either individually or in a group, are essential to Rohit's well-being during the hospitalization. Because Rohit presents with gross-motor deficits and exhibits behaviors suggesting that he might be seeking tactile and proprioceptive stimulation, it is important to provide him with safe movement opportunities and toys that are rich in texture. These play activities can incorporate supervised indoor or outdoor team/small-group games involving movement; construction with building blocks or large Lego pieces; pretend play/storytelling using stuffed animals or puppets; tabletop games, etc. While the hospital rules might not allow for toys or any types of play equipment to be left unattended on the unit, the occupational therapist can still advocate for Rohit to have access to a small durable stuffed animal or fidget toy/stress ball in between the activities he attends on the unit, so that he can experience the sensory input he appears to be seeking in socially acceptable ways.

It is also crucial to take into consideration the fact that Rohit has been subjected to corporal punishment at home and might be experiencing symptoms of trauma as a result, which may provide an additional explanation for his challenging behaviors and more insight about his current needs. The occupational therapist has to create a physically and emotionally secure play environment for Rohit and must refrain from unintentionally encouraging peer activities that might be perceived by Rohit as a potential threat (e.g., roughhousing).

Play activities can also be used to help Rohit begin to acquire the coping strategies and social skills he will need after his discharge to a residential program. While Rohit plays with his peers on the unit or at the hospital playground, the occupational therapist can praise his adaptive behaviors (such as following the game rules, sharing toys with other children, waiting for his turn, or addressing his playmates politely) and redirect his less-adaptive behaviors, such as touching others during play, ignoring his peers when they try to involve him in a game, or making hostile comments/pushing them when feeling upset. Moreover, conflicts that occur during play can serve as an opportunity for the therapist to teach Rohit simple grounding strategies, such as "Take a five," "Reach for the sky as you breath in, lower your arms and breathe out slowly," "Count to five," "Squeeze your stress ball," and "Use your words to tell us how you feel."

One of the most challenging tasks you may encounter in your role as Rohit's occupational therapist might have to do with his discharge planning. For instance, because other disciplines might not be fully aware of the sensory processing differences that often accompany ASD and the effects these differences have on one's behavior, daily functioning and play patterns, occupational therapists have the duty of educating their coworkers on these important topics and advocating for discharge referrals that take into consideration clients' sensory differences. In Rohit's case, it might be crucial for us to convey to the rest of the treatment team that Rohit would benefit from sensory modifications in his residential program and direct occupational therapy, particularly play- and sensory integration-based interventions.

Top-Down and Bottom-Up Interventions

Occupational therapy practitioners use professional reasoning to determine whether to use a top-down approach, a bottom-up approach, or a combination of both. (Please see **Table 12.2** for examples of both approaches.) Both top-down and bottom-up approaches refer to the order of areas of the brain being addressed based on neurodevelopmental principles. The therapist determines which approach is a better match for the child's development and abilities.

When we design play-based interventions from a *top-down* approach, we are engaging the neocortex, the rational brain, which controls

thinking, language, personality, and decision making (Van Der Kolk, 2014). An example of a top-down approach is the use of cognitive behavioral therapy (CBT). This approach teaches the child to examine thoughts, emotions, and behaviors. Once the child has a shift in thinking to gain insights into their emotions and behaviors and develops the capacity to modify dysfunctional beliefs, changes occur in their emotional responses and behaviors. Because of the focus on thinking and language, top-down interventions require that the client has adequate cognitive and language processing to support their use or that caregivers are available to assist (Lillas, TenPas, Crowley & Spitzer, 2018; Martini, Cramm, Egan, & Sikora, 2016).

Table 12.2 Top-Down and Bottom-Up Play-Based Interventions for Children and Youth with Mental Health Conditions

