# Group Play Therapy for Children with Developmental and Learning Disabilities

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## Introduction

Children and adolescents with developmental disabilities (e.g. ADHD, Down Syndrome, ASD) and learning disabilities (e.g. dyslexia, dyscalculia, dyspraxia, dysgraphia) have to bear similar emotional difficulties like others without disabilities. On top of their emotional distress, they have their own specific disabilities to deal with. At home, they are often developmentally overtaken by their siblings and this can cause much anger, pain and self-loathing. The many visits to specialists for their problems to be fixed and the medical treatments make them feel inferior and unaccepted. Therapeutic interventions that meet the emotional, intellectual and physical needs of those with these disabilities are essential and they are available (Cattanach, 1996).

Group play therapy[1] is often offered to small groups of children in schools in order to address a specific problem or developmental issues. It responds to the intrapersonal and interpersonal needs of children and addresses the interpersonal issues that affect or impede academic progress.[2] The effectiveness of play therapy (including group play therapy) in schools has been established and reported.[3] This case study documents my experience in providing group play therapy to a small group of primary four students in a neighborhood primary school in Singapore. The gains among these children with developmental and learning disabilities after six sessions of group play therapy are reported in this paper.

## Referrals

Four children from a Primary School were referred to me by their school counselor for lacking in social skills and being disruptive in class. They were also not coping well with learning in class. The four children were all 10-year old boys from the same school. They come from lower income families with different home circumstances. The parents and referrer (the school counselor) completed the SDQs and were interviewed in order to establish the difficulties the boys were facing.

I met each of the four boys individually to assess their appropriateness for group therapy. They completed the SDQs and the House-Tree-Person (HTP) drawings. None of the boys seemed too aggressive or interpersonally limited to benefit from group play therapy.

They were from the same class and had the same form teacher and I believed that they should be able to relate to one another. I worked out a schedule with the school counselor for these boys to meet for six sessions, for one hour immediately after school every Friday.

All four children showed signs of Attention Deficit Hyperactivity Disorder (ADHD) although only one was actually diagnosed with the developmental disability. Two of them were diagnosed as being dyslexic. There were a number of similarities in the behaviors of the four members in the group. Their teachers indicated that they were not coping well in academic learning, unable to stay focused in class, losing control of their emotions from time to time, disruptive, rude to teachers, and often gets into trouble with their peers.

The first member of the play therapy group to be formed is AMH. He is a Malay boy who lives with his parents and two older sisters. He claimed that he was bullied by his sisters at home and he does not like them. He loves his parents, especially his father. He is not coping well in his studies and cannot stay focused in class. According to the school counsellor, AMH loses control of his emotions in school from time to time. The referrer hopes that he could develop better attitude towards learning; listen to his teachers and follow instructions; and get along better with his schoolmates.

BMS is the second member of the group. He is an Indian boy. He lives with his mother, step-father and an older sister who is in primary six in the same school. BMS is both ADHD and dyslexic. BMS's step-father believes that at home, BMS only listens to him. He thinks BMS is playful and mischievous. He cannot concentrate in his school work and always want to go downstairs to play (soccer, cycling) with his neighbors and friends. He does not get along well with his sister who is academically better. BMS has to attend remedial classes (tuition) in English, Science and Mathematics. His school counselor reported that he is unable to stay focused in class and at times disruptive. He often gets into trouble with his classmates. She hopes that through play therapy, BMS will be more interested and focused in class; listens to teachers and follow instructions; and gets along better with his classmates..

CMY, a Chinese boy, is the third member of the group. He lives with his parents and a 6-year old brother. His mother works in the day and returns home at 7pm. His father works at night. CMY is diagnosed as dyslexic, likes Mathematics but not languages. His father thinks he is a bit slow in his school work and is easily distracted. His school counsellor (referrer) reported that the boy was not coping well in his school work and learning in general, was unable to stay focused in class; and lost control of his emotions from time to time. She hopes that through group play therapy, CMY will be more interested and focused during lessons; able to control and manage emotions better; able to listen to teachers and follow their instructions; and have higher self-esteem.

The fourth member DNS is also an Indian boy. He lives with his parents, uncle (father's elder brother) and his four years old sister. His father informed that DNS is stubborn and argues a lot with his parents. He hates Mathematics and procrastinates where homework is concerned. He spend a lot time outside playing football with his neighbours. The school counsellor reported that he is not coping well in his studies. He is unable to stay focused in class and has poor attitude towards learning. He is also rude to his teachers. She hopes that DNS will be more respectful towards his teachers and seniors; have better attitude towards learning; and stay focused during lessons. DNS has some signs of ADHD too.

In schools, groups are commonly used for educational purposes and economic efficiency (serving a larger number of children with much less resources). The main concern of this primary school is to help children progress academically. It is therefore imperative to connect the intervention of group play therapy to school success. Group play therapy in schools serves to address the interpersonal issues that affect or impede academic progress[4] (Sweeney et al., 2014).

The goals for the group were only formulated after the meetings with the children, the parents and the school counselor, and after studying the SDQ scores and the interview forms with regard to the expressed hopes and expectations of the stakeholders. The House-Tree-Person (HTP) drawings of the children were also interpreted to derive hypotheses before forming the group play therapy goals.

Therefore both the parents and the referrer contributed to the formulation of goals for group play therapy and later, the outcome of the play therapy would also be discussed with them. All four children apparently need to develop better social skills and to get along better with their classmates and family members.[5] They also need to change their attitude towards learning, be more focused in class, and be motivated to learn.

## Using Embodiment-Projection-Role (EPR) Structure For Group Play Therapy

Therapists operate from a theoretical approach[6] to facilitate group play therapy. Several approaches are available for use in group therapy.[7] The developmental constructs or model used in the group therapy examined in this case study is based on Jennings' (1999) EPR developmental structure.[8] EPR is of crucial importance in ordinary healthy development and therefore as an effective methodology for doing play therapy.[9] It also ensures that the therapist follow a developmental progression in the groupwork. According to Jennings (1999), the EPR developmental structure can be effectively used with any type of group.

### Embodiment

Embodiment play refers to the first stage of development when children are still exploring the various parts of their bodies and then using their bodies to explore the world around

them. This exploration makes children aware of their senses. The use of the senses leads to a new awareness of the sensations in the body. The children then become more connected to their own bodies. They would then be able to interpret these new body sensations as emotions. They will be more connected to their emotions and this might help them to be more self-aware.

