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THE ROLE OF SOCIODRAMATIC PLAY IN PROMOTING SELF-REGULATION

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Issues of self-regulation are pervasive in the psychological research and treatment literatures. In the past several decades, basic and applied research in this area have grown significantly (Eisenberg, 2002; see Tobin & Graziano, 2006, for a review of empirical self-regulation research). More recently, efforts have been made to link the basic research literature on self-regulation to improvements in the delivery of interventions, particularly those targeting preschool children (Tobin, Sansosti, & McIntyre, 2007). In this chapter, we begin by defining self-regulation and reviewing the typical developmental course of these processes. Building on this literature, we then discuss the relation between sociodramatic play and the development of self-regulation. We conclude with a discussion of the roles of therapists, parents, and teachers in promoting self-regulation in children and demonstrate the play therapist's role with a case illustration.

We thank W. Joel Schneider and Laura E. Berk for helpful suggestions and comments.

WHAT IS SELF-REGULATION?

Self-regulation is a broad set of processes that are the building blocks of positive development. The development of self-regulation includes mastering such skills as impulse control, self-control, self-management, self-direction, and independence (Bronson, 2000). Self-regulation is

the ability to comply with a request, to initiate and cease activities according to situational demands, to modulate the intensity, frequency, and duration of verbal and motor acts in social and educational settings, to postpone acting upon a desired object or goal, and to generate socially approved behavior in the absence of external monitors. (Kopp, 1982, pp. 199–200).

Self-regulation has also been defined as “an array of complex mental capacities that includes impulse and emotion control, self-guidance of thought and behavior, planning, self-reliance, and socially responsible behavior” (Berk, Mann, & Ogan, 2006, p. 74). The development of self-regulatory behaviors sets the stage for children’s positive development in school, at home, and with peers.

WHY IS SELF-REGULATION IMPORTANT?

The development of self-regulatory behaviors assists children in monitoring their own thoughts, behaviors, and emotions using more internal control (Bronson, 2000). Children who are well self-regulated are more likely to have better long-term outcomes. Specifically, self-regulatory behaviors assist children in developing goal-directed behavior and planning and organizational skills (Bronson, 2000). These executive functions become increasingly important for high academic performance. Past research has indicated that self-regulation is related to better adaptation to the classroom (Shields et al., 2001) and later academic performance (Gumora & Arsenio, 2002).

Children who are well self-regulated are also able to maintain appropriate behavior and tend to have positive interactions with others. Children who are well self-regulated are more likely to comply with adult demands and are able to control their behaviors when given a particular command (Bronson, 2000). Moreover, because children who are well self-regulated are more likely to control their emotions and behavior, they are likely to have increased social competence in preschool and are less likely to be rejected by peers (Denham et al., 2003; Eisenberg et al., 1997).

In contrast, approximately 10% to 15% of preschool children engage in problem behaviors that are likely to be attributed to poor self-regulation (Campbell, 1995; Cornely & Bromet, 1986; Earls, 1980), and these children

are commonly referred for intervention services. Deficits in self-regulation are central to a broad range of mental health disorders including attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, mood disorders, anxiety disorders, and other childhood disorders. These findings suggest that fostering self-regulation skills may be profitable, particularly at a young age. Development of these processes may be facilitated through play interventions and other play-based interpersonal treatments such as parent and teacher training.