Intervention	Description/Examples
Top-Down	
Cognitive behavioral	Cognitive restructuring/reframing before, during, and after play experiences such as: <ul style="list-style-type: none"> ■ Positive self-talk strategies ■ Play scenarios that afford opportunities for expression and interpersonal relating ■ Meaning making with use of symbols and metaphors during play
Executive function	<ul style="list-style-type: none"> ■ Cognitive and self-management strategies during play ■ Play activities that require focus and attention ■ Problem-solving and goal-directed strategies during play ■ Understanding possible outcomes during structured play scenarios ■ Play for development of decision making
Positive Behavioral Interventions and Supports (PBIS)	<ul style="list-style-type: none"> ■ School-based context initiative of three-tiered approach to creating a positive environment for children ■ Child taught social skills and appropriate social behaviors during play and recess time, with and without others
Cognitive-based emotional regulation	<ul style="list-style-type: none"> ■ Cognitive awareness of emotional responses, identification of triggers, and selection of emotional regulation strategies during play. ■ Use of social-emotional checklists or measures during play. ■ Identification and use of self-regulation and calming strategies. ■ Instruction in specific sensory/emotional regulation programs during play (for example, Kuypers & Winner, 2011; Oetter, Richter, & Frick, 2019; Williams & Shellenberger, 1995)
Behavioral interventions	<ul style="list-style-type: none"> ■ Training of child in appropriate play behaviors ■ Use of positive reinforcement and external motivators during play ■ Use of behavioral charts during play
Social skills training	<ul style="list-style-type: none"> ■ Unstructured and structured play activities with others ■ Emphasis on connection with others through play ■ Development of Social Stories™ (Gray, 2015) in preparation for and implementation during play
Bottom-Up	
Sensory supports and techniques	<ul style="list-style-type: none"> ■ Creation of play/sensory environment that is comfortable and safe for the child ■ Before, during, and after play, emphasis on use of the body and the sensory play space; calming and organizing strategies (breathing; rhythm; deep pressure; movement; sound and vibration) ■ Use of attachment principles—coregulation and joint attention during play ■ Use of arousal principles—seeking window of tolerance during play; seeking “just-right” state of being; emotions, arousal, and behavioral changes affected through vestibular activation during play ■ Sensory diet strategies (use of weight, chewy toys, swings, rough-and-tumble play)
Specific sensory/emotional regulation programs during play	<p>The following programs first require top-down instruction; however, once learned, the strategies can be used with a child for a bottom-up approach to self-regulation during play:</p> <ul style="list-style-type: none"> ■ Zones of Regulation: A curriculum designed to foster self-regulation and emotional control (Kuypers & Winner, 2011) ■ The Alert Program (Williams & Shellenberger, 1995) ■ The MORE Program: Integrating the mouth with sensory and postural functions (Oetter et al., 2019)

(continues)

Table 12.2 Top-Down and Bottom-Up Play-Based Interventions for Children and Youth with Mental Health Conditions *(continued)*

Intervention	Description/Examples
Mind–body awareness strategies	<ul style="list-style-type: none"> ■ Mindfulness ■ Progressive muscular relaxation ■ Guided imagery ■ Therapeutic yoga ■ Dance
Nature and outdoors	Sensory awareness through play: breath, smells, sound, touch, movement, etc.
Physical activity and sport	<ul style="list-style-type: none"> ■ Exercise—walking, running, climbing, swimming ■ Ball games—throwing, bouncing ■ Team games—basketball, soccer, volleyball, baseball
Contextual interventions	<ul style="list-style-type: none"> ■ Modify play materials ■ Modify physical environment ■ Modify social environment ■ Parent/caregiver education

When an occupational therapist designs play interventions from a *bottom-up* approach, the focus is on engaging the brain stem functions (e.g., arousal, breathing, somatic awareness, etc.) and the limbic system, the parts of the brain that process emotions and memory, regulate autonomic or endocrine function in response to emotional stimuli and are also involved in regulating emotional and behavioral responses (Van Der Kolk, 2011). The bottom-up approach emphasizes somatosensory and sensorimotor interventions (e.g., practicing mindfulness as a strategy for emotional regulation in preparation for play or during play participation).

Use of Consequences and Behavioral Strategies

Employing natural and logical consequences can promote adaptive behaviors in young people. While natural consequences represent the inevitable ramifications of one's actions at some point in the future, logical consequences are reasonable immediate disciplinary measures that make the most sense, considering the nature of the undesirable behavior, and can be explained to a young person clearly and without power struggles (Dreikurs & Soltz, 1992). For example, a child who constantly refuses to share play objects with peers might eventually discover that other children avoid playing with them, which is a natural consequence of their behavior. However, if a child uses outdoor

playground equipment unsafely despite the supervising adult's redirections, the adult may replace playground time with indoor activities for the day, which represents a logical consequence for the child's actions. Natural and logical consequences are often more powerful than either punishments or material rewards because they are more conducive to a young person's learning and better foster their sense of responsibility, "contribution, participation and satisfaction" (Dreikurs & Soltz, 1992, p. 75).