Embodiment play is beneficial to ADHD children for other reasons. Exploring the body and how it functions could help these children to have more direct control over their impulses and movements. Giving them a sense of control over their own bodies appear to be a fundamental step towards healing. Many embodiment activities can help to facilitate groundedness. It was suggested that helping children to be more grounded would help them to be less active (Cattanach, 1996; Gaffney, 2000).

In the Embodiment stage, the physicality of play is predominant (Jennings, 1999). The child's early experiences are physicalized and are mainly experienced through bodily stimulus and the senses. It is through these physical experiences that the child develops a body-self which is needed for the development of an identity. These physical experiences can be recreated in therapeutic work with children.[10]

Each group therapy session therefore began with physical (neither aggressive nor competitive) play. The children needed as many outlets for body-movements as possible. Warm-ups and games that were used to start each session involved movements and touching.

In Session 2, they touched and played with clay. To begin the activity, they were asked to close their eyes and feel the clay, pinching it, stretching it and rolling it with their hands, beating/patting it, squeezing it, and so on using their hands.

Later in the 4th session, group members were in role as tiny seeds (in crouching position) and slowly grew up to be tall trees (standing upright with their arms fully stretched out). They then role-played animals in an imaginary forest. Each put on a mask of the animal of his choice. Everyone was in role as animals. The emphasis here was on movement and it placed more imaginative demands on the children. They had to imagine being hungry and thirsty, tired, frightened, etc. They were squatting, crouching, kneeling, on all fours, curling up, huddling together, etc., depending on the part of the "story" narrated by the play therapist, e.g. looking for a resting place, seeking shelter from a thunderstorm, and hearing frightening noises at night. The children were also asked to imagine smelling the scents of the flowers and leaves, and taste the river water. All these activities involved using the five senses and movements.

The children played with sand in the sand tray in the fifth session. They started by feeling the sand, shoving their hands into the sand and then sprinkling, dropping, and pouring sand using their hands.

**Projection**

The second stage is projection where the child relates more to the external world beyond the body. Although the child may respond physically to various media, nevertheless there is a focus on toys and substances and objects that are separate from the child. The child has moved on from exploration through movement to the exploration of other things. They explore their own relationship to other objects as well as garnering/ putting them together in different types of relationships.[11]

According to Jennings (1999), projection play begins when the child starts to explore the world around him. This leads to encounters with toys and other objects. Symbolic play occurs when children realizes that these toys are representation of the real things. They will also understand that in play, anything can be used to represent a specific object. Cattanach (1996) described this as playing in the "as if" or pretend mode. Projection can be progressive as it leads from two dimensions, as in drawing, to three dimensions, as in plasticine, sand tray figures and puppets. Stories and story telling can occur at the end because they seem to be the most natural lead in for role-play (Cattanach, 1996; Gaffney, 2000).

In Sessions Two and Three, the children used visual and tactile materials such as clay, newspapers and glue to express their feelings and ideas and gave form to them. Working with these materials is usually termed "Projective Activities" [12] (Jennings, 1999).

Each person was given a packet of quick drying clay in Session Two. Each was also given a set of clay modeling tools to cut and to create different shapes and patterns in the clay. Their goal was to make a cake for somebody they like, admire or love.

In Session Three the group members were invited to draw a head and shoulder outline and then tear up pieces of old newspaper and glue them within the outline to make a collage portrait of themselves. They were encouraged to experiment with this rather than being shown one that was completed, otherwise they would just copy it. They might cut out features from the newspaper to create their face but the idea was to make the face from pieces. They sat around a plastic sheet where all the material for that activity were placed. This provided some physical play boundaries quite apart from the boundaries set by time and room-space and by the basic rules [13] (Landreth, 2012).

In Session 5 they were involved in sand play. They worked together to create a story by putting miniatures and objects into the tray. Each took turn to tell a story of the Happy

Family as shown in the sand box. Again the sand box provided the physical boundaries.[14]

**Role and Dramatic Play**

The third developmental stage is role-play. According to Cattanach (1995, 1996), it is at about age four that children begin to play socially with other children. It is a natural progression after projection because it moves from using objects "as if" they were something else to "pretending" to be someone else. This is the stage where dramatic playing is seen most clearly and the child takes on various roles rather than projecting them through various toys and objects.[15] In their role playing, they can create make believe scenarios, discussing and negotiating their roles.

It is important that the child has the opportunity to play distanced roles (e.g., the story of the animals in the forest narrated to them while they act out their animal roles)[16] because "the paradox is that the child is likely to come near to their own experience" (Jennings, 1998).

There was some dramatic distancing of themselves in a different role when they were asked to take on the role of the exhibition visitors (in Session Three) and to talk about or react to the artworks on the wall. In Session 4, there was substantial dramatic distancing as the children first take on the roles of growing trees in the forest and then of animals later.

In these cases the roles become the medium for more social interaction and care and trust as well as the development of imagination, and the development and understanding of social norms and behaviours.

The group was engaged in role playing many times during the play therapy sessions. There were adequate warm-ups and movement and projective activities before making the transition into role-playing.

In Session 2, after making the (clay) cakes, they have to present the cakes to the one they had in mind. They then pretended to be the persons receiving the cakes and to say and do something to show their appreciation. The activity encourages the development and understanding of social norms and behaviours.

In the Forest (Session 4), they first wore masks and role-played animals. They then put puppets on their hands and talked about events/situations at home or in school that made them feel very happy or sad. There was substantial dramatic distancing as the children take on the characters of either the animals or the growing trees in the forest. The group found it easier to talk about themselves through the puppets.

In the Visit to an Art Exhibition in Session 3, there was also some distancing as they were asked to take on the role of the exhibition visitors and to talk about or react (at least in posture and facial expression and tone of voice) to the self-portraits hung on the wall.

The intention of role play was for the group to practise life and social skills and at the same time encourage the development of their creativity and imagination. At the end of each role-playing activity, a "de-roling" procedure was included whereby the group acknowledge that they are "themselves" again. It could be something as simple as shouting out their names before pasting their session feedback on the schedule board.

According to Jennings (1999), the sequencing of EPR is important. I tried to stick to this sequence to structure each of the group therapy sessions, always starting with movement and physical warm-ups, then moving onto drawing and paintings, and then to playing roles. A session plan has to be drawn up for each session.