DEVELOPMENTAL ISSUES

Self-regulation processes improve gradually throughout development, beginning as early as infancy. In the Kopp (1982) model, self-regulation is described as an evolving process with five phases. The first developmental phase occurs in infants' first 2 to 3 months. During these months, infants begin regulating their neurophysiological functions such as arousal states, reflex movements, and self-soothing behaviors such as thumb sucking (Kopp, 1982). By the end of the first 3 months, infants tend to master one critical self-regulatory skill, wake cycles. During the second developmental phase, 3-month-olds to 1-year-olds begin to regulate their sensorimotor states such as adapting behavior on the basis of environmental stimuli (Kopp, 1982). Infants in the second phase focus on adapting their behaviors such as holding, reaching, and playing. These behaviors are modulated on the basis of interaction with environmental stimuli such as a parent's gaze or contact. During the third developmental phase, 12- to 18-month-olds begin to develop control of both behavioral and cognitive systems (Kopp, 1982). Within behavioral systems, these children become aware of social demands and adapt their behavior and emotions accordingly. According to Kopp, control over cognitive systems such as intentionality and awareness of action also occur during this stage. Together, the development of these systems enables young children to control their behaviors and actions on the basis of a parent's demand (e.g., "Don't touch!") or a past learning experience.

During the last developmental phases of self-regulation, young children begin developing self-control and self-regulation (Kopp, 1982). During the fourth stage, which occurs around 24 months, young children begin to develop self-control. The behavioral and cognitive systems continue to develop, assisting children in the ability to comply and use delay of gratification in response to adult demands. By 36 months, children who are beginning to master the fifth stage begin to use self-control and adapt their behaviors depending on situational demands. During this stage, children's regulatory abilities are much

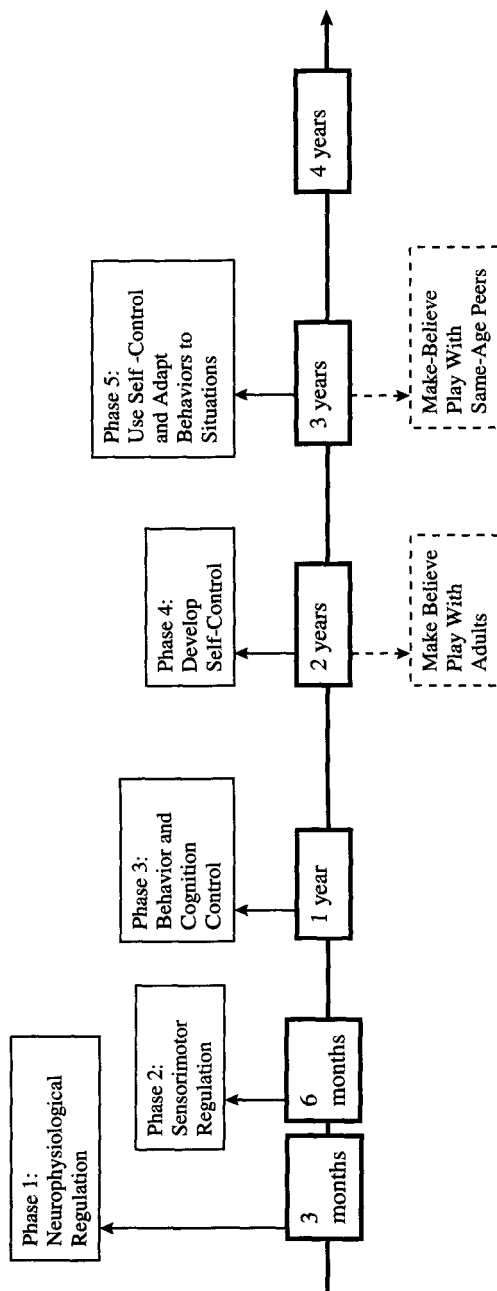
more flexible and typically generalize to new settings and situations. Young children who have mastered the five phases of self-regulation tend to display self-control and compliance when engaging in a variety of behaviors such as playing, eating, dressing, spending time with adults or peers, and behaving independently (Kopp, 1982).