When relying on behavioral strategies in a therapeutic environment, it is important that therapists use them wisely. Often it is best to ignore the child's undesirable, but not dangerous behaviors and instead compliment their desirable behaviors; apply natural and logical consequences rather than punishments if simply ignoring the negative behavior does not work; and refrain from using a child's basic needs, such as food, affection, or play, as rewards for a positive behavior and instead offer praise or special privileges (e.g., watching a movie or going on trips). The importance of not withholding play from young clients to punish undesirable behaviors cannot be overemphasized. As one of our study participants noted, many of these youngsters "... have been through trauma and may have lost their childhood or never really experienced one to begin with. Incorporating play into their group and individual therapy is vital for their overall mental health" (Halperin, 2020).

Child-Centered Play Therapy and Adlerian Play Therapy

Child-Centered Play Therapy (CCPT) has been recognized as one of the most effective evidence-based modalities that help children overcome aggressivity, poor impulse control, disruptive behaviors, and other emotional and behavioral issues (Axline, 1974, as cited in Landreth, 2012; Bratton et al., 2013; Meany-Walen & Teeling, 2016; Ray, 2011, as cited in Wilson & Ray, 2018). CCPT is based on Carl Rogers's person-centered theory that children show a natural desire to do well when exposed to nurturing relationships and that their undesirable behaviors mirror their inner conflicts that need to be understood before these behaviors can be changed. CCPT also assumes that children rely on play as a form of self-expression (Axline, 1974, as cited in Landreth, 2012; Meany-Walen & Teeling, 2016; Ray, 2011, as cited in Wilson & Ray, 2018). Helping children reflect on their emotions and thoughts, while providing encouragement, returning responsibility, and setting limits during play, assists them with developing empathy, self-regulating better, and assuming responsibility for their actions (Wilson & Ray, 2018).

CCPT prioritizes creating a safe space, allowing the child to choose and lead the play activity, paraphrasing their statements (to reflect feelings and content), inviting her/him to label their experiences, and establishing boundaries (Landreth, 2002, as cited in Patterson et al., 2018). Dripchak (2007) also recommends the use of storytelling during play, with gentle redirection from the therapist, to guide "scary" play toward more acceptable resolutions. For example, if a child uses dolls to reenact an abusive scene, the therapist can intervene and model for the child how the dolls instead can "talk to each other" in order to resolve the imaginary conflict between them. Such redirection, however, is most effective after therapeutic rapport has been established, and the child has had enough opportunities to express self through play, with the therapist observing rather than directing it (Dripchak, 2007).

Adlerian play therapy (AdPT) is a powerful, evidence-based treatment modality grounded in Alfred Adler's individual psychology theory (Dillman Taylor & Bratton, 2014; Meany-Walen & Teeling, 2016). AdPT consists of building a trusting, collaborative rapport with the young client; gathering information about their interests and beliefs (including misperceptions); and enhancing their insight as well as teaching

them coping and social skills through creative play, storytelling, and similar activities (Dillman Taylor & Bratton, 2014; Meany-Walen & Teeling, 2016).

While both CCPT and AdPT were developed outside of the occupational therapy realm and are predominantly used by play therapists, psychologists, counselors, social workers, and so forth, many of their guiding principles are widely accepted and might be instrumental to other disciplines serving pediatric populations, including occupational therapy. Moreover, these principles are in agreement with the therapeutic modes already used in occupational therapy practice, such as empathizing, collaborating, and problem solving with a client and encouraging and instructing them (Taylor, 2008). For instance, an occupational therapist witnessing angry nonverbal behaviors during play (e.g., throwing or kicking stuffed animals) in a verbal child might say to the child in a calm voice, "You seem to be upset. Can you try to use your words to tell me what is upsetting you right now?" If the child is able to identify what has triggered their behavior, the therapist can then say, "You did a really good job telling me what makes you angry. I can see why you are upset. But it makes me sad when you throw or kick things. Let's see if we can play again and this time try to be gentler." If the child is not able to verbalize how they feel, the therapist should still set limits by saying, "I am sorry to see you so upset. I would really like to keep playing with you, but please try to be more careful with the toys." In both cases, the therapist can also offer options to the child, such as, "We can keep playing with the same toys or try something different, if you would like, but we have to play nicely. What do you think we should play with next?" Every time the child shows more caution when handling toys, the therapist should reward them with a positive comment, until aggression toward play objects becomes a nonissue.

