CHAPTER - 1

INTRODUCTION

Children with behavioral and emotional disorders, whose symptoms persist into adolescence, are at high risk for developing conduct disorders, antisocial behavior, substance abuse, learning problems and so on. Emotional disorders reflect a heterogeneous group of problems in a child’s social emotional relationship with peers and family and with members of society. These problems begin during toddler phase after an initial period of normal social development (Venkatesan, 2004). Behavior and emotional disorders are caused by a combination of factors. It is important to recognize the problems and seek treatment as soon as possible. Early identification and treatment allow such children to grow into happy productive adults. Among researchers and clinicians around the world, there are concerns that youngsters with attention deficit/hyperactivity disorder and disruptive behavior disorders ADHD/DBDs are not receiving the appropriate treatment that they need (Kutcher, Aman, Brooks, Buitelaar, Daalen, and Fegert, 2004).

Because the behavioral and academic difficulties associated with ADHD are often so prominent, it can be easy to overlook the impact that ADHD may have on less obvious areas of children's functioning. For example, children's peer relations are often adversely affected by ADHD and despite the importance of good peer relations for long-term development, this area is often neglected in treatment. Aspects of emotional functioning i.e. feelings of sadness, worries, etc., also tend to be adversely affected in many children with ADHD but often go unaddressed.
These issues were examined in an interesting study by Bussing (2000), on self-esteem in special education children with ADHD. The most important message from this study is that ADHD alone does not appear to be associated with lower levels of self-esteem in school-age children. Instead, it is the presence of a co-occurring internalizing problem - either alone or in combination with an externalizing disorder - that is predictive of dramatically lower self-esteem.

1.1 Child Psychiatry Disorders

Child psychiatry has been recognized as a division of the field of psychiatry and neurology since the mid 1920s. By about the mid-1950s, the American Board of Psychiatry and Neurology had officially recognized the subspecialty and defined training. In the latest edition of the Diagnostic and Statistical Manual essentially all psychiatric syndromes are listed as various kinds of disorders. 

Disorder, generally and literally define as, lack of order, disruption of order once present. This term has become one of the favored in contemporary psychiatry. In the latest edition of the Diagnostic and Statistical Manual essentially all psychiatric syndromes are listed as various kinds of disorders. It is also gradually taking over the role that the term neurosis previously played in the psychologist’s lexicon (Reber, 2001). Psychological illnesses require rehabilitation whereby learned skills that have been lost are retrained. Illness is generally treated completely or successfully if identified/diagnosed early in the life of an individual (Venkatesan, 2004).
1.1.1 Prevalence

In 1946 the World Health Organization (WHO) defined health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. This definition provides a base for the broad perspective needed to analyze a population health (Law & Yip, 2003).

Mental disorders are common, affecting more than 25% of all people at some time during their lives. They are also universal, affecting people of all countries and societies (Murthy et al., 2001). Common disorders that usually cause severe disabilities are: depression, substance abuse, schizophrenia, epilepsy, mental retardation (MR) and disorders of childhood and adolescence (WFMH, 2003). The overall prevalence of mental and behavioral disorders among children has been investigated in several studies from developed and developing countries. Though the prevalence figures vary considerably among studies, it appears that 10–20% of all children have one or more mental or behavioral problems (Murthy et al., 2001).

1.1.2 Types and Characteristics of Disruptive Behavior Disorders:

Disruptive Behavior Disorder is an expression used to describe a set of externalizing negativistic behaviors that co-occur during childhood; and which are referred to collectively in the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV) as: "Attention-Deficit and Disruptive Behavior Disorders". Disruptive Behavior Disorders involve consistent patterns of behaviors that “break the rules.” Young people of all ages break some rules, especially less important ones. More serious oppositional behavior is a normal part of childhood for children two and three years old and for young teenagers. At other times, when
young people are routinely very, very oppositional and defiant of authority, a mental health disorder may be identified. There are three subgroups of externalizing behaviors:

- Oppositional Defiant disorder (ODD)
- Conduct Disorder (CD)
- Attention Deficit Hyperactivity Disorder (ADHD)

### 1.1.2.1 Oppositional Defiant Disorder

In Oppositional Defiant Disorder, the rules broken are usually those in the family and the school. Oppositional Defiant Disorder may occur in children of any age and in adolescents. Sometimes Oppositional Defiant Disorder leads to Conduct Disorder. Between one and six percent of children and adolescents have Oppositional Defiant Disorder. Oppositional defiant disorder children usually exhibit a pattern of defiant and disobedient behavior, including resistance to authority figures. However, this behavior pattern is not as severe as conduct disorder. The behavior pattern may include recurrent temper problems. In younger children, it is more common in boys, but during adolescence, it occurs as often in boys and girls. The onset is usually gradual, and the severity of behavior problems increases over time. Some children will eventually develop a conduct disturbance, if the oppositional disorder is left untreated.

### 1.1.2.2 Conduct Disorder Behaviors

In Conduct Disorder, the rules broken include the regulations and laws made by society. Conduct Disorder usually occurs in older children and adolescents. Between one and four percent of young persons aged seven to seventeen have
Conduct Disorder. Conduct disorders are thought to be the single largest group of psychiatric illnesses in young people. Often beginning before teen years, the symptoms of these problems are frequently mistaken for juvenile delinquency or the turmoil of growing up. Some common behaviors include stealing, consistent lying, cruelty, deliberate destruction of property, fighting with or without weapons, or even rape. There are many studies into the biological, psychological and sociological causes of conduct disorders, but like many other disorders, conduct disorders are probably caused by a number of factors. Conduct disorders will not go away with age, and therefore treatment is critical.

1.2 ATTENTION DEFICIT/HYPERACTIVITY DISORDERS

1.2.1 Meaning and Definition

ADHD was first described by Hoffman in 1845, a physician who wrote books on medicine and psychiatry. Since then, several thousand scientific papers on the disorder have been published, providing information on its nature, course, causes, impairments, and treatments.