INFLUENCE OF MAKE-BELIEVE PLAY ON DEVELOPMENT OF SELF-REGULATION

Play provides repeated opportunities for children to acquire skills in self-regulation. One developmentally important form of play is *make-believe* play, also known as *symbolic* or *dramatic* play (Smilansky & Shefatya, 1990; Wolfgang, Mackender, & Wolfgang, 1981). In make-believe play, children express their thoughts and feelings through the use of objects, materials, and gestures. With the support and encouragement of parents, children show the very beginnings of pretending in the middle of the 2nd year. Around age 2, young children engage in make-believe play by pretending to talk on the phone or eat with objects (Wolfgang et al., 1981). As shown in Figure 9.1, at the same time developmentally, children also begin to initiate self-regulation skills, although the foundation for the development of these skills is set in infancy.

As discussed previously, at around 24 months children's behavioral and cognitive systems continue to develop, assisting with their ability to meet adult demands. In terms of play, children between the ages of 2 and 3 years also begin to engage in make-believe play by substituting similar and dissimilar objects for real objects. Children's *sociodramatic* play, or collaborative make-believe play with others, is present by the 2nd year, although it is more often achieved with a *scaffolding* adult (i.e., an adult who selectively provides support when children are engaging in tasks within their zone of proximal development and remains unobtrusive when children are fully capable of completing the task independently) than with a peer. In fact, by age 3 children's interest in make-believe play is in part the result of adults' ability to make play an exciting and interesting learning experience (Haight & Miller, 1993). Around 36 months, adults' scaffolding attempts transfer to make-believe play interactions with same-age peers. By age 3, children tend to focus on engaging in make-believe play during parallel play and associative play interactions with same-age peers (Wolfgang et al., 1981). It becomes increasingly important for children who are playing with same-aged peers to engage in self-regulatory behaviors such as self-control and regulation of emotions and behaviors so that they can get along with these other children.

Self-Regulation Development



Make-Believe Play Development

Figure 9.1. Children begin to initiate self-regulation skills (top, data from Kopp, 1982) at the same time that they develop make-believe play patterns (bottom, data from Wolfgang, Mackender, & Wolfgang, 1981).

BASIC RATIONALE AND THEORY

Theorists agree that play provides children with opportunities to develop socially and emotionally. Erikson (1950) described play as opportunities for children to practice, experience, and test out different social roles. By setting up situations such as school or the doctor's office, children can begin to become proficient in the demands and roles expected of them. Piaget (1936/1951) described play as a developmental progression from reflexive behaviors to symbolic play. Play, then, provides children with opportunities to develop schemas and symbols for objects. As children further their cognitive development, play provides an opportunity to use environmental objects as symbols for children's own schemas such as falling asleep and eating dinner.

Vygotsky (1930–1935/1978) also viewed play as a core process in children's development. Vygotsky posited that specific types of play are particularly effective at facilitating the development of regulatory skills within an adult–child relationship. He noted that sociodramatic play promotes the development of self-regulation. Smilansky (1968) proposed six required elements for play to be considered sociodramatic. First, sociodramatic play requires that children pretend to be a certain role by imitating the person or thing using language. Second, in imitating the role, children who engage in sociodramatic play use materials or toys that are substituted for a real object. Third, children use language to substitute for their actions. For example, rather than pretending to watch a movie, a child might say, "OK, we're watching a movie." Fourth, sociodramatic play requires that children engage in the role for at least 10 minutes. Fifth, within the play theme, children must be engaged with at least two other children who also have roles. Finally, within sociodramatic play, children must be communicating verbally to one another. Make-believe play differs from sociodramatic play in that it does not require the last two essential elements, and this form of play is consistent with what play therapists often provide when intervening (Smilansky & Shefatya, 1990).

According to Vygotsky (1930–1935/1978), there are distinctive features of make-believe play that contribute to children's development. First, make-believe play allows children to create separate internal ideas from external words, gestures, and objects. This enables children to use their ideas and thoughts to control their own behavior and impulses. Second, make-believe play provides opportunities for children to practice rule-based behavior. In other words, children practice following social rules that are typically expected in their own family and community experiences. Together, these unique features of make-believe play allow children to strengthen their internal socialization and adhere to external demands of behaving in socially appropriate ways (Berk, 2001). Vygotsky theorized that make-believe play provides children with opportunities to develop emotional regulation and

socially responsible behavior (Vygotsky, 1930–1935/1978). Together, the development of these areas contributes to self-regulatory skill building and is the core of many play therapy approaches.