Group Interventions

Group interventions provide opportunities for social learning in the presence of a therapist, who can guide the group process appropriately. Group play can be particularly beneficial, and occupational therapy practitioners working in pediatric psychiatric institutions often design group play activities that foster cognition, emotion regulation, and motor and social skills all at once. Please see **Practice Example 12.2** for a description of the use of a modified board game with a group.

PRACTICE EXAMPLE 12.2 A Modified Board Game for a Social Group

An occupational therapist modified an older version of the commercially available SAFETY FIRST™ board game for a social group she facilitated with elementary school-age children in an acute psychiatric setting. This game came with cards describing real-life scenarios pertaining to community mobility, school/playground/fire safety, and so on for the children to discuss and problem-solve. In the modified version, each child received the same number of cards and two plastic cups of different colors, an empty one and one with a fixed number of poker chips in it.

Players took turns solving the situations described on their cards. After each child presented their solution to a specific safety-related scenario on their card, other group members used poker chips from their “Give away” cup to evaluate their peer’s answer on a 1–3 scale and explained their decision, while the therapist assisted them with providing constructive and respectful feedback to each other. Children used empty cups to collect the chips they received from peers. The child who collected the largest amount of chips by the end of the group won the game. Modifications made to this game provided opportunities for the players to exercise impulse control, make judgements about potentially dangerous situations, communicate with peers effectively, and experience a sense of mastery.

Consultation

Parents of children with mental health conditions may use the recommendations of occupational therapy practitioners to improve their ability to encourage family play. Practitioners working in community settings for mental health or in the

schools may find the consultant role quite important for facilitating participation. Please see **Practice Example 12.3**, Lucy and Alex, for an example of how an occupational therapist might consult with a family to recommend appropriate play activities for children with mental health conditions.

PRACTICE EXAMPLE 12.3 Lucy and Alex

Lucy and her brother, Alex, are 9-year-old twins born in Belarus, where they were institutionalized at an orphanage. At the age of 2.5 years, they moved to the United States, where they since have lived with their adopted parents. Lucy has fetal alcohol syndrome and an IQ of 55. She attends a private school for persons with intellectual disabilities. She usually plays with a couple of children at her school, but often misperceives social cues, has a low frustration tolerance, and cries easily. Lucy occasionally becomes explosive and physically aggressive and sometimes engages in name-calling when she feels intimidated.

Her brother, Alex, attends the local public school. Alex has a history of being violent toward his classmates. At home, he has recently been aggressive with his family members and intentionally destroyed the family’s laptop. He cropped the family dog’s ears with a pair of scissors, which resulted in the dog’s placement in a shelter and the initiation of mental health services.

The occupational therapist met with their mother, who is especially concerned about the after-school hours, when both twins are at home. They fight constantly. Alex teases Lucy and can be physically aggressive with her. Lucy is nervous around him and often becomes verbally assaultive toward him, which then further escalates his aggressive behaviors at home.

The parents have attempted to engage Lucy and Alex in family play/leisure activities, such as playing board games, shooting basketball, and playing tug-of-war, but they did not seem to relieve the tension between the children. Lucy’s mother would like the therapist to recommend leisure activities for all of them to participate in as a family.

The occupational therapist completes an informal play observation of the two children together and finds:

- High levels of competition between the children
- Alex has better cognition
- Alex’s activity choices are too hard for Lucy so she gets frustrated

Given these observations, the occupational therapist recommends noncompetitive activities for the family that are easily completed by individuals with various levels of ability such as nature walks in different locations, kicking or throwing a ball to each other, playing with bubbles, dancing/moving to music, looking for bugs, mud play, simple meal preparation tasks, movie night, and acting out stories from movies.

For Lucy, the occupational therapist also recommends activities she is able to complete independently so she can experience mastery. Specifically, these activities include chalk play, arts and crafts, specific toys, and books.

