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Role of Play Therapy in Enhancing Social Skills and Emotional Regulation among Children with Intellectual Disabilities

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ABSTRACT
Intellectual disabilities (IDs) are often accompanied by multiple deficits in adaptive functioning, beyond cognitive functioning, affecting the abilities of social interaction and emotional self-regulation. Play therapy has been suggested as a developmentally appropriate alternative to verbal interventions, as these children do not have the verbal and abstract-reasoning skills that many interventions rely on, to build relational competence and self-regulation. This article covers the theoretical underpinnings of using play as a medium for development and therapy, reviews the primary models of play therapy adapted for children with intellectual disabilities, and reviews the empirical evidence surrounding the use of play in social skill acquisition and emotional regulation. The review summarizes the basic developmental theories, the meta-analytical evidence from the general play therapy literature, and outcome research studies with intellectually disabled children to support a theory-based, evidence-based pathway for children with ID to rehearse social reciprocity, externalize emotional distress, and develop concrete emotional regulation strategies through play therapy. The implications for clinical and classroom practice and recommendations for future, more powerful studies investigating the population are provided at the end of the article.

***Keywords**: Play Therapy, Intellectual Disability, Social Skills, Emotional Regulation, Child-Centered Play Therapy, Theraplay*

Introduction

Play has a unique role in the lives of children as it is a spontaneous activity they engage in for its own sake and as a form of structured activity, a place where adults have long tried to understand and support the inner life of children (Landreth, 2012). Play is relatively unsupported by outside adults, and gradually develops from sensorimotor to symbolic and social forms during the preschool and early school years for typically developing children. However, for children with intellectual disabilities (IDs), the cognitive processes that hinder language acquisition, abstract reasoning, and executive functioning also hinder spontaneous emergence of this symbolic and cooperative play. This leaves children with a double disadvantage in that the primary cognitive disadvantage is compounded by their limited access to the activity that is essential for most of the early social and emotional learning that takes place.

It's not a small population. According to a joint report by the World Health Organization and the United Nations Children's Fund, tens of millions of children around the world have a diagnosed developmental disability, and one of the most common types of these disabilities in low- and middle-income regions is idiopathic developmental intellectual disability (World Health Organization & United Nations Children's Fund, 2023). For many of these children, struggles don't just happen in school or the classroom, but they are a part of life at home, in the classroom, and in the community, including the ability to make friends, read social cues, tolerate frustration, and recover from emotional upset.

Relying on introspection, articulating self-report, and abstract insight, traditional verbal psychotherapies often fail to fit the cognitive profile of intellectual disability. An alternative is play therapy, which is a process that does not require the child to describe an internal state, but rather involves the child expressing, symbolizing and slowly assuming the state by using toys and symbolic materials and through play activity, both guided and unguided. Over the past few decades, a few different traditions of play therapy have attempted to explain the therapeutic effects of play, with some approaches focusing on non-directive, child-centered play, others on structured play and cognitive-behavioral play, and others on attachment-based approaches like Theraplay; each of these traditions has, in varying ways, been adapted for use with children who are intellectually impaired and would otherwise not have access to more traditional therapy.

The implications of the question are far reaching and transcendent of the child. The child's social/behavioural problems are often more of a problem than it would be the intellectual disability itself, and families often report that the social/behavioural issues have the greatest impact on family life, sibling relationships and on family involvement in community life. Teachers, on the other hand, frequently have reported that the management of dysregulated behaviors is the greatest challenge to meaningful inclusion of children with intellectual disabilities in mainstream classrooms, in comparison to any academic accommodations. An intervention that is measurable to enhance a child's ability to play reciprocally and to self-regulate has implications which extend beyond the therapy room, into the home, into the classroom and ultimately into the question of how an entire society can educate and support its children with disabilities. This is particularly important in settings where a relationally-based intervention like play therapy is a low-cost treatment that is one of the only possible options that can be both feasible for families and feasible for schools.

This article explores how play therapy can improve two very similar and important developmental outcomes for children with intellectual disabilities: social skills and emotional regulation. It opens with a discussion positioning play therapy in the context of broader theories of development, then defines intellectual disability and its associated vulnerabilities, then outlines the history of play therapy models for children with intellectual disabilities, and finally describes the empirical evidence, from the general child population and from studies directly related to children with intellectual disabilities, relevant to social-skills outcomes and emotional-regulation outcomes. The implications for practice and research priorities are discussed, and the challenges facing the field in the future and the practical challenges of working in the field are considered.