PLAY INTERVENTION PROCEDURES

Because make-believe play occurs within the home, school, and other contexts, parents, teachers, and therapists can play an important role in shaping children's make-believe play. When children engage in make-believe play, their play is guided by their own observations of appropriate adult social behavior and speech. A central tenet of Vygotsky's (1930–1935/1978) theory is children's experiences in their zone of proximal development. A task within a child's zone of proximal development is a task that the child could not ordinarily accomplish alone, but can complete with appropriate adult support (Berk et al., 2006). When facilitating children's social or academic learning, adults play a role in challenging children's learning while simultaneously supporting it. Two key components of the zone of proximal development are intersubjectivity and scaffolding. *Intersubjectivity* refers to shared understandings between two people that stem from empathic mindfulness of the other's experiences and perspectives (Berk et al., 2006). Adults capable of relationships characterized by such intersubjectivity are in the position to provide scaffolding for children. Adults can use scaffolding and intersubjectivity to promote self-regulation when engaging in make-believe play with their children. Together, adult support, scaffolding, and intersubjectivity increase the likelihood of successful practice of social norms, autonomous functioning, and impulse control when children engage in challenging play.

Because adult support and scaffolding can play a vital role in the facilitation of children's self-regulation, there are several recommendations play therapists can follow. For example, one of the greatest resources an adult can provide is his or her time. It is recommended that adults take time out of their week to engage in make-believe play with children in need of self-regulatory skill building. During play, adults such as therapists who engage in joint play with children can serve multiple functions, including teaching, enlivening daily routines, defusing conflict, expressing emotion, regulating emotion, influencing another's social behavior, and having fun (Berk, 2001). When jointly interacting in make-believe play, these adults can teach children social norms, life skills, and prosocial behavior (Berk, 2001). For example, if a child is pretending that a doll is hurt and crying, the therapist can take another doll and show the child's doll empathy by asking if it is all right and comforting it.

Play therapists can use make-believe play to facilitate children's development of prosocial behaviors and, eventually, their social competence with peers. The development of self-regulation contributes to the development of children's socially responsible behavior (Berk et al., 2006). In one study of preschool children's behavior, conducted in the fall and spring of the academic year, Elias and Berk (2002) examined the relation the children's complexity of sociodramatic play and their degree of self-regulation as measured by independent clean-up behaviors in the spring. The researchers found no evidence of a significant relation between complex sociodramatic play and attentiveness during circle time.

Make-believe play also contributes to the development of emotional self-regulation, a key process that facilitates children's social competence (Eisenberg & Fabes, 1992). Eisenberg et al. (1997) defined *emotion regulation* as "the ability to inhibit, enhance, maintain, and modulate emotional arousal to accomplish one's goals" (p. 642). The regulation of emotions assists children in using problem-focused coping when they are engaged in an emotionally arousing situation. Past research has found that children who engage in optimal levels of emotion regulation are also more likely to have higher social competence, social skills, and popularity as assessed through sociometric status (Eisenberg et al., 1993, 1997). Theorists, including psychoanalysts, have believed that make-believe play provides children with opportunities to regulate their emotions (Bretherton & Beeghly, 1989; Fein, 1989). Specifically, make-believe play is likely to result in conflict with other children and other emotionally arousing situations. Therefore, make-believe play in home, school, and therapeutic contexts creates opportunities for children to learn skills such as emotional expression, emotion management, conflict resolution, and other problem-solving strategies.