Attention - deficit hyperactivity disorder (ADHD), often referred to as hyperactivity, is characterized by difficulties that interfere with effective task-oriented behavior in children particularly impulsivity, excessive motor activity, and difficulties in sustaining attention (Carson, Butcher & Mineka, 2000). This disorder is usually thought to occur in about 3 to 5 percent of school age children (Goldman, Genel, Bezman & Slanetz, 1998). This disorder occurs most frequently among preadolescent boys- it is six to nine times more prevalent among boys than girls.
1.2.2 Classifications

Attention–deficit/hyperactivity disorder (ADHD) and disruptive behavior disorders (DBDs) are classified somewhat differently internationally due to the use of two different classification systems-the Diagnostic and Statistical Manual of Mental Disorder, 4th Edition (DSM-IV); (American Psychiatric Association, 1994) and the International Classification of Diseases, 10th Edition (ICD10).

According to DSM-IV ADHD is one of the most commonly diagnosed childhood psychiatric disorders, (Popper, 1988; Buitelaar, 2002). It is characterized by persistent impairments in attention (or concentration) and /or symptoms of hyperactivity and impulsivity. ADHD is a chronic condition, associated with poor outcome in terms of academic achievement, social problems and employment instability (Mannuzza, Klei, Bessler , Malloy, & LaPadula, 1993; Weiss & Hechtman, 1993).

The World Health Organization International Classification of Diseases, 10th Revision 1992 (known as ICD-10) has a similar list of symptoms for 'hyperkinetic disorder'. To be diagnosed with hyperkinetic disorder, child must have: at least 6 out of 9 symptoms of inattention and 3 out of 5 symptoms of hyperactivity and 1 out of 4 symptoms of impulsivity.

1.2.3 Prevalence Rate of ADHD in Iran and Other Countries

Study on prevalence rate of ADHD on Iranian children showed that rate of ADHD in a large sample of Iranian primary-school students ranged from 3% to 6%. Prevalence rates were separately calculated based on each scale. On the parent's
scale, the prevalence rates of ADHD were 3% for age 7, 4% for age 8, 6% for age 9, and 5% for ages 10, 11, and 12. On the teacher's scale, the prevalence rates were 4% for ages 7 and 8, 5% for age 9, 4% for ages 10 and 11, and 3% for age 12 (Khoshabi, Pourtemad, Homan & Mohammadi, 2004).

In the United States, an estimated 1.46 to 2.46 million children (3 percent to 5 percent of the student population) have ADHD (American Psychiatric Association, 1994). Boys are four to nine times more likely to be diagnosed, and the disorder is found in all cultures, although prevalence figures differ.

In India, it was found that the prevalence of ADHD increases with age; the prevalence at the age of three to four years was 5.2 % (Bhatia, Choudhary & Sidana, 1999). In Germany, researchers reported a prevalence of 9.6% at the age of five years (Baumgaertel, Wolraich, & Dietrich, 1995). Shealy (1994) estimated prevalence between 3% and 20%, depending on the age, the criteria and the instruments used for evaluation of ADHD. In Colombia, ADHD was found in 18.2% of preschool children (Pineda et al, 1995).

ADHD may be culture-dependent; what is considered abnormal in one culture may be acceptable in another. For instance, “to talk excessively;” intuitively, parents decide what “excessively” means according to their own culture (Reid et. al., 1998). So, the lower rates of ADHD may be attributed to under-recognition and delay of parents in seeking treatment for their preschool children or to the hesitance of some clinicians in diagnosing children in this age group (Andersen, Arvanitogiannis, Pliakas, LeBlanc, & Carlezon, 2002).
Findings of studies conducted in New Zealand, Canada, Germany, and the United Kingdom show an overall prevalence rate of 3% to 7%, similar to prevalence rates in the United States. The diagnosis of ADHD is most often made in children aged 6 to 12 years, during which time the American Academy of Pediatrics estimates a prevalence rate of 4% to 12%. Not only do these figures indicate a large problem, but the numbers are increasing rapidly. According to the US National Ambulatory Medical Care Survey, the number of children who received a diagnosis of ADHD increased 250% from 1990 to 1998. Kelleher and colleagues (1997), reported that pediatricians identified ADHD disorders in 9.2% of children in 1996, compared with 1.4% of children in 1979, an increase of 657% (Pomerantz, 2005).

1.2.4 Types

**DSM-IV.** The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (known as DSM-IV-TR) classifies ADHD in three ways, based on the possible combinations of these two types of symptoms.

- **ADHD combined type:** this is the most common type, and means the child has six or more symptoms in each category of attention and hyperactivity symptoms.

- **ADHD predominantly inattentive type:** this means the child has six or more inattention symptoms but fewer than six hyperactivity-impulsivity symptoms.

- **ADHD predominantly hyperactive-impulsive type:** this is the least common type and means that the child has six or more hyperactivity-impulsivity symptoms but fewer than six inattention symptoms *ICD-10*.

These symptoms can be severe enough and last long enough to significantly impair a person’s daily life. Children with ADHD may be experiencing complex
negative emotions stemming from their environment. They may suffer from depression and low self-esteem but may mask these feeling with aggression and denial.

1.2.4.1 Inattentive and Hyperactivity Symptoms

The key features associated with symptoms of inattention include failing to give close attention to details and difficulty in sustaining attention in task or play:

- not listening when spoken to
- not following through on instructions and failure to finish task
- difficulty organizing task and activities
- avoiding, disliking or being reluctant to engage in tasks that require sustained mental effort
- losing things necessary for tasks or activities
- easily distracted

Picture 1.1: ADHD children and difficulty of playing or engaging in leisure activities and interrupting others in play room.
The key features associated with symptoms of hyperactivity (sometimes known as hyperactivity-impulsivity) include:

- Fidgeting with hands or feet, squirming in seat.
- Leaving seat when remaining sitting is expected.
- Running about or climbing excessively.

Some children fit the criteria for both affective disorders and ADHD. These children are irritable, angry, distractible, inattentive, impulsive, unpredictable and unmanageable (Coleman, 2002). Mood disorders can worsen with medication used to treat ADHD.

- Difficulty playing or engaging in leisure activities and often “on the go”.
- Talking excessively and blurtting out answers before a question is completed.
- Interrupting others.

1.2.4.2 Similarities and Differences between ADHD Subtypes

A study published in the Journal of the American Academy of Child and Adolescent Psychiatry takes a careful look at the similarities and differences between children with these different subtypes of ADHD. This is a very interesting article and here are some of the highlights (Rabiner, 2004).