Theoretical Perspectives on Play and Development

It is important to remember that any discussion of the importance of play therapy to children with intellectual disabilities must start with understanding the developmental importance of play. This understanding is dominated by two classical developmental theorists. Piaget put play into a wider cognitive development theory, where he claimed that play (symbolic or pretend play) is the way children practice and consolidate developing cognitive structures, incorporating

new experiences into their existing schemas without having to adjust to outside reality (Piaget, 1962). According to this view, the process of play is not separate from development; it is itself a type of cognitive rehearsal that gradually increases in symbolization as cognitive ability develops. Vygotsky provided a complementary, but different account, which focused on social and self-regulatory aspects of play rather than cognitive. For him, play establishes a "zone of proximal development" where the child can temporarily perform at a higher level than his or her current developmental abilities, for example, by controlling impulses, following rules set by the player, and adopting roles which demand a level of self-control that is not yet present without the play activity (Vygotsky, 1978). This focus on play as a means of early self regulation is especially important for the present discussion, in that it indicates that play is not just a setting in which early self regulation can be observed but instead is also a mechanism in which early self regulation is constructed.

These two accounts together suggest that play has at least two developmental functions, one cognitive (new experience is assimilated and understanding is consolidated) and one self-regulatory and social (practice behavioural and emotional control in a less consequential real world context). Children with intellectual disabilities have two functions, which are two different functions. The cognitive function of play can be limited by the processing capacity that is associated with the disability itself, and thus symbolic play may appear after, be delayed, or be less complex. In contrast, the self-regulatory function may be more easily accessible, as it does not require the same amount of abstract symbolic manipulation—a child does not have to imagine a complicated, pretend scenario in order to practice waiting his turn or tolerating a minor frustration or following a simple rule. This distinction accounts for the continued efforts to use play-based intervention with this population despite the limited symbolic capacity, because play has regulatory and relational benefits that are not exclusively reliant on a child's ability to engage in complex, symbolic play.

These developmental accounts provide information about the clinical use of play, but they fail to explain. That involved understanding what happens in children's brains and bodies as they play, which are now known as the "therapeutic powers of play. A popular approach to the contemporary field organizes these mechanisms into themed clusters (e.g., communication, emotional wellness, social relations, and personal strengths) and gives the clinician a roadmap of the ways a specific play activity could be anticipated to assist a specific child (Schaefer & Drewes, 2014). This framework is relevant for the current review because it makes clear that "play therapy" is not one single technique but a set of techniques that can be chosen and used in combination based on the particular social/emotional deficits identified, and the mechanism or mechanisms accessible to the child, which is important when adapting play therapy for children whose cognitive profile may make some of these mechanisms easier to access than others.

The definition of Intellectual Disability and its developmental correlates.

In the diagnostic nosology currently in use, intellectual disability is characterized by the presence of significant impairments in intellectual functioning, adaptive behavior (conceptual, social and practical), and by onset of these impairments during the developmental period (American Psychiatric Association, 2013). This adaptive-behaviour aspect is important to this present discussion because it highlights the fact that the impairment that intellectual disability entails is not limited to reasoning or academic skill; it reaches right into the social domain, including the child's capacity to decipher social cues, hold reciprocal relationships, and convey feelings in a socially recognizable fashion.

This developmental profile has a number of downstream implications for social and emotional development. Children with IDs often fail to develop the ability to take turns, to engage in joint attention or cooperative play, and are more likely to express distress verbally than by withdrawal, tantrum or aggression, since the vocabulary and ability to reflect on their inner states needed for verbal distress expression may not yet be available. When the child consistently experiences social failure in this way, over repeated experiences, the child becomes more deeply entrenched in these negative patterns of behavior and these patterns are more likely to persist regardless of normal classroom management methods. The fact that this population does not have the motivation or the ability to use the verbal and abstract tools that are normally the foundation for developing these abilities has made play, as a nonverbal, self-motivated activity, a therapeutic medium of interest.