## Operating in Quadrant II of the The Play Therapy Dimensions Model (PTDM)

The therapy sessions with the group of school children operated within Quadrant II of the PTDM[17] (Yasenik & Gardner, 2012). The sessions are considered to be conscious and directive in nature and could involve open discussion and exploration.[18] This quadrant is well suited to working with the group of children who have encountered difficulties in self-regulation and have impoverished coping skills.[19]

In my work with the group, there was little need to move from Quadrant II to other quadrants (within a session or over the six sessions) since the children continued to remain engaged in the directed activity. They remained engaged in the structured activities, have high play skills, relatively high verbal abilities and high levels of problem-solving ability.

### Use of Self or Degree of Immersion

The term immersion is meant to describe the various ways and degrees to which the therapist was engaged in specific behaviours, language (verbal or non-verbal) and emotions during the play therapy session. They indicate how directive the group play therapy sessions were and how active the therapist was. The degree of directiveness and therapist immersion in the play may shift in either direction (vary) throughout the play process; as the therapist, I had to decide.

The "use of self" during the play therapy sessions was done through verbal discussion [20] ; use of reflective statements[21] ; emotionality[22] ; use of physical self [23] ; and interpretations[24]. Elaboration of the above concepts and illustrative examples of use of self are given in the End Notes.

## Group Dynamics

Observation and understanding of the group's dynamics[25] reveal the current process of the group; the identification and understanding of these dynamics allow the therapist to better intervene, and to help the group accomplish its goals/ objectives. The basic group dynamics to observe include level of participation, communication patterns, feelings expressed, resistance and conflicts.[26]

We cannot expect a new group to be cohesive when members first come together. Forming a group takes time, and members often go through recognizable stages as they change from being collections of strangers to a united group with common goals.[27]

Certain anticipated group member behaviours occurred during the group's development, and these are associated with the stage or level of growth that had occurred for the group. Different theorists and authors may use different terms for these stages, but the descriptions for members' behaviours and needs have considerable similarities.

In this case study, the group member behaviours, needs, and major leader tasks were analyzed using Gladding's (2014) four-stage model as a framework.

### Forming

The behaviours of group members are reflective of the behaviours and internal states many people experience in new situations where there is ambiguity and uncertainty. Members are usually anxious about acceptance-rejection, the ability of the group to meet their needs, the type of person the play therapist is and whether he is like one of their teachers in school, what is expected of them, and what will they will be doing in the group.[28]

Their past experiences and relationships with authority figures (teachers and parents) also factor into their behaviours, fears, and expectations when working with the group.[29]

I had to be aware of the anxiety that this initial stage of group engenders in the group members, and be focused on establishing trust and safety[30] so that the group becomes a safe place for members' possible disclosure and self-exploration, and for contributing to each other's growth and development.

### Storming & Norming

Gladding (1995) describes the storming in group development as a time when members struggle over power issues that may result in anxiety resistance, and conflict. This stage is normally characterized by dissention, discord, and disagreement, no matter how minor they were. Group members started to assert their independence and individuality.[31]

They could lash out in confusion and frustration, displacing their conflicting needs on others in the group. Members may also challenge each other and the therapist. This stage can be uncomfortable and difficult for group members and the therapist.

I found that conflict management/resolution skills of the therapist are a very important requirement for the successful transition of this stage because how I react to challenges could demonstrate how I perceive them and their participation in the play group.

The most difficult situation that could occur in this stage is when the therapist is challenged (even though verbally). This challenge could be from only one or two members but the challenge could also be expressing something about what the other members are thinking and feeling. I was aware about this possibility. This situation, however, did not arise this group during the six therapy sessions.

For most groups, the interdependency among group members and the stability of the group as a whole cannot deepen until intragroup hostility has surfaced, been acknowledged, and dealt with (Gladding, 2014). Work done during storming is the foundation on which the group will be built (Mahler, 1969).[32]

Norms are expectations about group members' behaviours that should or should not take place (Forsyth, 2010). They "regulate the performance of the group as an organized unit" (Napier & Gershenfeld, 2004, p. 123). Norming is the first sign of transition to a cohesive group.

Several important changes occur in peer relationships during norming. Among these are outlook and attitude. Group members usually have a positive attitude toward others in the group. They feel a newfound sense of "belongingness" and "groupness" (Saidla, 1990). This positive mindset is likely to result in learning, insight, and feelings of support and acceptance (Gladding, 2014, p. 142-143).

This is a "normal" developmental process in which group members see themselves as being similar to one another. This explains why some strong friendships begin in groups. Those groups in which there is more identification with other members will be more cohesive and less resistant to change than those that are not. In norming, identification with others grows.

**Performing**

This stage as characterized by achievement of individual and group goals as the group becomes more unified and productive. Members are able to confront one another appropriately (Gladding, 2014).

At this stage, the level of group development can be very productive for group members. Sufficient trust and safety has already been developed so that many of the fears around

self-disclosure, acceptance, and positive regard are answered and are of lesser concern. There is a spirit of cooperation, support, and hope in the group. Members can be more confident in their self-efficacy, and more willing to engage in personal risk taking for disclosure and exploration of issues. There appears to be a deep intimacy for the group.

As the therapist for the group, I was relatively less active during this stage. Group members derived enjoyment, and were able to take charge of much of their development at this point. Members were more independent and interacted with each other. They were more willing to support and encourage each other, and considerable therapeutic work was done. These sessions were noticeably more harmonious.[33]

**Closing**

Gladding (2014) believes that termination is as important as the other stage of the group, and it is often overlooked. It is a transition event that leads to a new set of experiences in the group members as members begin to practice new (socially acceptable) behaviours outside the group.

The ending stage should be part of the initial planning done in advance of the group's beginning (Brown, 2014). I was aware that the closing sessions of individual therapy where there could be some regression to behaviours of earlier stages. It is the same for group therapy. The potential loss of the established security, connections, and support can be frightening to some group members, and they can fear being left alone again and without the resources to lean on, that the group and the play therapist have provided.

Some groups may even deliberately produce dilemmas in an effort to prevent the group from ending. Expected member behaviours can include panic, withdrawal, sadness, and devaluing of the group experience as defenses against feeling the loss of the group.[34]

My major tasks at that stage were to prepare members for separation and to become independent. These include reminding members of the time boundary, highlighting progress and growth, reviewing personal goals and accomplishments, and affirming the members' strengths. It could be helpful for some members to verbalize their fears so as to assess their realism and validity. The group went through the pages of the photo album that they have created and reminisce. There was plenty of laughter and they were evidently a cohesive group.