- The combined type group is the most common, occurring in 61% of identified cases compared to 30% for the inattentive type and 9% for the hyperactive impulsive type.
- For each subtype, there was a significant time lag from when symptoms were first evident to when the child was referred for treatment. This ranged from
1.9 years for the hyperactive/impulsive type to 4.4 years for the inattentive type. This is an extremely important and disturbing finding because it indicates that most children with ADHD do not receive any treatment until several years after their symptoms were first apparent. Children with the combined type had higher rates of behavior disorders (conduct disorder and oppositional defiant disorder) than the other two subtypes. They also had higher rates of bipolar disorder. Even children who had the inattentive symptoms only, still had higher rates of these disorders than children without ADHD.

- Children in the different groups did not differ in how often they were diagnosed with an anxiety disorder. Children with the combined type or inattentive type were more likely to be depressed than children with the hyperactive/impulsive subtype.

- On an average, all three groups scored lower than non-ADHD children on measures of intellect, academic functioning, and social functioning. Children with different subtypes of ADHD did not differ from one another on any of these dimensions.

1.2.5 Etiology

The causes of ADHD are still a mystery although current research is pursuing the quest on three fronts; genetic, biological and environmental. According to Coleman (2002), ADHD can also be acquired in infancy from a variety of severe illnesses or injuries. Coleman (2002) distinguishes between primary (inherited) and secondary attention deficit disorder. Secondary disorders occur as a result of any of the following:
• Disorders of mood or affect such as depression or bipolar disorder.
• Primary neurological disorders such as epilepsy or Tourette’s syndrome.
• Chromosomal disorders such as Fragile X syndrome.
• Exposure of a baby to drugs, alcohol, infection, toxins or brain injury.
• Premature birth.

Critiques from different disciplines and cultures have argued that explanations for emotional and behavioral problems such as ADHD, which place a strong emphasis on biological factors, are merely convenient labels that are used to cover up the true, social causes of these problems (Cooper & Bilton, 1999). The researchers were disturbed by the fact that almost all the symptoms and diagnostic criteria of ADHD are behavioral and there seems to be very little investigation into the motives, purpose and need underlying such behavior. Also, it seems that child with ADHD is rarely consulted about what she/he feels and thinks about himself and his world.

The DSM-IV does not directly take note of ”systemic” issues such as family dynamics, and the demands and responses of environment are not perceived as critical to the diagnosis, even though children are especially vulnerable to environment influences (Diller, 1999). Unfortunately, there is also a tendency which encourages the polarization of views on ADHD, to see ADHD as a set of problems induced by biological factors or as problems generated by the environment. This nature-versus-nurture argument does nothing other than highlight the tribalism of competing professions and disciplines. It seems best to adopt a holistic approach, and strive towards understanding how biological, psychological and social factors interact in children with ADHD (Cooper & Bilton, 1999).
1.2.5.1 ADHD and the Nature of Self-Control (Revisiting Barkley's Theory of ADHD)

Barkley (1997), argues that the fundamental deficit in individuals with ADHD is one of self-control, and that problems with attention are a secondary characteristic of the disorder. Barkley emphasizes that during the course of development, control over a child's behavior gradually shifts from external sources to being increasingly governed by internal rules and standards. Controlling one's behavior by internal rules and standards is what is meant by the term "self-control".

Picture 1.2: Lack of self control is the fundamental deficit in children with ADHD.

Self-Regulation as the Core Deficit in ADHD

Barkley (1997), argues that the critical deficit associated with ADHD is the failure to develop this capacity for "self-control", also referred to as "self-regulation". He suggests that this results primarily for biological reasons, and not because of parenting. As a result of this core deficit in self-regulation, specific and important psychological processes and functions subsequently fail to develop in an optimal way. These include the following:
Working Memory, which refers to the ability to recall past events and manipulate them in one's mind so as to be able to make predictions about the future. This is an important part of dealing effectively with day-to-day situations that Barkley feels is diminished in individuals with ADHD. In fact, recent research has documented a deficit in working memory in individuals with ADHD.

Internalization of Speech, which refers to the ability to use internally generated speech to guide one's behavior and actions. Think about how often you use internal speech - i.e., talking to yourself, to help regulate and guide your behavior and to solve problems you may be confronting. Barkley argues that this capacity develops later and less completely in individuals with ADHD.

Sense of Time, which refers to the ability to keep track of the passage of time and to change/alter one's behavior in relation to time. Consider how often one needs to evaluate the time required to accomplish a particular task and how the time you are devoting to a particular task compares to what is available, and what will be required for other tasks. Barkley suggests that for an individual with ADHD, the psychological sense of time is impaired, which prevents them from being able to modify/alter their behavior in response to real world time demands. This is seen, for example, in the adolescent who may become engrossed in a project and wind up spending far more time on it than should have been allocated, given other demands that need to be met.

Goal Directed Behavior, which refers to the ability to establish a goal in one's mind and use the internal image of that goal to shape, guide, and direct one's
actions. This is an incredibly important capacity as it underlies consistent effort and persistence. Imagine how much harder it would be to persevere through difficult and frustrating times if you were not able to hold a long-term goal in your mind. Barkley argues that individuals with ADHD have great difficulty doing this, and thus have difficulty with making a consistent effort to achieve long-term goals.

1.2.5.2 Implications of Considering ADHD a Disorder of Self-regulation

Conceptualizing ADHD as a disorder of self-regulation, and not a disorder of attention, has significant implications for understanding the difficulties experienced by individuals with ADHD and how to assist them in coping more effectively with those difficulties. Below is a brief summary of Barkley's views on this.

First, he argues that individuals with ADHD may not lack the skills and knowledge to be successful, but rather, their problems with self-regulation often prevent them from applying their knowledge and skills at the necessary times. As Barkley puts it, "ADHD is more a problem of doing what one knows rather than knowing what to do." For example, although a child with ADHD may "know" that sharing and cooperating are an important part of making and keeping friends, he may fail to apply this knowledge with peers because the immediate rewards associated with getting one's way overpowers the less salient goal of keeping a friendship. Or, the child may know the steps to follow to do a good job on a school project, but not act on this knowledge because of problems with managing time and using a long-term goal to guide behavior.
The treatment implication that follows from this conceptualization is that treatment should focus on helping individuals apply the knowledge they already have at the appropriate times, rather than on teaching specific knowledge and skills. This will require frequent external cues and reminders to apply this knowledge, because their internal guides for behavior are less effective.