An important point to note is that intellectual disability is not the only type of developmental and behavioral vulnerability. As many as 40% of children with these disorders have other developmental or medical issues, including autism spectrum disorder, attention-deficit/hyperactivity disorder (ADHD), and communication disorders, which have their own social and emotional implications. For a child with an intellectual disability who has a co-occurring communication disorder, for example, the pathway to conventional social learning may be doubly limited because both the scaffolding of the cognitive pathway and the social rules themselves are transmitted linguistically are impacted together. This vulnerability stacking is one of the reasons why interventions primarily focused on verbal instruction or abstract explanation — the typical social skills arsenal used in school settings — may not perform as well with this population as with typically developing students and why a medium free of verbal instruction and abstract explanation, like play, might be particularly valuable in the context of its potential for underperforming in the other domain.

The historical development of Play Therapy for Intellectual Disabilities children

The use of play therapy for children with intellectual disabilities is not recent; it has been suggested as an intervention with children with intellectual disabilities for several decades and some techniques originally used with typically developing children have been adapted. A review that traced this history found four historical models that have been used and applied specifically with children with intellectual disabilities: structured and unstructured play therapy, imaginative play therapy, Theraplay, and child-centered play therapy, and concluded that accumulated clinical experience and case-based evidence were generally encouraging, but that the field had not yet amassed the same number of controlled outcome studies as other populations of children, a gap the review's authors explicitly requested be filled by researchers (Astramovich et al., 2015). The following is a useful organizing principle for the rest of this article the sections that follow explain what has changed, and what hasn't, since that phone call.

This unit involves the application of key play therapy models to children with intellectual disabilities.In this unit, student will apply major play therapy models to children with intellectual disabilities.

Non-Directive and Child-Centered Play Therapy

The non-directive model is the most important and influential model of play therapy and was first expressed in a series of principles that stated that the child has within him or her the capacity to solve his or her own problems, provided the therapist establishes a warm, accepting relationship in which the child is free to express feelings completely, and the therapist is limited to reflecting these feelings (Axline, 1947). This non-directive non-intrusive approach was later expanded to a more concrete clinical model, child-centered play therapy, which is based on “the assumption that childrens' natural growth process and natural drive toward self-direction are

released and fostered by the therapeutic relationship, rather than imposed upon it" (Guerney, 2001, p. 20). This nondirective posture is frequently beneficial for children with intellectual disability because it is not a performance-based interaction that involves the adult, but rather a child's interaction with the therapist and materials at his/her true developmental level, not the level that the adult expects.

Relations-based and advanced clinical practice.Relationship-based and advanced clinical practice.

Subsequent scholarship builds on this foundation, clarifying the specific relational conditions and clinical skills through which the child-centered play therapist puts the philosophy of the approach into practice in the moment, such as the therapist's empathic tracking, limit-setting and return of responsibility to the child, which, according to Ray (2011), represent the "essential" ingredients of the approach regardless of the presenting concern or population. Another account extends the perspective on child-centered play therapy as a therapeutic system to include the fact that what the child plays with and how he/she chooses to play with it is a choice made by the child, not the therapist (Ray & Landreth, 2015). Both formulations are pertinent to work with children with intellectual disability as regards the aspects that must be retained (the structure directed by the child and the therapist's empathic attitude) while others are adapted to the developmental level of the child (such as pacing of sessions, complexity of symbols, and language).

Therapy and Attachment Based Approaches

A very different theoretical approach moves away from symbolic or toy play and toward direct, embodied, adult structured interaction. Theraplay employs activities that foster attuned, playful interactions between therapist and infant, which are thought to underpin secure attachment, with the specific purpose of assisting the child's development of trust, engagement, and self-regulation, by the therapist's active facilitation of the interaction, rather than through the child's symbolic initiative (Booth & Jernberg, 2010). Theraplay has been found to be more suitable for children with greater cognitive impairments than child-centered approaches because it does not rely as heavily on the verbal and symbolic reasoning skills. These findings from developmental research provide empirical support for the premise that the underlying regulatory capacity of children can be shaped by attuned, co-regulatory interaction like that Theraplay structures, with securely attached children exhibiting more adaptive patterns of physiological and affective recovery in response to stressful social interactions than less securely attached children (Movahed Abtahi & Kerns, 2017).