To facilitate these activities, therapists can also be gatekeepers to the physical context of play. They can control play environments by providing appropriate play materials and arranging the environment to encourage make-believe play consistent with a structured play therapy approach (Bronson, 2000). For instance, play materials should be placed at children's level so they can prepare to play independently. Play therapists can arrange the environment so that each spot has a relevant, designated activity. These can include dress-up, house, blocks, art, quiet area, and computer. Within each of these areas, play therapists can discuss expectations and rules with children. These rules should explain how to use, share, and put away materials. By arranging the environment, children learn to take initiative, plan, and make choices about their own behavior, all of which contribute to their development of self-regulation (Bronson, 2000).

Zahn-Waxler and colleagues (Robinson, Zahn-Waxler, & Emde, 1994; Zahn-Waxler, Radke-Yarrow, & King 1979) examined another aspect of

adult–child relationships that influences the development of self-regulation processes. Specifically, they examined parental behaviors within the context of play that are associated with children’s development of prosocial behavior. Findings from this line of research offer several ways for parents to promote their children’s social and emotional development. These recommendations, although directed toward parents, can also be used by play therapists and other adults. First, adults who provide children with clear rules are more likely to foster prosocial behavior. For example, adults who provide children with rules such as “We don’t hit people” are more likely to see them engage in prosocial behavior across settings than those who say “Don’t do that” or “Stop.” Second, when providing rules and expectations, adults should convey these messages with emotional intensity. When these rules are conveyed with conviction, children are more likely to understand the rules of prosocial behavior. Third, adults who attribute children’s prosocial behavior to their prosocial nature are more likely to motivate children to engage in socially responsible behavior. For example, children feel good when they are told they are “kind” or “helpful.” Children then internalize these statements and begin to take the initiative to be kind and helpful in social situations, particularly when the connection between their behavior and these attributes is made clear. Next, adults who model prosocial and altruistic behavior are more likely to have children who behave in a similar manner. Just from seeing these behaviors modeled, children learn a great deal about social rules and responsibilities. Finally, adults who are warm and responsive to children’s needs and emotions are likely to motivate children to do the same for others. The environmental climate that adults create sets the stage for children’s prosocial behavior. Sociodramatic play provides repeated opportunities for adults to engage in these five behaviors that assist children’s development of prosocial and socially responsible behavior. Furthermore, these methods can be used to facilitate these processes within a play therapy relationship.

EMPIRICALLY SUPPORTED PLAY INTERVENTION

For children who are struggling to develop adaptive social and emotional skills, previous research has supported the role of play as a therapeutic treatment (see Reddy, Files-Hall, & Schaefer, 2005). In the context of play therapy, the therapist’s role is to develop rapport with the child, encourage the child’s self-exploration, and conceptualize the child’s behavior (Schaefer, 1993; Webb, 1999). The therapist provides toys and other objects to act as a child’s words. The communicative exchange, then, is represented in the child’s and therapist’s play (Landreth, 2002). In doing so, play therapy provides children with opportunities to learn new skills, cope with difficult

stressors, and address emotions while being supported emotionally by a therapist (Clark, 2007). Schaefer (1993) recommended that play therapists use a prescriptive approach, specifically, that play therapists individualize play therapy on the basis of each child's symptoms.

Play therapy is an empirically validated intervention for children with various backgrounds and experiences (see Reddy et al., 2005). For example, research has supported the use of play therapy for children who have experienced extreme stress, including witnessing domestic violence (Kot & Tyndall-Lind, 2005). Play therapists working with children exposed to domestic violence often use the core elements of sociodramatic play, including imagination and the use of materials to substitute for real objects. Therapists use play materials as a means of communication. For example, a child coping with domestic violence may be provided with a dollhouse, whereas a child coping with a medical illness may be provided with a doctor's kit. By providing specific objects related to the stressor, therapists set the stage for children to develop self-regulatory skills through self-direction and imaginal coping by supporting and scaffolding their play (Clark, 2007). These methods are in line with the promotion of self-regulatory abilities seen in nondisordered populations.