1.2.6 Management of ADHD Children

Several intervention approaches are available. Knowing something about the various types of interventions makes it easier to develop techniques for managing the patterns of behavior. Beside stimulants which are most commonly used for ADHD children, Parenting skills training, social skills training and different types of psychotherapy have been used to manage the ADHD symptoms.

1.3. PSYCHOTHERAPY

1.3.1 Meaning and Definitions

Psychotherapy is an interpersonal, relational intervention used by trained psychotherapists to aid clients in problems of living. This usually includes increasing individual sense of well-being and reducing subjective discomforting experience. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships.

Psychotherapy works to help children with ADHD to like and accept themselves despite their disorder. It does not address the symptoms or underlying
causes of the disorder. In psychotherapy, patients talk with the therapist about upsetting thoughts and feelings, explore self-defeating patterns of behavior, and learn alternative ways to handle their emotions. As they talk, the therapist tries to help them understand how they can change or better cope with their disorder.

![Picture 1.3](image)

Picture 1.3 : ADHD children explore self-defeating patterns of behavior and learn alternative ways to handle their emotions by Play Therapy.

### 1.3.2 Types of Psychotherapy

Psychotherapy, involves verbal and nonverbal communication about thoughts, feelings, emotions and behaviors in individual, group or family sessions in order to change unhealthy patterns of coping, relieve emotional distress and encourage personality growth and improved interpersonal relations. It is sometimes also referred to as counseling or talk therapy. Common types of psychotherapy include: Behavior Therapy, Cognitive Therapy, and Cognitive–behavior Therapy, Interpersonal Therapy, Psychoanalysis, Psychodynamic Psychotherapy, Psycho Education, Yoga Therapy, and Play Therapy.
PLAY THERAPY

1.4.1 Meaning and Definitions

According to Schriver (2001), play is defined as, "the way children learn what none can teach them. It is the way they explore and orient themselves to the actual world of space and time, of things, animals, structure, and people. To move and function freely within prescribed limits. Play is children’s work." Children learn many things through play. They learn to develop positive relationships with others, they learn to use play materials and equipment, they learn to take turns, they learn how to verbalize their needs and wants, they learn to understand the role of others in their life, and they learn to master skills. There are four main characteristics of play. It is pleasurable, it serves no particular purpose, it is spontaneous and voluntary, and it actively involves the player. Play helps children solve problems, it allows a child to express their needs, and it helps stimulate language growth (Schriver, 2001).

What’s central to playfulness, says Millar (1968), is “an attitude of throwing off constraint”. These constraints might be physical, emotional, social, or intellectual. Play detaches messages, experiences, or objects from their context of origin, creating a new frame that allows for greater freedom, interactivity, and creative possibilities. When we throw off the constraints of a given context, we are free to move, to engage with new contexts as well as to engage the context of our recent experience as an object of play.
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Picture 1.4 : Playing is a normal part of a child’s life and development.

For nearly 70 years, Play Therapy has been used to treat children who have psychological disorders or who have experienced trauma (Benedict, 2003). Playing is a normal part of a child’s life and development (Lieberman, 1979) and as such, children who experience Play Therapy are able to deal with the emotions that are experienced after the traumatic event in a way that is developmentally appropriate for them. According to Schaefer (2003), “One of the strengths of Play Therapy is the diversity of theoretical approaches that are currently being applied in clinical practice with children. This diversity is a reflection of the fact that there are a multitude of therapeutic change mechanisms inherent in play. Among the more well-known therapeutic factors of play are its communication, relationship-enhancement, ego-boosting, and self-actualization powers”. In play therapy, the actual act of playing becomes a child’s primary form of communication to the therapist. Play Therapy gives verbal and non-verbal children the opportunity to develop a relationship with the therapist and according to Erikson (1941), is "the most natural method of self-healing that childhood affords". When children play they can communicate about current and past events, can use verbal and non-verbal expressions to describe events in their lives, and can safely develop play themes around the child’s current problem (Lieberman, 1979).
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Picture 1.5: When children play they can communicate about current and past events.

### 1.4.2 Aims of Play Therapy

- Play Therapy helps children in a variety of ways. Children receive emotional support and can learn to understand more about their own feelings and thoughts. Sometimes they may re-enact or play out traumatic or difficult life experiences in order to make sense of their past and cope better with their future. Children may also learn to manage relationships and conflicts in more appropriate ways.

- The outcomes of Play Therapy may be general e.g. a reduction in anxiety and raised self esteem, or more specific such as a change in behavior and improved relations with family and friends.

- Play Therapy relieves the emotional distress of young children through a variety of imagination and expressive play materials such as, puppets, clay, board games, art materials and miniature objects (Webb, 1999). The play activity of a child, as natural medium for self-expression, has stimulated much thought, experimentation, and conclusions as to the ways in which play can be used in the treatment of children.
In the process of growing up, children’s problems are often compounded by the inability of adults in their lives to understand or to respond effectively to what children are feeling and attempting to communicate. Play is to the child what verbalization is to the adult. Communication is one of the most important powers of play. Because play is the language of the child, it allows the child to speak to us without words.

Play Therapy is geared mainly for young children at specific developmental levels. It makes use of a variety of techniques, including playing with dolls or toys, painting or other activities. These techniques allow children to more easily express emotions and feelings if they lack the cognitive development to express themselves with words.

Picture 1.6 : Play is to the child what verbalization is to the adult.

Picture 1.7 : Play Therapy relieves the emotional distress of young children through a variety of imagination and expressive play materials.
• Play and Brain-Mind Maturation. If animal data is a valid guide (Panksepp, et al., 2003), abundant play will facilitate maturation of the frontal lobe inhibitory skills that gradually come to regulate children’s impulsive primary-process emotional urges. Panksepp, Burgdorf, Turner, and Gordon (2003) developed the idea that more the children indulge in pro-social play, the sooner and more completely will they develop frontal lobe regulatory functions that allow children, indeed all of us, to inhibit impulsive urges - allowing us to “stop, look, listen and feel.” Such frontal lobe regulatory skills promote enhanced capacities for “self-reflection, imagination, empathy and creative/play”: These executive abilities promote the kind of “behavioral flexibility and foresight” that constitute “well-focused, goal-directed behaviors” that may last a lifetime.