Cognitive-Behavioral Play Therapy

A third strand is the explicit incorporation of cognitive-behavioural (CB) elements directly into the play medium, with structured games, therapist modeling and guided role-play to teach children explicit coping skills and to identify and change unhelpful thoughts about themselves or their situation. Formalized as cognitive-behavioral play therapy, this approach is purposefully directive and the therapist presents activities for the child to engage in rather than allowing the child to lead, select, or invent the activities. The activities are generally focused on specific behavior and/or emotional goals that have been identified in advance, and often are introduced to the child through the use of puppets or structured games that model a sequence of coping steps before the child has the chance to rehearse them on his or her own (Knell, 1993). The explicit, skills-based organization may be one reason why directive, cognitively oriented play strategies have grown to be well suited to the goal-oriented instructional logic used in special education, where clearly-stated measurable goals are routinely expected to be met within the school context where children with intellectual disabilities are served.

This Research did not include any trials of play therapy with the general child population.

While developing adaptations for children with intellectual disabilities, it is important to begin the process with an understanding of the evidence base regarding the effectiveness of play therapy in general, as this serves as the foundation for adaptations for children with intellectual disabilities. Overall, a treatment effect size of 0.80 was found from a landmark meta-analysis that combined 93 controlled outcome studies from 1953 to 2000, with humanistic, non-directive play therapy producing slightly better results than more behaviorally-oriented approaches, and parent involvement as co-therapists producing the greatest results of any type of play therapy (Bratton et al., 2005). A later meta-analysis of 52 controlled studies on child-centered play therapy found a statistically significant moderate treatment effect, and recommended the practice as a developmentally and culturally appropriate intervention that is applicable to a diversity of presenting concerns (Lin & Bratton, 2015). The third meta-analysis, conducted on 23 RCTs that included more than 1,000 children in school play therapy programs, yielded significant results for externalizing behavior, internalizing behavior, and academic self-efficacy (Ray et al., 2015), relevant to the present discussion because so much of the intervention literature on children with intellectual disabilities has been conducted in school or classroom settings. This collection of meta-analytic evidence constitutes a general support for the efficacy of play therapy for children overall, and offers the empirical foundation for drawing more specific conclusions about play therapy with children with intellectual disability.

Play Therapy and the Development of Social Skills in Children with Intellectual Disabilities

Social-skills deficits for example, in initiating interaction, reading nonverbal cues, and sustaining cooperative play are among the more consistent features of the intellectual disability profile and have implications that resonate far beyond the playroom into the classroom and the world of relationships. These deficits are tackled in play therapy in a number of converging ways and the case-based and controlled literature available on this population is still in its infancy, but the evidence in various methods is encouraging.

In terms of individual case evidence, a detailed case study of a 6-year-old boy with severe autism showed that during the course of therapy, the child made significant improvements in joint attention, imitation, symbolic play, and responsiveness to the therapist and parents, demonstrating measurable social gains despite having significant communicative and cognitive deficits (Josefi & Ryan, 2004). At the systematic-synthesis level, a review of controlled and quasi-experimental studies focused on social-skills training with ID students revealed that, along with classroom-based training, peer-network-based interventions, and emotional-intelligence training, puppet-based play therapy was one of a small number of interventions in the literature that showed positive outcomes for communication skills and emotional recognition among students with ID; however, the available literature has significant methodological and outcome measurement differences, which makes no single conclusion possible (Jacob et al., 2022). Group based delivery seems to be especially relevant here as children have the opportunity to develop reciprocity skills directly with peers, not just with the therapistchild relationship dyad; a controlled clinical trial of group play therapy with several hundred pre-school children with developmental vulnerabilities demonstrated statistically significant gains in self-awareness, self-regulation, social interaction and adaptability relative to a control group, and the general hypothesis that structured group play can foster exactly the reciprocal social skills that pre-school children with developmental vulnerabilities lack most commonly (Chinekesh et al., 2013).

Play Therapy and Emotional Regulation in Intellectual Disability Children.

In normal development, emotional regulation — the ability to monitor, assess, and regulate emotions in oneself — relies on the development of cognitive appraisal processes as well as on

the early relational experiences of the child where he is offered and learns to regulate his emotions in relation to his caregivers. Children with intellectual disabilities experience both cognitive deficits and communication deficits that often impact the appraisal/reappraisal process of mature regulation and the responsive and attuned care-giving interactions that typically support early regulatory development. Theories of play therapy suggest that emotional regulation is achieved in a variety of different, yet related ways and the evidence available specifically regarding children with intellectual disabilities is in a state of evolution, but broadly validating this theoretical explanation.