Similarly, play therapy has also been empirically validated for children with externalizing symptoms such as attention deficits, aggression, and other behavior problems (Crenshaw & Mordock, 2005; Drewes, 2001; Reddy et al., 2005). Children who have deficits in attention and self-control typically act impulsively and tend not to think before they act. Therapists working with children with externalizing problems also use key elements of sociodramatic play, including the use of language to substitute for behaviors and the use of materials to substitute for real objects. By communicating with the therapist through sociodramatic play, children begin to practice self-regulatory behaviors such as developing plans and expressing their thoughts and ideas. Play therapy also provides an opportunity for therapists to assist in managing children's aggression and anger (Crenshaw & Mordock, 2005; Drewes, 2001). Certain toys used in sociodramatic play, such as balls or clay, can be used with children to assist their emotion regulation of anger and aggression. Using particular sociodramatic materials and methods, the play therapist's role is to teach children to regulate their anger and learn other techniques to solve problems in ways that do not involve aggression. Progress occurs not because of the use of punishment, but because of the play therapist's unconditional assistance and support.

Parent-child interaction therapy (Eyberg & Calzada, 1998; Hembree-Kigin & McNeil, 1995; see chap. 10 of this volume) is another empirically supported play therapy technique used to assist with children's development of self-regulatory skills. Parent-child interaction therapy is structured to teach

parents effective parenting techniques while also teaching children prosocial behaviors such as sharing, taking turns, and complying with adult requests (Herschell & McNeil, 2005). Working with children and parents, play therapists use elements of sociodramatic play, including practicing the new roles by using imitation. With the play therapist's assistance and coaching, parents practice using effective parenting strategies while playing with their children, including forms of sociodramatic play. Eventually, parents transfer skills to the home setting. Children also use play materials to imitate and practice new prosocial behaviors and social responsibilities. The goal of parent-child interaction therapy, then, is for the therapist to use play as an outlet for teaching parents and children new behaviors and ways of interacting.

Another type of play therapy, *child-centered* play therapy, focuses on providing the child with a safe environment that encourages the development of self-regulation. Specifically, play allows children to release and/or reduce undesirable emotions (Axline, 1969; Clark, 2007). Play therapists use elements of sociodramatic play such as imagination to provide children with opportunities to reenact situations and express their emotions in a safe environment. In child-centered play therapy, children have control and guide the session, but only within the therapist's limits. Specifically, the therapist sets up rules and then allows the child to explore within those limits. This approach enables the child to practice taking initiative and being in control of his or her behavior, which assists the child in learning socially responsible behavior. The goals of child-centered therapy are to provide opportunities for children to develop self-regulation by communicating their thoughts, to learn and express their emotions, and to learn self-control.

CASE ILLUSTRATION

At the time of treatment, Mike was a 4-year-old boy with self-regulation difficulties, particularly in dealing with his negative emotions and aggression. Mike had two older siblings and lived in a single-family household. His mother reported that he was often defiant, disobeying her commands frequently and even slapping her when upset. She also stated that she could not leave him alone with his siblings or other neighborhood children because he often engaged in physical fights with them when playing.

Mike attended a full-day classroom at a day treatment facility with 12 other children between the ages of 3 and 5. Mike's classroom teacher expressed concern about his aggressive behaviors. She described Mike as impulsive and inattentive, reactive and angry, and aggressive toward his teachers and peers. When playing inside, Mike was unable to appropriately attend to and

transition from activity areas in the room appropriately. He ran around the room, knocked down other children and materials, and was unable to keep his voice at an "inside" level. When playing outside, Mike was unable to share basketballs and other toys with his classmates. Instead, he frequently had tantrums when it was not his turn, stole toys from other children, and hits and kicked when he lost privileges or toys.

On the basis of the empirical literature, Mike was an ideal candidate for an intervention focused on make-believe play therapy. Given Mike's impulsive behaviors and inattention, it was clear that he had difficulty regulating his thoughts and behaviors. He also has difficulties with regulating his emotions, judging by his emotional reactivity and aggressive behaviors. In this case, the therapist's role was to facilitate Mike's development of self-regulation and emotion regulation.