1.4.3 Types of Play Therapy

There are several different theoretical models of Play Therapy that may be used with children. Their modes can be directive, non-directive, or a combination of both. They range in theoretical orientation from psychoanalytic play therapy, which uses a Freudian approach, to cognitive behavioral play therapy, which uses a cognitive behavioral approach. For the purposes of this study we will focus on child-centered play therapy, which is a person-centered approach to working with children and object relations thematic Play Therapy (Schaefer, 2003). For younger children child-centered and object relations thematic play therapies are the treatments of choice.
According to British Association of Play Therapy (BAPT), Play Therapy emphasizes the client as trustworthy. It is based on three critical theoretical principles of actualization, need for positive regard and as means of communication. There are several theoretical approaches to play therapy, such as: psychoanalytic perspective, nondirective or client-centered play therapy, family play therapy, Adlerian Play Therapy and others.

1.4.4 Theoretical Orientation

Play Therapy can follow almost any theoretical orientation. Behaviorists use structured play and reinforcement to shape behavior. Psychoanalytic Play Therapy aims to help the child gain insight into forbidden instinctual wishes and to find ways to integrate them more acceptably. Psychodynamic therapists use play to deal with anxieties related to attachment and separation. Client- centered Play Therapy follows the child’s lead in play; the therapist provides connectedness, empathy, and unconditional positive regard. Existentialists use play to help the therapists see the world as the child does and convey interest, understanding, and acceptance. The time – limited Play Therapy model outlined in this manual incorporates aspects of client-centered and psychodynamic play therapies. The client–centered aspects help instill self- efficacy and self-worth in the participants. The psychodynamic aspects help ensure productive interactions between group members and increased self understanding or insight (Bonner, Walker & Berliner, 1999).

1.4.5 Client-Centered Therapy

Rogers developed this approach for therapy with adults. And Virginia Axline modified the client centered approach into a Play Therapy technique for children.
Client centered Play Therapy aims at resolving the imbalance between the child and his/her environment so as to facilitate natural self-improving growth. The child-centered Play Therapy approach is based on the assumption that a non-directive Play Therapy approach is the most effective because the therapist does not direct the treatment, allowing the child to be responsible for the direction of the treatment (Guerney, 2001). Child-centered, non-directive Play Therapy is based on Rogers’ philosophy of personality development (1951) and is based on the principal that, "...all individuals, including children, have the innate human capacity to strive toward growth and maturity if provided nurturing conditions" (Guerney, 2001). Allowing the child a safe and nurturing environment allows the child to heal from their traumas and gain insights and perspective into what they are feeling and experiencing.

According to Guerney (2001), there are five basic tenets to child-centered play therapy. The first is that the child directs the content of the Play Therapy and the therapist allows the child to follow their own path to healing and does not direct the therapy in any way. The second is that child-centered Play Therapy is not problem oriented but instead it is successful because by its very nature this approach is able to be used with children with many different traumas without looking at symptoms and behaviors directly (Guerney, 2001). The third tenet is that words, symbols, and other expressions that the child uses to communicate in the Play Therapy session are not readily interpreted by the therapist; instead the therapist works toward the goal of providing a safe environment for the child to be able to expose their personal world at their own rate of expression. The fourth tenet is that child-centered Play Therapy is a system that is dependent on the full use of the
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system and does not deviate from its path; it is not a set of techniques or principles that are used at the therapist’s discretion. The fifth and final tenet is that the therapist must believe in the fact that the child is the one who can best direct their healing and the therapist must provide full therapeutic support to the child (Guerney, 2001).

![Picture 1.8](image.png)

**Picture 1.8**: Client Centered Therapy allows the child to heal from their traumas and gain insights and perspective into what they are feeling and experiencing.

1.4.5.1 Theory of Client- Centered Therapy

The theory of Carl Rogers is considered to be humanistic and phenomenological. The client - centered theory of personality structure is based on three central constructs: 1) the person, 2) the phenomenal field, 3) self (Rogers, 1951).

**Person**: The person is all that a child is: thoughts, behaviors, feelings and physical being. This total person is always in the process of developing. A basic proposition is that every child “exists in a continually changing world of experience of which he is the center” (Rogers, 1951). As the child interacts with and responds to this changing, very personal world of experience, the child does so as an organized whole so that a change in any one part of the person of the child results in changes in
other parts. Therefore, a continuous dynamic intrapersonal interaction occurs in which the child (person), as a total system, is striving toward actualizing the self. This dynamic, active process is an inner-directed movement toward improvement, independence, maturity, and enhancement of self as a person. The child’s behavior in this process is goal-directed in an effort to satisfy personal needs as experienced in the unique phenomenal field which for that child constitutes reality (Landreth, 1991).

**Phenomenal Field**: The second central construct of the child-centered theory of personality structure is the phenomenal field—which is everything the child experiences, whether or not at a conscious level, internal as well as external. It is this internal reference that is the basis for viewing life. Whatever the child perceives to be occurring is reality for the child. Therefore, the child’s perception of reality is what must be understood if the child and behavior exhibited by the child are to be understood. Rogers (1951) proposed that “behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced in the field as perceived”. This concept is central to child-centered play therapy.

**Self**: The third central construct of the child centered theory of personality structure is the self. A portion of the child’s total experiences, that is the interactions with significant others and experience from the total phenomenal field, are gradually differentiated by the child as the self.

**Self Concept**: The organized consistent conceptual gestalt composed of perceptions of the characteristics of 'I' or 'me' and the perceptions of the relationships of the 'I' or 'me' to others and to various aspects of life, together with the values attached to these
perceptions. Most of a child’s behavior is consistent with the child’s concept of self, and behaviors inconsistent with the self-concept are not owned. Psychological freedom or adjustment exists when the self-concept is congruent with all the child’s experiences. When this is not the case, tension or maladjustment is experienced by the child (Rogers, 1951).