The group's ending is a threshold or boundary. There will be change, the future is uncertain, and there is fear and concern about their ability to cope with changes. Before the group was disbanded, I reminded them of the things they have learned in the therapy sessions and the read out the feedback they gave at the end of each session.

## Conclusion

The outcomes of the group play therapy were positive. The post therapy SDQ scores show that the boys overall stress/difficulties have been reduced. Although there was some improvement in prosocial behavior, the scores are still low. The post therapy SDQs were completed almost immediately after the six sessions of therapy and therefore do not show the longer term positive effects of play therapy. Interviews with the parents and the school counselor (referrer) were carried out much later and their feedback were all positive indicating that the children have benefitted from the group play therapy sessions.

The referrer reported that AMH is getting along better with his friends. He listens to the teacher in class. The parent indicated that the child is more focused in his schoolwork now. He is obedient and listens to instructions at home. His relationship with his elder sisters have improved and he does not feel so lonely. He appears to be happier and not so angry. He does not procrastinate as far as schoolwork is concerned. He is more responsible towards his work. In fact he indicated that he is worried about his PSLE (National) Examinations the following year and said he has to work harder.

The referrer is of the view that BMS is lot more composed in school. He is aware that he needs to put in effort in his work and is able to focus better. Parents noticed changes in the child's behaviour, for the better. Their view is that the child is more obedient and willing to listen to their instructions. He is more disciplined and has time-tables and schedules which he often refers to. He completes his homework now. His relationship with his sister has improved. He also gets along better with his friends in school.

According to the referrer, CMY is coping well in class and is able to regulate his emotion better. He hardly throws tantrums in class now. He is happier too and more positive. Client's father is very happy that his child is motivated to go to school and to do well. He performed very well in Mathematics and did not say he dislikes language classes anymore. He has picked up good habits like having a study time-table and schedule at home. He is happier at home and in school. He is helpful – he helps in housework. He is more open and talks to his mum about school and schoolwork. He has stopped throwing tantrums at home.

The referrer reported that the DNS is coping better in class. He tries to listen to the teacher and follows instructions. The parent's view is that he is more serious towards school work and wants to do well. The child is able to focus on his work. He has quietened down a lot. He listens to his parents and has a lot of friends now. He likes to extend help to others. His parent thinks play therapy has helped NS.

My clients had the opportunity to grow in a setting and process that helped them transfer the social skills they acquired during play into their classroom and homes. Through interaction with fellow group members each child received direct and immediate feedback

related to his current socialization skills. Through vicarious learning experiences, the children were able to make positive changes that would enable them to co-operate more fully in their classroom and approach learning experiences with more confidence. Each child came to the group with individual needs and addressed them through the play process. Regardless of whether they had low self-esteem, were passive & introverted, were attention-seeking & disruptive, or were emotionally dis-regulated, they had developed skills that are essential to their ability to cope in social situations and help ensure success in future relationships. "Friends are forever" was the feedback given by one of the children in the final session.

The increase in the activity levels that occur in the group therapy sessions with children when compared to individual play therapy or psychotherapy with adults can be quite intimidating for those not used to it. I experienced in the first session a momentary lack of control, an inability to be therapeutic in response-giving to all the four children, and a reduced feeling of intimacy with them. To overcome these challenges and reactions, I reminded myself to have confidence and courage, to embrace the value of group play therapy process, and to focus on building strong therapeutic relationships[35] with my four young clients (Hass-Cohen and Carr, 2008; Landreth, 2012; Paul and Charura, 2014). A high degree of immersion and appropriate use of therapeutic responses (Yasenik and Gardner, 2004) were indispensable in order to communicate warmth, genuineness, trust and accurate empathic understanding of the children's feelings, concerns, and experiences. Through working collaboratively with the children and creating a supportive and safe environment, they felt freer to explore feelings, attitudes, and experiences that led to personal understanding, change, healing and growth. Their growth /development continued, as reported by their parents during the interviews many weeks after the final session of group therapy.

The building of relationship between the therapist and the children in the group, and amongst the children themselves was therapeutic and had contributed to growth-promoting and healing of the children. "The power of human relationships is at the heart of psychotherapy" regardless of the modality used (Cozolino, 2010, p. 358).

**Endnotes**

(1) Literature on psychoanalytic play therapy was the first to address group play therapy and provide a clear structure for its delivery (Ginnott, 1961). Slavson and Schiffer (1975) have identified elements of group play therapy that make it the preferred modality over individual therapy. The reasons are : it enables therapists to treat large number of children; through stimulation by others, children perceive, learn, and utilize different methods of play; it makes the young child more conscious of others; children grow in the realization that a child's pleasure-seeking urges must be accommodated to the needs of others; it provides a psychological miniature setting within which reality-setting can take place; and children become consciously aware of similarities with others.

(2) According to Sweeney et al. (2014), play therapy can be used to help the children feel safer, build positive relationship, and learn with less internal distractions, all issues that will potentially lead to academic progress. When children accept themselves and develop positive self-regard, they will be more open to learning from others (Ray, 2011). The goal of play therapy in schools is to "help children

get ready to profit from the learning experiences offered" (Landreth, 2012, p. 148). Axline (1949) noted that play therapy allowed children to overcome emotional limitations that hindered expression of intelligence and to release them to demonstrate their full potential, leading to school achievement.

(3) Sweeney et al (2014) reported the findings of a recent meta-analysis of play therapy research carried out by Ray, Armstrong, Balkin, and Jane (unpublished). The results from 23 experimental studies demonstrated that play therapy was statistically and qualitatively supported as an intervention in the schools. Children participating in play therapy in these studies improved problematic behaviours or characteristics at a statistically significant level when compared to their peers who received no intervention. Children demonstrated positive effects for internalizing and externalizing behavior, self-efficacy, academic, and other problems. When compared to alternative interventions, children participating in play therapy performed 0.20 standard deviations over their peers. The meta-analysis included the review of 13 studies utilizing individual play therapy and 10 studies utilizing group therapy. There was no difference in outcome between individual and group modalities.

(4) The emphasis of offering group therapy to the students is on providing a group experience in which the children can communicate through their language of play and interact with peers in a play setting. The children will face peer interaction and will be encouraged to develop the interpersonal skills to facilitate such interaction. The structured developmental activities they will engage in are most conducive to support focus on interpersonal interaction and skills.

(5) The written summaries of interpretative hypotheses of their HTP drawings show that the boys do have similar difficulties such as feelings of inadequacy, insecurity, instability, interpersonal relationship, defensiveness, and guardedness.