A single-group evaluation of child-centered play therapy for 42 children with intellectual disability, ages 4 to 16 years, who all had reported emotional, behavioral, or mental health issues, reported statistically significant improvement in prosocial behaviors, and reductions in emotional and behavioral difficulties after treatment, with the greatest improvements reported by children with the most severe initial presentations and the most extensive training of the therapists who delivered the therapy (Mora et al., 2018). In the random-controlled trial study on play therapy and its impact on sensory processing and distress tolerance, particularly, the researchers found improvement in sensory processing and distress tolerance that persisted even at a follow-up assessment, suggesting that structured play experiences can foster a lasting and valuable emotional resilience and adaptive coping capacity, not just momentary in-session calm (Rathnakumar, 2020). In addition to these outcome studies, a systematic review specifically on the common and specific therapeutic factors in play therapy for children with mild intellectual disability who struggle with aggression found that the quality of the therapeutic relationship and the therapist's use of play as a non-verbal language related to the child's inner world emerged as key mechanisms of change, and some factors such as the need for increased concreteness and repetition were identified as specific to this group of children compared to play therapy for typically developing children (Bent et al., 2022). When taken together, all three types of evidence indicate that the emotional regulation outcomes of play therapy in this population are not by-products of play therapy, but are associated with identifiable and replicable aspects of the play therapy process.

Provide Supporting Evidence from Related Disability and Vulnerable Populations

Comparable literature pertaining to intellectual disability is relatively small, so it is helpful to review literature to see how similar populations with similar communicative and regulatory limitations perform in comparison; findings from similar populations will lend support to the underlying therapeutic mechanisms. The nonverbal nature of play-based intervention, combined with its proven effectiveness for enhancing social skills among pre-school children with hearing impairment, serves to further validate the potential of play-based, nonverbal intervention for strengthening social competence in children with intellectual disabilities, who, like children with hearing impairment, often have restricted opportunities for traditional verbal social learning (Movallali et al., 2015). Likewise, a non-experimental study of play therapy for behaviourally maladjusted preschoolers in general showed that, in comparison to a non-play therapy control group, play therapy led to a decrease in disobedience and related behavioural problems, providing further support for the generalizability of play-based mechanisms across the broader population of preschoolers whose behavioural presentation is indicative of an underlying regulatory problem rather than a purely motivational one (Jafari et al., 2011). Both of these studies have not been conducted with children with intellectual disability specifically, but both confirm the theoretical rationale based on the developmental and therapeutic-mechanism literature reviewed above that play-based intervention is particularly appropriate for children for whom the verbal/insight-oriented approach is not developmentally accessible.

It's important to point out this convergent pattern across disability groups for a brief moment, since it has direct implications on the confidence the field can have in generalizing from the limited evidence base for ID. If the benefits of play therapy were limited to some aspect that is specific to intellectual disability, it would be expected that it would not be as effective (or would act in entirely different ways) in other groups dealing with different but structurally similar challenges to verbal social learning. Rather, the available evidence from each of the three areas of hearing impairment, autism, and general behavioral maladjustment suggests a common thread: when children are unable to experience verbal, insight-based learning, due to any particular reason, a relationally structured medium like play seems capable of accessing social and emotional skills that are more difficult to access with verbal, insight-based learning. This convergence is no substitute for trials specifically aimed at intellectual disability but does offer a good foundation for ongoing clinical confidence until this more specific evidence base is established.

Challenges and Limitations

There are some limitations that restrict the use of play therapy with children with intellectual disabilities and also the evidence to support its use. Initially, therapist preparation programs in play therapy have been created for typically developing children and the ability to pace sessions, incorporate symbolic play and communicate with children who have significant cognitive deficits calls for another level of expertise that is not always shared among all therapists. Second, the population of children with intellectual disabilities is quite diverse in terms of the severity of their disabilities, their communication skills and often their co-occurring condition (autism spectrum disorder), which complicates the ability to generalize the results from any one study to the population as a whole. Third, measurement across the studies that have been conducted is inconsistent, with extensive use of parent- or teacher-rated behavior checklists which are easy to administer but susceptible to reporter bias and may not be sensitive to the internal regulatory processes postulated to be affected by play therapy.