1.4.5.2 Limit Setting

Play Therapy facilitates the development of self-control, self-responsibility, and appropriate self-esteem. In this mode of play therapy, the child is offered a safe and consistent environment together with a safe and consistent relationship with the play therapist. All feelings are accepted and are explored symbolically and/or explicitly, depending on how the child or young person is able to use play therapy. Not all behavior is acceptable, so the therapist sets firm and consistent limits.

Limit setting alters the atmosphere in the play room, the perception of the therapists by the children, and ultimately, the course of therapy. Too frequent limit setting can defeat the course of therapy. Too little can leave children feeling unprotected and without appropriate boundaries. Therefore, limit-setting should be prudent, thoughtful, and firm.

1.4.6 Applications

Research has shown that Play Therapy can be effective for many kinds of childhood problems (Schaefer & O’Conner, 1983). Because many of the symptoms that children have seen in their play, it is the natural course of intervention. Children can benefit from Play Therapy in deferent way as:
1. Develop a new respect and acceptance of themselves and others.
2. Replace old patterns of reacting to another with mutually satisfying ones.
3. Develop new ways to exercise self-control.
4. Experience and express emotion in proportion to the interaction.
5. Learn to be more empathic to the thoughts and feelings of others.
6. Develop a renewed feeling of well-being.

Picture 1.9: Experience and express emotion in proportion to the interaction and learn to be more empathic to the thoughts and feelings of others.

1.5 YOGA THERAPY

1.5.1 Meaning and Definitions

The word “Yoga” is Sanskrit, meaning “union.” The principles of Yoga combine relaxation, physical postures, and imagery, allowing almost all ages and ability levels to benefit from its focus. Rehabilitation therapists have a long history of using Yoga as a supplement to therapy. There are many reports highlighting the therapeutic benefits of Yoga for children with Down Syndrome, Autism Spectrum Disorder/Pervasive Developmental Delay, Cerebral Palsy, Attention Deficit Hyperactivity Disorder, and Sensory Processing Disorders (Richmond, 2007).
Children with developmental, genetic, or neurological disorders all have unique therapeutic needs. While there is no global therapeutic treatment for children with special needs, using Yoga as therapeutic intervention is beneficial for all children. With correct instruction, Yoga supplements traditional therapeutic interventions to improve fine and gross motor strength, breath support, concentration, and communication skills.

Yoga is claimed as one of the surest remedies for man’s physical as well as psychological ailments. Yoga makes the organs of the body active in their functioning and has good effect on the internal functioning of the human body (Iyengar, 2005). Yoga is a method of studying and understanding the human personality in terms of body processes. In Yoga theory, it is believed that the body and mind are functioning identically. What happens in the mind reflects what is happening in the body and vice versa (Sharma, 2004).

As a therapeutic technique, Yoga utilizes a lot of bodywork methods and exercises to help an individual become aware of tension in the body and releases them through appropriate movements. As a bodywork approach and bioenergetics, Yoga focuses on the pattern of muscular tension in a person and how that tension directly relates to the person’s emotional history and childhood relationship. Among many other things, Yoga includes body movement and breathing exercises.

As holistic form of psychotherapy, Yoga combines the physical, emotional and mental rhythms. Theoretically, Yoga is based on the belief that psychological
stress in body can be released. By allowing spontaneous self-expression, Yoga enables the individual to reduce stress and focus more on feelings of well-being.

Yoga Therapy has become widely accepted as an effective method of treatment for a variety of ailments, largely due to its unique ability to treat a person at all levels: mental, emotional and physical (Binzen, 2006).

![Picture 1.10: Meditation improve the mental activity in children with a feeling of confidence in every sphere of life](image)

### 1.5.2. Aims

It is known that many children with special needs have one or more sensory deficits. They have difficulty integrating the information from their eyes, ears, hands, and body. They may not move easily and appear clumsy. Most learning problems are the result of poor sensory integration of all these systems.
Each child demonstrates a different set of symptoms. Their nervous system is working in an irregular way and they tend to have disorganized response to their environment. But Yoga is a stimulating way to reach children, especially those with learning differences. Anyone can maximize his or her potential from consistent practice of Yoga and these children are no exception. Yoga calms the physical body and once that occurs, the mind can be quiet. Gradually, a child becomes more organized and focused. Yoga enhances flexibility as a positive effect on gross, fine, visual motor conditions. It also promotes strength and self-esteem and encourages a gentle spirit (Rutstein, 2006).

There are different ways to treat ADHD. Mostly, used behavioral approach, pharmacological approach or a combination of both known as the multimodal approach. Teaching Yoga to children with ADHD involves using behavioral approaches and aim to:

a. improve relationships
b. increases appropriate behavior
c. improve concentration
d. enhance self-esteem
e. increase independence

1.5.3 Schools of Thought

There are numerous schools of thought in Yoga like: Hatha Yoga: Physical Yoga -Bhakti Yoga: Yoga of Devotion - Jnana Yoga: Yoga of Knowledge or Wisdom-Karma Yoga: Yoga of Action- Raja Yoga: Yoga of Physical and Mental Control-Tantra Yoga: Yoga to Awaken Body's Energies. In the West, Yoga is
associated largely with the physical practice of body postures and breathing
techniques known in Sanskrit (the language of Yoga) as Asana and Pranayama. The
postures, along with breathing practices, are part of the Hatha branch of Yoga, and
are but one aspect of the varied field of philosophy and practice known collectively
as Yoga. Within the Hatha Yoga branch there are numerous schools and lineages.
Most of these schools have certain guiding principles formulated by a particular
teacher or guru. These branches of Yoga schools where notably defined and named
after their creators: Ashtanga Yoga, Bikram Yoga, Iyengar Yoga, Kundalini Yoga,
Sivananda Yoga, and Viniyoga.

1.5.4 Yoga Calm for Children

A special area of study is Yoga for children. Yoga is a great form of exercise
to introduce to children as young as two years old. The poses emphasize
coordination, flexibility, strength and good posture, while increasing concentration
and body awareness. Yoga develops self-esteem and will check developmental
disabilities (Randall, 2004).