Using sociodramatic play, the play therapist targeted self-regulatory behaviors using a structured play therapy room that had multiple centers including a block area, an art area, a kitchen area, and a truck or train area. Throughout 10-minute sessions, the therapist used imitation as a means of developing Mike's self-regulatory behaviors. For example, the play therapist used a dollhouse and people figurines to describe appropriate ways to transition from activities and model how to plan and control behaviors. The play therapist also used other aspects of make-believe play such as substituting language for actions. The therapist elicited Mike's thoughts and described his behaviors to scaffold his development of self-regulation. By modeling and describing new ways of behaving, the therapist was able to target areas of self-regulation, including self-control, attentional control, and delay of gratification.

To target emotion regulation, a play therapist also used a Lego structure and child figurines. To facilitate Mike's development of emotion regulation, the play therapist used make-believe situations that drew on his imagination to assist in the teaching of appropriate social behaviors. In this case, the therapist used a figure that resembled Mike, other figures that resembled his classmates, and small toys such as a toy computer or toy basketball. Within the play setting, the figures played out social situations such as sharing toys and joining in activities. The therapist's role was to model appropriate prosocial behaviors such as sharing, compromising, and communicating with peers and adults. The therapist also elicited Mike's imitation and practice of prosocial behaviors. Once Mike developed social awareness and knowledge, the play therapist moved from make-believe play to the use of sociodramatic play to assist Mike. Thus, at least two other children joined Mike in communicating and playing with one another. In this case, Mike practiced these prosocial behaviors with same-age peers either in the play therapy setting or in his classroom.

EXTENDING TO THE HOME AND TO THE CLASSROOM

Beyond the play therapy context, research on sociodramatic play also has implications for improving children's functioning at home and at school. Play therapists can serve an important role as consultants to both teachers and parents in promoting self-regulatory behaviors in young children through the use of make-believe play.

Parents can use make-believe play to enliven daily routines such as cleaning and other household chores (Berk, 2001). Converting everyday tasks such as preparing a meal into a joint make-believe play interaction may facilitate positive development by providing the child with an opportunity to develop new skills, engage in creative activities, and deepen the parent-child bond while simultaneously completing a household task. For example, while cleaning up a child's room, an adult may pretend to be in a race to see who will be the winner of the fastest cleaner award. Adults can also use make-believe play to defuse conflicts between parent and child by increasing the likelihood of child compliance. Make-believe play also provides parents and therapists with an outlet to provide examples of different emotional expressions within a safe environment. For instance, children often pretend to be hurt or scared when playing, and this may create an opportunity for an adult to explain the child's feelings in a comforting and safe environment. Finally, adults who engage in make-believe play create opportunities to have fun, laugh, and enjoy spending time with their children.

Teachers can also use playtime as an opportunity to scaffold their students' development of self-regulatory abilities. For instance, teachers can incorporate opportunities to engage in make-believe play into their daily lesson plans. Wolfgang et al. (1981) provided several play activities based on the types of play, including sociodramatic play. Activities that assist with children's development of self-regulation include acting with puppets, being in a parade or a fashion show, pretending to work at a restaurant or a grocery store, or acting out favorite bedtime stories. Together, these activities will assist children in language development, prosocial behavior, and abstract thought while they learn about their thoughts, feelings, and actions (Wolfgang et al., 1981). In terms of intervention, play therapists engage in similar sociodramatic play behaviors that likely facilitate the development of these processes.