Addressing Barriers and Challenges to Play-Based Occupational Therapy with Children and Youth with Mental Health Conditions

Many practitioners in the mental health field report having faced challenges that result from both complex clients' presentation and contextual obstacles within the settings they have practiced (Halperin, 2020; Preyde et al., 2009). Challenges pertaining to clients' status/symptoms include inattentiveness, difficulty with following instructions, emotional dysregulation, poor impulse control, and lack of interest. Institutional challenges include limited access to age-appropriate play materials due to lack of funding and restrictions pertaining to supplies/equipment; lack of a safe play space; stringent policies regarding play privileges; restricted use of touch when interacting with clients; insufficient time; limited training among staff; and therapist's lack of confidence. For example, pretend play could lead to reenactment of experienced trauma beyond a therapist's comfort level or felt scope of practice. Because the primary aim of inpatient psychiatric facilities in the United States is to ensure immediate safety, the length of stay in these institutions is usually limited to a number of days, with treatment focusing on stabilization and discharge planning, which leaves little time for more rehabilitative approaches and often results in occupational therapy being delivered in groups rather than individually (Mahaffey et al., 2019). Diverse needs and high levels of symptom severity among patients in acute psychiatric settings often jeopardize their daily structure and create an environment of constant safety monitoring and restricted physical space. Additionally, varying training levels of staff members and frequent misconceptions about the need for overly controlling and forceful patient management practices also contribute to a challenging atmosphere in these facilities (Delaney & Hardy, 2008). Moreover, budget cuts significantly compromise the quality of care across psychiatric institutions (Baker & Gutheil, 2011), inevitably limiting access to nonmedical equipment and supplies. The aforementioned issues also might be encountered in outpatient, residential, community-, and school-based settings serving children and adolescents with psychiatric diagnoses, even if to a lesser degree. Expectations from caregivers, teachers, and other team members that reflect limited

understanding of the occupational therapy role and lack of parental involvement are also reported (Halperin, 2020). However, many of these challenges can be mitigated by addressing maladaptive play and environmental and activity modifications.

Managing Maladaptive Play in Children with Mental Health Conditions

Managing the behaviors of children with mental health conditions requires special considerations on the part of the occupational therapy practitioner. Creating a "just right" and nurturing play environment; catering to young client's intrinsic motivation, while simultaneously setting limits and enforcing social rules; modeling play behaviors for the child; and involving typically developing peers and caregivers in the play process can all be helpful when addressing maladaptive play behaviors/patterns in children and adolescents (Rizk & Howells, 2019; Wilkes-Gillan et al., 2016). However, managing aggressive or "scary" play might require continued effort and additional competencies.

As discussed earlier, some children may experience posttraumatic play (PTP). When guided by a skillful adult and coupled with storytelling (and retelling of it in a more adaptive way), PTP can help traumatized children relive their trauma in a therapeutic manner and experience a sense of mastery and control over their lives, eventually leading to a resolution of the traumatic experience. Children may be able to relive the event through play but in a less passive role, thus through fantasy becoming the hero or at least demonstrating one's capabilities as opposed to being a victim (Chazan & Cohen, 2010). However, when the PTP is not handled properly (e.g., the therapist either dismisses the distress signaled by the child or becomes overly directive while trying to resolve it too early in the therapeutic process), children might become retraumatized, "stuck" in their trauma, and exhibit symptom worsening and even developmental regression with continued negative play patterns (Dripchak, 2007).

Many adults become concerned when witnessing aggressivity in children. However, themes of potential danger and fear are commonly present in children's play. Moreover, some levels of impulsivity and aggression are evident in most young children and represent an age-appropriate developmental milestone (Wilson & Ray, 2018). Playful aggression may, in fact, serve beneficial purposes and has been suggested as an important aspect of young play that should be

allowed (Hart & Nagel, 2017). Playful aggression can be defined as “verbally and physically cooperative play behaviour involving at least two children, where all participants enjoyably and voluntarily engage in reciprocal role playing that includes aggressive make-believe themes, actions, and words; yet lacks intent to harm either emotionally or physically” (Hart & Tanock, 2013, p. 108). Therapists need to determine the level of aggression they are witnessing in play and whether it is typical.