(6) In addition, comprehensive theory offers explanation of problems faced by people and a description of dynamics or conditions for change. Providing group play therapy from a specific theoretical approach offers direction for the therapist in intervention planning. By understanding and conceptualizing children in a way that addresses their development, thoughts, feelings and behavior, a therapist can determine therapeutic goals and how to reach those goals. Theoretically-driven practice serves as a roadmap for the therapist to operate consistently and effectively. It provides the therapist with a practice model or a methodology.

(7) In their books, Sweeney & Homeyer (1999) and Sweeney et al. (2014) briefly introduced the basics of the following theoretical orientations and their approach to group play therapy:

a) Psychoanalytic Play Therapy
a) Child-Centred Play Therapy (CCPT)
b) Cognitive-Behavioural Play Therapy (CBPT)
c) Adlerian Play Therapy (AdPT)
d) Gestalt Play Therapy
e) Jungian Play Therapy
f) Ecosystemic Play Therapy

(8) To Jennings, the primary goals in play and play therapy are:

a) To reskill and empower children through play therapy in order for them to live life in a fulfilled manner
b) To maximize their play functioning which will enable self-healing processes and promote greater well-being (Jennings 1999).

Through playing the child is beginning to distinguish between everyday and playing or dramatic reality. Children begin to take examples of behavior from adults, which is referred to as the 'process of role modelling'. These roles can often be rejected as the child becomes a teenager, but can be rediscovered when the child reaches adulthood. There seem to be a closeness and a distance in relationship with peers and parents which are ritualized dramatically through statements of sameness and difference. Adolescents like to dress up like their peers and very differently from their parents. Apparently young people hate it when their parents dress too young, like them.

(9) The EPR developmental structure can be used with any type of group (Sue Jennings, 1999) and ensures that the therapist follow a developmental progression in the groupwork. EPR is appropriate as a working form for all groups of children because it is based on the general stages that all children appear to go through. EPR follows the same developmental sequence that takes place in child development from birth to 7 years. The first 12 months of a baby's life is mainly physical and sensory (E). Around 13 months, the infant becomes more interested in the world beyond the body in terms of objects and substances (toy, sand and water, messy play), progressing to puzzle play, drawing and painting, doll and puppet play. These are all forms of projective play (P). At around 3-4 years old children start to go back into themselves again and instead of projecting roles and stories through puppets, they play the roles (R) themselves. Usually the 3 stages of E, P and R are completed by the age of 7 years. Apparently it does not stop there. People continue to visit these stages in pre-teen and teenage development, though not always in the EPR sequence. They are experimented with, tried and tested as identity continues to develop. According to Jennings (1999), people make choices as adults based on the stages that we have dominance in, usually take up jobs and hobbies that have either an E or P or R focus. These 3 stages which are markers of life changes are crucial. There are certain intrinsic learnings that happen in these stages for life preparation. There may be sub-stages and overlaps in between but they give a general framework within which play and play therapy can be developed

(Jennings, 1999). Sometimes, due to a lack of a nurturing environment in their infancy, these children might not have experienced embodiment play, which might effect the levels that follow.

(10) During the Embodiment stage, we start to develop our body-self. We are learning an awareness of our own body as well as an awareness of the space around it. During the first year of life so much of our playing is sensory in terms of hearing, seeing, smelling, touching and tasting. Sensory experience validates the child's relationship with the environment and initiates a whole range of choices in terms of soothing and stimulus, likes and dislikes. Ultimately the child who develops a confident body-self will also be able to take reasonably physical risks. Through Embodiment activities, the child rediscovers a range of touch that may be absent or distorted. They will enable a greater range of expression and communication, and allow a greater accessibility to the child's life experience. Therapeutic expression and the development of play ability are mutually enhancing and beneficial. Also, most children's play and games involve varying degrees of touch and Jennings (1999) regards it as artificial not to allow this as part of the therapeutic value of the play. In the group therapy sessions, the children touching each other is inevitable and necessary. For each session, the warm up activities for the group involved a lot of physical movements and touching. Appropriate touching is healthy and therapeutic (Jennings, 2004).

(11) During the Projective stage, the various media become less a part of the child's body and more a part of the child's world. Toys, substances and objects are being organized outside the child's self and are symbolized to create situations. Whereas in the Embodiment stage the child explored the body and immediate bodily world, the child now extends into sensory play through a variety of materials. Initially it seems to be an exploration and a sensory stimulus rather than the actual 'making of something'. As the child gradually exercises control, patterns, shapes and groupings occur. Manipulative dexterity and eye/hand co-ordination increase and there is a sense of satisfaction from balancing something or the creation of a pattern. As the child develops the capacity to pretend, we observe an increase in symbolic playing with objects. Animals take on human characteristics, a box becomes a house, as a child is both creating and recreating past, present and future experiences as well as exploring the borders of the material itself.

It is possible for the child to create an experience that is satisfying, or to recreate a pleasurable or frightening experience or to reformulate the experience in new ways that demonstrate the possibility of change. Children need to experience sensory, exploratory and manipulative play in order to play objectively in symbolic form. Symbolic play can only happen with the increasing development of imagination. Projective play is important for learning how we organize the world outside and also to be able to have imaginative responses to the world of flexibility and change. It is a crucial period of child development where we can observe very clear phases of the progression from the sensory to the symbolic. This stage culminates in drawing and painting, story-telling and the creating of dramatic scenes through objects.

As a young child increasingly develops the capacity to pretend, there is an increase in projective and symbolic play (Jennings, 2004). Simple objects can become toys. The child is projecting ideas and feelings into the toys and objects around. The stage of Projection is normal human development. Projective play can be exploratory, sensory and manipulative. In therapy a child may need to learn or re-learn the capacity to play with and through various media.

(12) Developmentally, these activities come after physical and embodied techniques. The children were assured that they do not have to be good at art to enjoy artistic playing.

(13) Not providing boundaries can create an experience that is very overwhelming for the child. Physical boundaries act as a container for the experience.

(14) There was also a tendency for the children to romanticized their family background and they often revealed the opposite scenario and not an authentic picture of their relationship with their families (Feilden, 1990). Also, all the boys come from poor homes and there were many things they wanted to have which they were not getting from their parents.