Findings from the sociodramatic play literature also inform educational practices for young children. Berk (2001) suggested indicators of high-quality preschools that are likely to assist children's development of self-regulation and other adaptive abilities. First, the classroom environment is divided into separate learning areas (e.g., science, math, books, art). Throughout the day, children are provided with a daily schedule that allows for ample time to engage in multiple activities. Second, within the daily schedule, children are

provided with opportunities to choose their own activity and learn through their own experiences. Teachers should encourage initiative and allow children to individualize their learning. Third, the teachers provide a climate that is supportive, facilitates learning, and conveys that each child is valued. In this context, the teachers also interact positively with each child to facilitate not only the child's learning, but also his or her prosocial behavior. Next, teachers promote parent interaction with the classroom and students. Teachers encourage parents to visit the classroom to observe or volunteer time and keep consistent and frequent communication a priority. Finally, for preschoolers the group size is kept at a maximum of 20 students, with one teacher for every 10 children. These are simple techniques teachers can use to encourage children's development of prosocial behaviors and self-regulation, and therapists may serve as consultants in implementing them.

Parents, teachers, and therapists can also support children's development of self-regulation by being gatekeepers to children's play practice with peers. As discussed earlier, at around ages 3 to 5 children's opportunities for play with same-age peers greatly increase. Children engage in elaborate make-believe play, assigning roles and working together toward common goals. Past research has indicated that unless disagreements or conflicts ensue, parents, teachers, and other adults tend to disengage from preschoolers' peer interactions (Berk, 2001; Howes & Clemente, 1994). Moreover, when parents and teachers do take action, it is typically to tell the children to stop, separate, or wait (Berk, 2001; File, 1993). Parents, teachers, and other adults are instead encouraged to take both a preventive and a mediator role in children's play. Before games and activities occur, adults should encourage children to set their own rules and agree to the activity. Should conflicts arise, parents, teachers, and therapists can then assist the children in problem solving. First, adults may assist the children in emotion regulation by asking them to calm down by taking a deep breath. A scaffolding adult may then encourage the children to identify their feelings and what they would like to see happen. Then, parents, teachers, and other adults can help the children problem solve to accommodate all of their desires (Berk, 2001). Adults should take the opportunity to let the children take initiative in problem solving, but provide support and suggestions on the basis of each child's social skills.

According to Berk (2001), parents, teachers, and other adults can follow three suggestions when mediating the child's social interactions with same-age peers. First, parents and teachers should mediate and intervene as early as possible. Second, adults should consider the child's social developmental level when addressing the current conflict. For instance, when a conflict arises, parents and teachers, perhaps in consultation with a therapist, should recall past situations that may have been similar and what skills they can provide the child to develop that particular social skill. Finally, parents

and teachers should use the least restrictive intervention strategies to maintain the child's independence and social responsibility. Therapists may help parents and teachers to identify the child's social goal and how much adult assistance the child needs to acquire the goal.

CONCLUSION AND FUTURE DIRECTIONS

Play therapists routinely rely on sociodramatic play approaches in their clinical work. Although not traditionally identified as main components of play therapy, elements of sociodramatic play are central to play therapy interventions. In this chapter, we have reviewed several ways in which play therapists currently engage in sociodramatic play to facilitate the development of self-regulation in preschool children. We also have highlighted new roles for play therapists as models for and consultants to teachers and parents in facilitating these self-regulatory behaviors in preschool children. Although serving as a consultant is not a traditional role for play therapists, doing so may increase the effectiveness of their individual therapy efforts over time by providing children with opportunities to generalize their skills to other settings. Thus, we provide details for applying sociodramatic approaches across settings, including the play therapy context, home, and school.

Sociodramatic play therapy literature would benefit from future research focused on determining the specific elements of sociodramatic play that facilitate the development of self-regulation processes. For example, it is unclear which or how many of the six elements of sociodramatic play are related to improvements in self-regulation, particularly as they are executed in a play therapy context. Future research may examine these relations by implementing each of the six independently and systematically and observing changes in self-regulatory behaviors over time. Previous research has indicated that play therapy is effective for treating various populations and behaviors and more focused investigation would assist in identifying the most promising elements and methods for intervention.

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