Picture 1.11: The poses emphasize coordination, flexibility, strength and good posture,
while increasing concentration and body awareness.
Ganesh Mohan is a doctor of Western medicine and Ayurveda as well as a Yoga therapist. He gave several recommendations for using Yoga Therapy with children. He suggests that visualization be kept neutral and not focused on anything specific, such as the chakras, because, “you don’t know what kids will keep in their minds. The focus for kids can be kept on body, breathing and sound. Since children love sound and movement, Yoga Therapy is a natural and appealing option (Binzen, 2006).

Yoga uses physical postures (Asanas), breathing exercises (Pranayama) and deep relaxation techniques to calm and strengthen the central nervous system. It helps children and teenagers with ADHD get in touch with their bodies in a relaxed and non-competitive way. There is also a spiritual side to Yoga that grounds its practitioners in their own silence and internal awareness - something that is becoming increasingly difficult to experience with the frenzied pace of life today.

Children with ADHD often experience learning delays due to their hyperactivity and distractibility. Yoga teachers will usually find it easiest to introduce Pranayama and a few Asanas to these children before attempting to teach them an entire Yoga routine. This will help them to calm down enough to follow instructions. Alternate nostril breathing will be of particular benefit to children with ADHD because of its ability to calm the mind and to balance the left and right hemispheres of the brain. Teaching these children proper respiration is an important aspect of their Yoga training. Once the child with ADHD is able to follow
instructions, the Yoga teacher can gradually introduce more Asanas and the deep relaxation portion of the Yoga routine.

1.5.4.1 Yogacharya Avneesh Tiwari

This Yoga series which has been used for this study, produced with the guidance of Yogacharya Avneesh Tiwari. Yogacharya Avneesh Tiwari has been conducting several, successful experiments with Yoga, to demonstrate its rejuvenating therapeutic powers, especially for people suffering with ailments like diabetes, heart disease and stress in children. Yogacharya underlines and facilitates in strengthening the links between the three elements, the Mind, the Body and the Soul, through Postures, Breathing Exercises and Meditation.

1.5.5 Applications

Among the several benefits of Yoga are, it builds self-esteem and self-respect, promotes physical strength, encourages children to use all of their muscles in new ways, helps build energy and stamina, calms a child and reduces stress, Yoga is non-competitive. It makes one less judgmental of both self and others. Yoga greatly improves internal health and concentration. Yoga promotes body awareness. Yoga is also for fun. Yoga is more than an adjunctive therapy because it is a practice that can be used throughout a lifetime. Yoga is the tools of awareness. It also can be listed as below (Randall, 2004).

- Cultivates conscious awareness
- Increases self-awareness and self-confidence
- Teaches children to be gentle with themselves and others
- Develops focus and concentration
Introduction

- Develops balance and mental equilibrium
- Develops discipline and a love of learning
- Improves performance in all areas of life, including schoolwork
- Relieves stress and provides a greater sense of general well-being
- Increases flexibility, coordination, and strength
- Assists in the performance of sports activities

The above outcomes govern the planning of the course and each lesson. Instructions are expressed simply and kept to the minimum. Children are taught a variety of activities in whole class, pairs and small groups. Pace and voice changes, and total involvement, ensure the students attention throughout the session. When the children come to recognize the structure and routine of the lesson and how easy it is to feel a sense of accomplishment, they soon relax.

Picture1. 12 : Yoga promotes physical strength, encourages children to use all of their muscles in new ways, helps build energy and stamina, calms a child and reduces stress.
1.6. PARENT TRAINING

1.6.1. Meaning and Definitions

Naturally, families play a critical role in children’s healing processes as they move through this extraordinary Play Therapy process. The interaction between children’s problems and their families is always complex.

Parenting children with ADHD is one of the greatest challenges in a lifetime. Doing a good job of it could produce some of the most creative adults in the world. ADHD is a condition in which children, adolescents and adults have difficulty maintaining attention, concentration, and following through on tasks. They can be hyperactive and impulsive. Research indicates that conservatively 3 - 5% of the population is affected by this genetic condition. The severity level of ADHD varies with each individual. Generally the condition is diagnosed when the effects of the symptoms significantly impair the major life areas of school, social interactions, work and home (Ochoa, 2004).

1.6.2. Aims

"When parents learn of their child's disability or disease, the initial reactions can be feelings of devastation, being overwhelmed and traumatized," explained Adams (2004). As parents try to cope with the news of a child's disability, they often feel a loss and grief about not having a "perfect child." They are caught in a mode of crisis and confusion. Parents may believe their expectations and hopes have been challenged or destroyed. Many parents experience feelings of guilt, responsibility, shame, or anger. There can be a tremendous amount of strain that is disruptive for
the family relationships and routines. Feelings of distress and uncertainty can lead parents to a sense of avoidance or denial.

Parents can be helped to adapt by identifying and validating the range of feelings, identifying their strengths, and increasing their support and coping as they work to build new dreams for their child. The healthcare team needs to encourage mutual support and sharing of information and promote parenting sensitivity and effective parenting skills. It is important to improve skills at seeking information, support, and resources regarding children's medical diagnoses and services for children and families (Barnett, Clements, Kaplan-Esrin & Fialka, 2003).

The behavior of an ADHD child is one area that requires considerable energy and involvement on the part of the parent. Children with ADHD respond to the world, and to their parents, differently. They are often able to see through the situation and manipulate the outcome because they are very smart, creative, and quick to perceive parental weaknesses. Disciplining the ADHD child requires quick thinking, creative parents. Parents are encouraged to learn as much as they can about ADHD so they can monitor their child's behavior and creatively intervene when there are differences (Ochoa, 2004).

1.6.3 Application

Numerous studies provide evidence for the relationship between empathic parental characteristics and child adjustment with a variety of child populations (Denham, Renwick & Holt, 1991; Domitrovich & Bierman, 2001). Studies found that parental warmth, affection, and positive involvement have been positively
associated with healthy emotional, social, and behavioral adjustment in their children. Parental empathy may be especially important for children who experience behavioral and emotional difficulties, such as those related to Attention-Deficit/Hyperactivity Disorder (ADHD). Hyperactive children have been found to have more conduct, learning, personality, and emotional problems than normal children, as well as greater interpersonal deficits, including poorer conversation skills (Barkley, Fischer, Edelbrock & Smallish, 1991). In fact, parents of children with ADHD were found to exhibit negative behavior toward their children three times more frequently than parents of non diagnosed children, particularly when asking their children to complete tasks (DuPaul, McGoey, Eckert & VanBrakle, 2001).