(15) Elements of the Role stage could be observed at a very early in a child's development, even during the Embodiment stage, for example when they mimic their mother's facial expressions or echo her sounds. During the Projective stage, the child will dramatize scenes with objects and use different voices. During the Role stage per se, the child takes on roles and characters and enacts scenes in dramatic form. By 4 to 5 years old the child takes on more and more roles and plays them in increasingly complex environments. The play world of the child has become more and more dramatized in form and content, and the outcome is important. The child's vocal and physical range is expended and dramas consist of both everyday situations and imagined events.

The capacity to play 'as if' is an essential component of our dramatic development and without it we are merely creatures of impulse or can lapse into psychiatric disorder. As we are increasingly able to play 'as if' we are increasingly able to understand how the other person thinks and feels. This forms the basis for the development of empathy and even more important, the beginnings of our conscience. Conscience is the development of our sense of what is right and wrong and our moral stance in the world. It is those aspects of ourselves that can be troubled through careless actions or that regulates our potential for violent or anti-social behaviours.

If as children we do not experience the feelings of 'the other' and how it is to be them, and instead receive moral code from others, we are more likely to grow up with a 'fear response' to the world rather than a deeper understanding of the way to live our lives, or the capacity to experience how other people feel. We learn through 'being the other' rather than receiving/imposed a moral code 'from the other'. Through playing we are able to discover our choices concerning the way to live and love. Playing has introduced us to a spiritual awareness.

Dramatic play is where the 3 stages are integrated and is the stepping-stone to drama itself. Dramatic play which progresses from Role, is a stage in normal development and may be applied in play therapy. It develops a sense of 'self and other' through appropriate role modelling, a child develops both a sense of autonomy as well as a sense of belonging to a group. The development of understanding, on one hand, and increase knowledge of 'self and other' grow in tandem as a child has the opportunity to be in and out of roles. The experience in drama will help the child know more about his everyday world just as new knowledge acquired in his everyday world will imbue his drama with new riches

(16) When the children were engaged in an imagined scene or character when they were playing with masks and puppets, this is 'distanced' from the children's experience. The distanced scene will always have connections with the children's own lives but it is being enacted through distance.

(17) Yasenik & Gardner's (2012) Play Therapy Dimensions Model (PTDM) conceptualizes the play therapy process according to two primary dimensions : directiveness and consciousness. The consciousness dimension reflects the child's representation of consciousness in play, and is represented by the child's play activities and verbalization. The second dimension, directiveness, refers to the degree of immersion and level of interpretation of the play therapist. **Consciousness Dimension** : This dimension is represented by the child's play activities and verbalizations. The child's play could be very direct and literal, accompanied by verbalizations, indicating that the child is working with a certain level of conscious awareness. At other times, the child needs distance and protection from troublesome thoughts or feelings, and utilizes play scenarios and objects in a less conscious and more symbolic manner. The younger the child, the less likely it is that the child will represent awareness in a direct manner due to the fact that language and cognitive schemas are still developing. Those working on the lower end of the consciousness continuum would not interrupt the child's lead and trust the inner drive of the child to recognize his/her experience without using interpretive comments to bring the issues to consciousness. **Directiveness Dimension** : This dimension represents the therapist's activity with respect to the degree of immersion and level of interpretation. Immersion relates to the degree to which the therapist enters and directs the play. At the lowest level of directiveness, the therapist is tracking the play through observation and reflection, and is not actually involved in interactive play with the child. At the high end, the therapist has entered the play as a co-facilitator, and is actively taking part in elaborating and extending the play. In non-directive play, the focus is on the person of the child, the non-diagnostic, non-prescriptive involvement of the therapist and highlight the innate capacity of children to direct their own growth and healing. In directive play, the therapist would be viewed as being fully immersed as evidenced by the child and therapist's involvement in a play activity structured by the therapist.

In the PTDM model, these two dimensions intersect, forming four quadrants. The **4 quadrants** are : Quadrant I : Active Utilization (conscious/non-directive); Quadrant II : Open discussion and exploration (conscious/directive); Quadrant III : Non-intrusive responding (unconscious/non-directive); Quadrant IV: Co-facilitation (unconscious/directive). Depending on the case and the theoretical approach of the therapist, a therapist might choose to focus therapy activities primarily in one quadrant. The model is not prescriptive but is intended to provide a way for the therapist to conceptualize the play therapy process. It allows for the reflection on and the use of numerous theoretical models, making it eclectic in nature.

The model is a decision-making and treatment planning tool. It guides the therapist to completely identify the critical elements of the play therapy process. There are **3 fundamental overriding assumptions** : each child is unique regarding his/her skills and abilities; all children follow a common developmental pathway; and the therapist has a central role in facilitating change and optimizing growth. The ultimate goal of the model is to help play therapists to answer the who, what, when why and how of the play therapy process.

The play therapist makes decisions throughout the play process, the degree of directiveness and therapist **immersion in the play may shift in either direction**. There may be a number of indicators that suggest movement is required amongst the quadrants Movement may occur within a session, or across sessions, as the therapy process evolves. This allows the therapist to tailor treatment approaches dynamically and optimize effectiveness. This approach also offers a process-oriented framework, providing guidance for tracking important change mechanisms.

(18) It represents a form of play therapy in which the **therapists select and present specific activities** based on the needs of their clients. This quadrant is positioned on the far right side of the directiveness dimension. This indicates that the therapist has to be immersed in the play through offering structure and direction. The play activities, and the interactive context surrounding these activities, also place this quadrant in the upper portion of the consciousness dimension. There were structure and sequence in the play activities to the extent that the therapist was the director and facilitator of the therapy process. Play activities are purposefully chosen that could prompt the children to gradually engage in conscious processing of the presenting issues.

Therapists working in settings that require a brief, accelerated approach to child therapy (that do not require extensive or lengthy interventions if children have transient or mild adjustment issues), including schools and private practices, frequently work in Quadrant II, as they rely on structured and pre-arranged activities to foster open discussion of the presenting issues.

A high degree of structure and direction in **Quadrant II** does not limit the range of play activities and materials accessible to the child. The manner in which these activities are used also varies according to the underlying theoretical orientation/underpinning adopted. As noted earlier, Sue Jennings' EPR model that encompasses the EPR stages of development was used in the group therapy sessions. The choice of activities and play material for group therapy was largely influenced by this theoretical model.