In typical development, children’s verbal abilities, emotion regulation, and sense of mastery over the outer environment increase, leading to a reduction in aggressive behaviors, usually between ages 6 and 10. However, when signs of persistent aggression continue to manifest in a child, they might be predictive of future misconduct, school-related difficulties, social deficits, and diminished mental health (Wilson & Ray, 2018). Additionally, externalizing behaviors (such as aggression, rule breaking, and other forms of disruptive conduct) often signal emotional distress in children, and increased awareness regarding this phenomenon among caregivers may result in more support and better outcomes for affected children (Meany-Walen & Teeling, 2016).

Safety Concerns in Play

In some instances, explosive behaviors during play become unsafe to a point where play might need to be modified or terminated. For example, one of this chapter’s authors has witnessed young clients attempt to push, bite, spit, and swing chairs at their peers and staff out of frustration during group play in an inpatient psychiatric facility. Because of the severity of these behaviors, a behavioral approach was necessary. This particular facility used the “three warnings rule” to encourage the acting out-of-control child or adolescent to use words instead. After three warnings and opportunities to change behavior, the client was required to leave the activity and was escorted to their room to take a break and talk to staff about what had happened and how a similar incident could be avoided in the future. To be able to participate in the next activity, the youngster had to demonstrate that they were able to regain control by interacting with others without physical outbursts. If aggressive behaviors reoccurred in the next group activity, the young client was removed from groups for the rest of the day and offered to engage in one-to-one activities (including play) with staff members instead, while practicing coping strategies, to earn group privileges for the following day. While this approach departed somewhat from the child-centered principles, it helped ensure

safety on the unit and taught children and adolescents that their behaviors had consequences.

Recognizing New Trauma and Stress

Another important consideration pertaining to maladaptive play patterns in youth has to do with reporting newly observed signs of distress during play. For instance, children and adolescents who have experienced sexual trauma may reenact it by using drawings, dolls, puppets, or stuffed animals; choose play themes with an unhappy ending; make threats toward play objects imitating the person who abused them; present as detached and stare into space while playing; and exhibit regressive behaviors (e.g., an older child sucking on a pacifier during play). While some of these behaviors can also result from more commonly encountered stressful events, such as familial conflicts or a birth of a sibling, it is essential that therapists note them, inquire about the reasons behind these behaviors (e.g., by gently pointing them out to the youngster and waiting for her/his response), and report the signs of suspected abuse to child protection services (Brown et al., 2008). Occupational therapy practitioners who witness such play behaviors in their young clients should document them and follow their treatment facility’s reporting procedures.

Overcoming Environmental Barriers to Play in Mental Health Settings

Occupational therapy practitioners working with this population across various facilities often resort to following the “Do what you can with what you have where you are” principle, to promote play opportunities and other meaningful activities for their young clients. With careful planning, creativity, and positive attitude, our profession can make a difference, even when situated in challenging contexts and environments.

Overcoming Material Barriers

Both individual and group play activities can be facilitated while operating on a limited budget. For instance, stuffed animals, dolls and puppets, building blocks, play dough, kinetic sand, and basic arts and crafts supplies are examples of affordable materials that can be used for expressive play. Play with simple sensory objects, such as stress balls, bean bags, and soap bubbles helps young people self-soothe and can be introduced to them as a coping

strategy to use outside of the treatment session. Many inexpensive board games promote cognition and social interaction skills.

Yet one of the biggest challenges with all of the listed materials is that potentially they can be used by young clients who are in distress to harm self or others (e.g., glue can be sniffed, soap bubbles and kinetic sand can be ingested, building blocks and stress balls can be thrown at a peer, intentional or unintentional misuse of jump ropes can cause strangulation, etc.), which indicates that close supervision is needed when utilizing these objects in play-based interventions. Moreover, it may also be necessary to have policies requiring that all materials, including toys, be screened for safety; stored outside of the hospital units; counted before being used in therapeutic activities; and then collected, recounted, and returned to the storage room right after the activity is over.