Another, more conceptual restriction is whether the question of generalisation can be addressed. The fact that a play therapy intervention shows positive outcomes in the therapy room or research setting does not necessarily mean that it will result in positive outcomes in the child's typical peer, classroom, or home environment. Some of the above studies used caregiver or teacher ratings taken following a treatment program, which can be useful for a general impression of behavior but cannot alone determine if a particular regulatory or social skill used in the session was being applied by the child in the contexts where it is most important. Solutions to this deficit are likely to involve intervention designs that explicitly provide for generalization supports, such as parents or teachers are coached to use the same relational supports the therapist uses, or some portion of the intervention is implemented within the classroom itself, rather than assuming that generalization will take place without intentional supports.

The implications for practice and recommendations for future research are provided.

From a practitioner's perspective, evidence presented in this review implies that none of the play therapy models is consistently best for every child with intellectual disability and that the selection of a model may be reasonably based on the cognitive and symbolic functioning of the individual child. More structured, adult focused approaches might work better for children with more serious impairment and/or less symbolic capacity, while child-centred, non-directive methods might prove more useful for children with better existing communicative and symbolic skills. The social and emotional benefits seen in play-based therapy (individual and / or small group) might also transfer to the children's mainstream classroom, where the real test of

generalization occurs if the strategies are incorporated into everyday classroom routines, not just those of therapy.

For practitioners working in under-resourced settings, a stepped or hybrid approach might also be considered, where paraprofessionals or trained TAs provide more simple, manualized play-based interventions and the more intensive individual interventions are offered on a regular basis by a qualified play therapist, for children with the more severe or complex presentations. Such a model would not supplant the need for specialist training, but could help to extend access in situations where the ratio of trained play therapist to children with ID is currently insufficient to address a proven need. Parental involvement whether brief filial style coaching or a simple feedback session about the principles of the work involving the child in the sessions is also likely to reinforce and enhance any positive outcomes achieved through the therapy, and this is in line with the overall conclusion that parental involvement boosts the effects of play therapy for the general child population.

Several priorities become apparent to researchers. Finally, the need for controlled trials, comparing particular play therapy models to active control conditions is felt within clearly defined subpopulations of children with intellectual disability, and not based primarily on the case studies and single group prepost designs that continue to be prevalent in this particular area of literature. Beyond caregiver-report checklists, there is a need for measuring outcomes to be diversified and include direct observation of behavior, as well as where possible, physiological measures of regulation that are already available in the broader attachment and emotion-regulation literature. Finally, most of the population-specific studies which have been conducted are from a fairly limited number of countries and regions, so that studies from a broader international cultural, linguistic and resource base would help clarify the influence of contextual factors (such as caregiver involvement, classroom structure, and access to trained therapists) on play therapy outcomes for children with intellectual disabilities in practice.

Conclusion

Children with intellectual disabilities often experience developmental delays in more than just cognition, but in their social relationship skills and emotional self-regulation as well; moreover, many children with intellectual disabilities lack the verbal and abstract-reasoning abilities that are used in conventional psychotherapy. In play therapy, a medium which is developmentally accessible to these children, they can rehearse social interaction, externalize and contain distressing emotion, and learn concrete regulatory strategies on terms appropriate to their developmental level, in the various theoretical variants of play therapy (non-directive and child-centred, attachment-based and cognitive-behavioral). The evidence reviewed in this article, ranging from the basic developmental theory to this general support, as well as a still emerging and growing body of studies with children with intellectual disabilities specifically, supports a multi-dimensional benefit for play therapy.

None of this evidence points to play therapy as the one definitive solution to the social and emotional problems of intellectual disability; rather, it is used in conjunction with a multi-faceted family support system, special-education teaching, and alternative modalities of treatment, where appropriate, for communication or behavior that seek to address the issues more directly. The evidence that does stand up to scrutiny, however, is the more modest but significant claim that play therapy can provide a genuinely usable avenue for children with intellectual disabilities into the social and emotional learning they receive as a part of play, in the absence of the cognitive tools traditionally required for learning. The full realization of this evidence base will require further rigorous research in this field, with a focus on children with intellectual

disabilities, and more people to be trained in the adaptations that will make play therapy truly accessible to children with all intellectual disabilities.

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