(19) Children who struggle with self-regulated functioning need specific help to learn how to control arousal levels and to express emotions appropriately. They also require assistance in developing problem-solving skills. In Quadrant II, self-regulation and problem-solving activities often occur through role-play, games or other structured techniques. The therapist might use role-playing, or other teaching tools, to help the child develop skills, such as negotiation skills or strategies for sharing/ turn taking. For emotionally deregulated children, these skills are essential to their ability to cope in social situations and help ensure success in future relationships. Quadrant II is also well-suited to this group of children who need to build a repertoire of adaptive coping skills through establishing greater self-awareness. Play offers the child experiential opportunities to make meaning. If the play activity is useful and developmentally appropriate to the child, then the processes of assimilation and accommodation will occur, supporting shifts in their cognitive schemas. There is now a large body of research that relates emotional self-regulation to social competence, linking reduced or diminished levels of control to behavioral difficulties (Jennings, 1999).

(20) Verbal discussion is related to the degree the play therapist was involved in talking directly to the child about his daily life or about a specific issue he came to play therapy to address. Sometimes, the children could raise issues, share something about their lives and want to talk directly and openly about something that are current in their life or something that are bothering them. Verbal discussion could also start by the therapist asking the child about his day, life circumstances or talking openly to the child about an issue of concern. The therapist may also talk to the child while the child plays. Practitioners using models of play therapy that make wider use of the consciousness and directiveness dimensions will make verbal use of self in play sessions. However, while the sessions were in progress, there was almost no verbal discussion with the children of their lives or their presenting problem (outside of the play activities). The increase in their self-awareness, which relies on consciousness was done through comments and reflections on their interactions and communication with each other during play. In a group therapy situation verbal discussion of personal problems will not only embarrass individual members of the group but will could also result in affected members resisting and even asking to leave the session.

(21) The use of reflective statements in play therapy is touted as one of the basic play therapy skills. Often referred to as tracking or reflecting, this skill is used in many approaches to play therapy although the child-centred, non-directive (UK model) play therapists (see Landreth, 2002) are often immediately thought of first when this skill is mentioned. It is a way to communicate to the children that the therapist is with them. It is one way to build therapeutic relationship. Reflections in play therapy relate to non-interpretive statements made during the course of play that reflect the children's behavior, play content and feelings states. There are no rules to tracking play activity. I had to decide on the frequency and timing of tracking and reflecting. Indeed it was impossible to track each child's behavior and articulation when all the boisterous children were speaking at the same time. Instead I had to reflect on the group's mood and general behavior.

Tracking statements demonstrate that the therapist sees the children and that the therapist is with them. In reflecting content, the therapist paraphrases verbal statements and comments made by the child. Reflecting feelings make the child more aware of emotions which he is presenting (Landreth, 2012). Tracking and reflection have other benefits :

-- Facilitating decision making is another reflective process. I will return responsibility to the child so that the child may succeed at an action, e.g. "You can use the miniatures in most of the ways you would like to" or, "Show me how you would like that to be used."

-- Esteem building and encouraging reflections could also be used by the therapist, "You are all doing a fine job."

-- Relationship-building reflections may include statements made about the child's response in relationship to the therapist. These could be positive comments about the relationship, e.g., "You are having a lot of fun with me right now."

-- Facilitative reflections may be made to deepen or enlarge the meanings of play interactions Play therapists can stay in the metaphor and provide a reflection about a character as well, such as, "Wow, the monster is really scary. You are running away. "

Tracking and reflection are important functions during group therapy. However, the speed in which the events were unfolding and the complex group communication network made it rather difficult to use reflective statements frequently. I tracked the children's play and reflected content, feelings and behaviours of the children in the group intermittently/ sparingly. (Landreth, 2002)

(22) It is important to bring emotions into sessions with clients. They provide emotionally-based responses, either using high levels of consciousness (using direct statements) or low levels of consciousness (staying in the metaphors of the play). The use of self emotionally is demonstrated in play therapy sessions through my tone of voice, cadence, intensity, volume and rhythm in addition to facial expressions and gestures. I had to communicate to the children that I was aware of the feelings that they may have. There was a need to use the emotional self throughout the play session because of the therapeutic need to be attuned and empathetically connected to the clients :

AMH : Mr. Chan .... I feel cold.

Chan : You feel cold .... I have already turned down the aircon.

BMS : (chipping in) He is hungry. No breakfast.

AMH : I feel weak. Nobody cooked breakfast at home. (This was revealed earlier during my interview with him. He disclosed later that he was not given pocket money to buy food during recess time. He comes from a poor family.)

Chan : I am sorry to hear that. I will make sure you have something to eat when we finish the session in five minutes time. Is that ok?

AMH : Thank you Mr. Chan.

Play therapy techniques or play therapy approach alone, will not elicit growth and change in the child, rather it is the varied ways the therapist moves with and through the techniques and/or approach as they connect with the person of the child that provides the restorative experience. Being aware of what I was doing during a given session will help me to modify my responses in ways that enhance clients' therapeutic growth and recovery.

(23) Use of Physical Self. Part of the restorative experience for children in therapy includes physical movement and touch as discussed in the previous section. In fact group play therapy can be one of the most physical therapies. It requires many decisions to be made by me including how physically assertive I play and move around the room. The degree to which I was physically involved during the group play therapy sessions was moderate. Use of physical self includes physical movement in play activities, physical proximity or touch, and level of physical energy. I had to be involved in physical play when demonstrating to the children what should or could be done, especially in the warm up exercises. I was also engaged in physical play with the children when directly invited to do so. There was some physical play with moderate contact. I moved around the room to give help to those who needed it when the children were engaged in their activities. A moderate amount of energy was expended but it was not tiring.

(24) It would be difficult not to use some form of interpretation in play therapy. Reflections and tracking can be interpretative too, such as " You are angry you are not able to do it like the others." In fact interpretative comments are able to raise the awareness and consciousness of the child client. Brief interpretations can be facilitative and provide insight to the child that may otherwise have gone unsaid and unanchored in language.

The following excerpt illustrates how reflections and interpretations were made during a play therapy session (Session Two). Interpretations were directly made and brought any matter to conscious awareness :

BMS : (raised his hand and looked perplexed) Mr. Chan. I ... (did not complete what he was going to say).

Chan : MS, you look puzzled.

BMS : I don't know how to use this roller (rolling pin).

Chan : MS, you don't know how to use the rolling pin.

BMS : Yes.

Chan : You want me to show you how to use the rolling pin.

AMH : (chipped in to offer help) You can follow what I am doing.

Chan : MH has offered his help ... to show you how it is done.

BMS : Can we talk while making the cake? Our teacher doesn't allow us to talk when we are doing our work in class.