1.7. Synthesize

Although there has been a vast amount of research on ADHD conducted over the years, the vast majority of this work has examined issues related to diagnosis, treatment, or behavioral functioning in children with ADHD without regarding their emotional problem. As a result, we know relatively little about other important aspects of functioning may be affected in children with ADHD. One very important domain that has been relatively neglected is the role of emotions in children with ADHD. Related to this general lack of information on emotional characteristics, there is a specific lack of research on empathy in children with ADHD.

Though treatment is essential to reduce symptoms of hyperactivity and impulsiveness and to improve school performance and self esteem in children with ADHD, but stimulant medication alone is rarely enough to take care of the many
therapeutic needs of ADHD children. Ritalin has been shown to be highly effective in more than three quarters of all children with ADHD, but it does have some side effects: nausea, headaches, stomachaches and reduced ability to sleep (Borek, 2000). Behavior therapy is often recommended to help a child increase self control and overcome problem behavior, but still look not sufficient. In fact, some studies suggest the entire family may benefit from psychotherapy as a means of coming to terms with the disorder, and thereby help the child improve and get on with home and school duties (Borek, 2000).

It also shows that one of the limitations of the dominant research approaches to ADHD is their tendency to search for explanations within the person (Cooper & Bilton, 1999). Critiques from different disciplines and cultures have argued that explanations for emotional and behavioral problems such as ADHD, which place a strong emphasis on biological factors, are merely convenient labels that are used to cover up the true, social causes of these problems (Cooper & Bilton, 1999). The researchers were disturbed by the fact that almost all the symptoms and diagnostic criteria of ADHD are behavioral and there seems to be very little investigation into the motives, purpose and needs underlying such behavior. Also, it seems that the child with ADHD is rarely consulted about what he/she feels and thinks about himself and his world. It is the researcher's opinion that chronic environmental stressors can have a profound emotional and/or psychological impact on a child, possibly resulting in changes in brain chemistry and leading to the behavioral symptoms of ADHD.

Emotional difficulties, understandably, is very commonly associated with ADHD. Children with ADHD struggle continuously with their environment (Venter,
Benn & Aucamp, 2003). They are often in trouble, and consequently develop poor self-esteem. The end result may be a psychiatric disorder such as depression or generalized anxiety disorder.

A relatively unstudied area in the field of clinical management of children with emotional and behavior disorders is effect of play and/or Yoga Therapy on betterment of their clinical symptoms. Children with ADHD often show behaviors that disrupt and may consistently be reprimanded or punished for their behaviors. They may do poorly in school and shy away from schoolwork. Sometimes it can be easier not to try than to try and fail. They may tend to shy away from social situations so that they will not be rejected. Sooner or later, they may stop trying and find only safe activities in which failure is not a possibility. But this creates its own problems, as they deprive themselves of enjoyment as well.

Researcher believe that, Play Therapy and Yoga are ways to encourage their creativity to flow; their fears, anger, sadness to release; trust in the inner self to shine; their minds and body to be in synch, reduce their anxiety and raised self esteem, become aware of themselves from the inside out. And from this awareness, changes and growth in new and positive direction can blossom. Yoga can help children, because, children love the postures and are thrilled to see their own progress. They realize that they can do it to the best of their ability irrespective of their problems, shape, weight or culture. The effect of stretching and exercising makes them feel good about their bodies. They enjoy stillness, quiet and calm, during which time they can relax and reflect. The Yoga inspires positive values, optimism, persistence and self-worth.
Each child demonstrates a different set of symptoms. Their nervous system is working in an irregular way and they tend to have disorganized response to their environment. But Yoga is a stimulating way to reach children, especially those with learning differences. Any one can maximize his or her potential from consistent practice of Yoga and these children are no exception. Yoga calms the physical body and once that occurs, the mind can be quiet. Gradually, a child becomes more organized and focused. Yoga enhances flexibility and has a positive effect on gross, fine, visual motor conditions. It also promotes strength and self-esteem and encourages a gentle spirit (Rutstein, 2006).

In the process of growing up, children’s problems are often compounded by the inability of adults in their lives to understand or to respond effectively to what children are feeling and attempting to communicate. Play is to the child what verbalization is to the adult. Communication is one of the most important powers of play. Because play is the language of the child, it allows the child to speak to us without words.

Research has shown that Play Therapy can be effective for many kinds of childhood problems (Schaefer & O’Conner, 1983). Because many of the symptoms those children have seen in their play, it is the natural course of intervention. From marginal behavioral difficulties to conduct disorder, ADHD, anxiety/fearfulness, depression, aggression, and impulsivity, and social withdrawal, Play Therapy has proved to be the most respected and most natural intervention for treatment. Play Therapy has been used successfully with children whose problems are related to life stressors, such as high conflict marriages, divorce, death, step families, abuse,
relocation, hospitalization, chronic illness and natural disasters. Other children may have emotional disorders that look like ADHD, such as severe anxiety. Most of us, when anxious, become restless and fidgety, and do not concentrate well. If anxiety and depression are treated with the drugs recommended for ADHD, they can be aggravated (Venter, Benn & Aucamp, 2003).

Parent’s treatment is one essential part of therapy because, according to Carl Rogers (1951), as children interact with the environment, they develop concepts about the self, the environment, and the self in relation to the environment. This suggests that because young children spend a great deal of time interacting with their parents, the child’s concept of self is largely influenced by parent-child interactions. In fact, one of the most fundamental aspects of the child’s self-experience is that the child perceives love from his or her parents, which allows children to perceive themselves as lovable and worthy of love (Rogers, 1951).

Combined parent–child interaction therapy and Play Therapy can help families of children with attention deficit hyperactivity disorder (ADHD) cope with their situation. Children with ADHD are more at risk to experience relationship conflicts, especially when the environmental demands exceed their capacity to cope. This leads to the whole family of ADHD children experiencing more stress and conflict (Jonson, Franklin, Hall & Prieto, 2000).

*Children are capable of much more than we think. They can go beyond our imagination if given the right environment.*