Overcoming Physical Environment Barriers

Outdoor play can be more complicated for many psychiatric facilities, due to stringent safety policies and, in some instances, a dominant culture of token economy use. For example, a psychiatric hospital may have access to a playground, but rarely make use of it if the staff members believe that children must earn the “privilege” of playing outdoors by behaving appropriately indoors. In such instances, the occupational therapist might need to educate her/his colleagues about play being a basic need and an important energy outlet for children and to suggest that other activities, such as watching TV, be used as a reward for positive behaviors instead. However, if the treatment team disagrees with this recommendation, the therapist will have to compromise and find creative ways to engage children in gross-motor activities indoors.

In some situations, children may not be able to participate in outdoor play safely due to acute symptoms and challenging behaviors (e.g., suicidality, aggression toward peers, risk of elopement), and playground visits might need to be temporarily replaced with indoor activities for them. When outdoor play is not available, the therapist may use indoor gross-motor activities such as parachute games, indoor obstacle courses built with reasonably safe materials (e.g., large balls, hula-hoops, cones), or yoga games, while also ensuring that a sufficient number of staff members are available to help supervise these activities. A valuable alternative to an outdoor playground is a sensory space, which uses colorful paths/activity maps incorporating curved lines, mazes, Lego walls,

and more, and can be installed in hallways, classrooms, offices, or homes to promote play, physical activity, fine-motor skills, core academic competencies, and social/emotional development (including self-regulation and decision making) among children (Action for Healthy Kids, 2020). Because sensory spaces are usually designed utilizing affordable materials, occupational therapy practitioners working with young people in psychiatric settings should consider advocating for installing these spaces in their facilities. Sensory kits, carts (trolleys), or boxes represent another effective, easy-to-implement and affordable intervention (Adams-Leask et al., 2018; Martin & Suane, 2012; OT-Innovations, 2020; Scanlan & Novak, 2015). They allow for carefully selected sensory items that are tailored to clients’ needs to be delivered to the unit, used individually or in groups under staff supervision, and stored outside of the unit in between therapy sessions.

Should an institution serving youngsters with mental health concerns gain access to additional funds (e.g., private donations, grants), it may be beneficial for the occupational therapy practitioner(s) employed by it to introduce the idea of designing a sensory room at the facility to their peers and administration. Sensory rooms (otherwise called sensory modulation rooms) are sensory-friendly therapeutic spaces designed to help prevent and manage emotional crisis by achieving “just right” levels of arousal. Sensory rooms offer a promising intervention for pediatric facilities (Bobier et al., 2015). While some companies design sensory rooms with pricey and sophisticated multimedia equipment, therapeutic spaces can also be created relying on inexpensive items and play materials, such as bean bags, yoga mats, therapy balls, small trampolines, rock waterfalls, weighted objects, stuffed animals, stress balls/fidgets, arts and crafts supplies, playing cards, and tabletop games (Bobier et al., 2015; OT-Innovations, 2020). Due to clients’ symptom acuity, the use of sensory spaces in inpatient facilities might need to adhere to a certain schedule and require consistent staff supervision. Staff members might need to limit access to a sensory room for a child/adolescent in the midst of a behavioral crisis, when she/he is acting out-of-control, if it would be perceived by them as a reward for an undesirable behavior. Instead, it can be provided to a youngster who is reporting distress, but is still able to contain it, or, after the out-of-control behavior has de-escalated and the young client has had the opportunity to reflect on her/his actions. This approach will allow them the opportunity to internalize the strategies they learned in the sensory room as coping skills for the future.

Conclusion

Play is essential to children's development and mental health. Play fosters therapeutic rapport making play-based occupational therapy interventions both legitimate and valuable. Psychiatric conditions, exposure to adversity, and other mental health concerns jeopardize young people's participation in play. However, when proper supports are provided, engagement in play significantly improves outcomes for this client population. Occupational therapy practitioners can utilize play-based interventions and impact mental health and well-being through "making play just right." Sensorimotor activities, object play, and social/team-based play are commonly used by occupational

therapy practitioners serving pediatric clients with mental health issues. Pretend play, storytelling and expressive/symbolic play, as well as board games and virtual-reality-based activities, can also serve as successful treatment modalities for this population. Therapeutic style as well as top-down and bottom-up interventions are matched to the present needs of the child and the activity demands. A child-centered approach should be considered whenever possible. Creative problem-solving can overcome contextual barriers. More robust training on specific play-based interventions including play therapy for occupational therapy practitioners serving pediatric populations with developmental and behavioral issues, as well as further research in this field are warranted.

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