Chan : MS, you are playing with the others in here. You are not competing with each other. You are free to seek help from the others. You are also free to help others. That is how we learn to be better in what we do. You learn from each other and enjoy your activities at the same time.

(25) Group dynamics as the powerful processes that take place in groups. Group dynamics focus on the continuous movement and progression of the group, and on the interacting forces that impact the group and its functioning (Brown, 2009).

(26) Basic Group Dynamics : (a) Level of participation : This includes the characteristic interaction and changes in interactions, input, and responses for individual members and for the group as a whole. (b) Communication patterns : Include both verbal and non-verbal communication. The verbal communication patterns can demonstrate inclusion or exclusion, deference, where the perceived power and influence rests, group norms, and current emotional state. Non-verbal behavior is the major and most important part of communication, and is valuable information about what the group and its members are experiencing at a deep level. Behaviours such as voice tone, body positioning, facial expression, body movements or lack of movements, and clusters of gestures all covey deep and important messages about emotional states for both individual members and for the group as a whole. (c) Feelings expressed: Can be an important indicator of overt or hidden issues in the group, as well as indicators for individual members' emotional state, sensitivities, and resistance. Hidden, disguised and suppressed feelings are important and significant for group members and for the group as a whole. (d) Resistance : This is an indicator of sensitive material that is threatening and thus, must be defended against, suppressed, or repressed. Acts mobilized as defenses include denial, deflection, intellectualization, and displacement. (e) Conflict : Conflict can be revealing of the group's fear, need, or wishes, and the most important signal is how the group itself manages conflict. Common group conflict management strategies are denial, suppression, ignoring, and working to resolve them.

(27) Tuckman (1965) was among the first to propose and document developmental sequences for groups, and they later became known as group stages. The literature shows several other ways to categorize these stages. All categorizations include at least four stages that are used for discussion in this case study : Forming, Storming & Norming, Performing and Closing. It has to be noted that these stages are not separate, distinct, or clear cut, but almost all types of groups seem to move through some sequence of development. The group's stage of development can be a rich source of information about what members' needs are at a particular time, can suggest interventions, and can provide clues for difficulties, challenges, and dilemmas that may emerge (Brown, 2013).

(28) The following comments and questions reflect group members' internal state during the forming stage:

BMS : "Will there be a more people joining us later ?"
=====
CMY : "This room is too small ... and smelly."
=====
AMH : "I feel very cold in here ... can you switch off the air-con ?"
=====
DNS : "I can't draw, I hate drawing ... do we have to draw every time ?"
=====
CMY : "I hate writing. I like maths (better)."

(29) This is illustrated in the following questions raised during the forming stage :

BMS : "Mr. Chan .... can we bring this (clay work) back and finish it at home?"
=====
DNS : "It is already 1.30 .... it is raining heavily very outside. Can we go now?"
=====
DNS : "Sorry I am late .... any punishment or not ?"
=====
CMY : "Do we have to do a lot of homework?"
=====
AMH : "Can I sit next to MS? ... he is my best friend."

(30) I had to establish trust and safety by :

- Openly addressing members' fears and concerns
- Identifying and highlighting similarities among members
- Collaboratively making decisions with group members
- Seeking out members' strengths to build on
- Fostering an atmosphere of inclusion
- Instilling realistic hope
- Modelling empathic responding

(31) My tasks at this stage were :

- Monitoring self-reactions and possible counter-transference to prevent defensiveness or reactive aggressiveness
- Giving constructive feedback
- Intervening to prevent member to member attacks (physical and verbal) and other forms of aggression
- Demonstrating and teaching conflict resolution that can strengthen relationships rather than destroy them
- Using opportunities to provide the corrective emotional experience
- Accept catharsis but provide guidance to foster intrapersonal and interpersonal learning so that it does not remain as just emotional venting.

(32) The following excerpt shows how a conflict was resolved :

DNS : Faster lah .... so slow! Didn't eat rice ah? (suggesting that MH has no energy)

AMH: (stood up wanting to go over to confront NS)

Chan : MH, you are angry.

AMH: Yes, he (pointing to NS) called me stupid.

DNS : (responded immediately) I didn't say he's stupid.

AMH : You said I am slow which means stupid.

Chan : MH, you are hurt by what NS said ?

AMH : Yes.

Chan : NS, remember what we promised ... about not hurting each other ?

DNS : OK lah. I am sorry. I really didn't mean you were stupid.

(33) The following excerpt from the fifth session illustrates the dynamics in the cohesion stage of the group :

CMY : We have one car each. Our family is very rich.

BMS : I can't drive. Can I put in skate-boards and a motor-bike instead? (Since there was no objection, MS went to get the items)

AMH : Now we can put in our family people (members). I start with putting in grandmother.

DNS : Grandma needs grandpa. I will put in grandpa.

CMY : I want a baby ... a baby boy in the house (ran over to the box to get a baby).

BMS : What about our mother and father? Can I put these two in?

CMY : No, only one item. We all agreed ... only one item .. and then you (will have to)wait for your turn again.

AMH : I don't know what to put in.

DNS : Think of what you like and then get it from the box. Do we need a garden? (A suggestion to MH.)

AMH : Oh yes ... I will put in a few trees. (Went to get the trees and put them in a corner of the sand box)

DNS : One thing at a time ... we agreed (earlier).

BMS : There are flowers too. (Went to get a bunch of miniature flowers)

(34) These feelings of the group are highlighted below:

DNS : Is this really the end? Can we come back again another time, Mr. Chan?
===== =====
CMY : Can we play with the soldiers and animals before we go?
===== =====

AMH : He is my enemy (referring to DNS) ... I stand next to him ? (Laughing and does not appear to be serious about what he said. He moved over to NS nevertheless.)

===== =====

BMS : Can we look at the album (again)? We will miss the fun (we had). We won't laugh (together like this) again.

(35) Paul and Charura (2014) in their book on Therapeutic Relationship summarized the current research in this area:

a) It is beyond doubt that therapeutic relationship is the most significant in-therapy factor for positive outcomes.
b) There is a strong correlation between levels of empathy, positive regard, congruence, and therapeutic outcomes with clients reported levels of improvement.
c) Special relationship factors such as rapport and positive engagement in therapy, both parties, are directly linked with outcomes in therapy.
d) Client-therapy matching with regards to diversity may be linked to outcomes; however, research is limited in this aspect.
e) Neuroscience demonstrates that through the therapeutic relationship, and the provision of empathy and other conditions that foster growth, positive therapy outcomes are achieved.

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