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## Play Therapy with Neuro-Diverse Children Who Have Experienced Trauma: A Multiple-Case Study

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Play Therapy with Neuro-Diverse Children Who Have Experienced Trauma:

A Multiple-Case Study

Caroline Gillespie

Submitted in partial completion of the

Masters of Arts in Child Development

Sarah Lawrence College

May 2023

## ABSTRACT

The purpose of this exploratory case study is to develop an initial understanding of the phenomenon of various themes and patterns that arise in play therapy sessions while working with neurodiverse preschoolers who have experienced trauma. The focus of this multiple case study design is to provide an insight into working with a complex demographic of children within the context and nature of Child-Centered Play Therapy. The play therapy sessions were conducted with three four-year-old children in a therapeutic preschool setting. The findings show the significance of identifying themes and patterns that emerge in children's play, while considering the child's diagnosis and experienced trauma. Lastly, identifying the trends in children's play helps to provide an initial understanding of what each child is trying to communicate through their external and internal behaviors.

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## TABLE OF CONTENTS

	Page
Abstract	ii
Chapter 1: Introduction: The Importance of Children’s Play	6
Play Across Development .....	7
Chapter 2: Literature Review	10
Play Therapy .....	10
Defining Neurodiversity .....	14
School-Based Play Therapy .....	15
Trauma and Play Therapy .....	15
Attention-Deficit Hyperactivity Disorder and Play Therapy .....	19
Autism Spectrum Disorder and Play Therapy .....	21
Chapter 4: Methods	24
Case Study Design .....	24
The Setting .....	25
Play Therapy Procedure .....	26
Data Collection .....	27
Chapter 5: Case Studies	31
Case Study I: Meet J .....	31
Case Study II: Meet G .....	40
Case Study III: Meet D .....	48
Chapter 6: Discussion and Reflection	57
Discussion .....	57

Reflection .....	61
Chapter 7: Conclusion	68
Further Research .....	69
References	70

## CHAPTER ONE

### INTRODUCTION

As Garry Landreth (2012) once said, “birds fly, fish swim, and children play”. For children, play comes naturally as it is their universal language, utilizing toys as a tool to communicate their experiences to the outside world. While play carries different forms across cultures, all children partake in some type of play. Play provides the most holistic approach for children’s development.

While children play, they are constantly internalizing new information shared in the world around them. Play “helps children make sense of their world, develop new concepts, increase social skills, gain emotional support, and take responsibility for their actions through meaningful experiences” (Jessee & Gaynard, 2018, p. 230). The idea of play has been widely studied by many theorists in order to understand the true significance of play in a child’s life.

Jean Piaget and Erik Erikson are leading theorists who are best known for their work in child development. Each believed that play is the most important tool for educating children. Piaget viewed play as a “tool that aids in intellectual growth” (Jessee & Gaynard, 2018, p. 230). Similarly, Erikson believed that play allows children to experiment with a wide range of experiences and simulates their potential real-life consequences (Nijhof, Vinkers, van Geelan, Dujiff, Marijke Achterberg, van der Net, Veltkamp, Grootenhuis, van de Putte, Hillegers, van der Brug, Wierenga, Bedners, Engels, van der Ent, Vanderschuren, & Lesscher, 2018). Play facilitates the development of social competence, emotional capacities and resilience, creativity, and problem-solving skills. Make-believe play, in particular, provides children with opportunities to recreate real-life conflicts, to work out ideal resolutions for their own gratification, and to

repair negative feelings (Nijhof et al., 2018). Narratives and storytelling help integrate a broad variety of positive and negative life experiences, which is an important characteristic for the benefits of play within a play therapy setting. Play comes in many forms and varies across child development.

### **Play Across Development**

Play for a young child looks different from play among teens and adolescents. As children develop and mature, so does their play. Understanding the development of play is beneficial for comprehending the reasons why play is important to utilize in therapy with children. For the purposes of this paper, it is important to touch on play development for infants and toddlers and preschool-aged children.

#### ***Infants and Toddlers***

The primary mode of play for infants and toddlers is exploratory. Young children are in the sensorimotor stage of development so they experience the world through the use of their senses (Jessee & Gaynard, 2018). Children use visual and motor actions while they play. Repetitious play is a key component of play during this stage so that toddlers can explore the world and their own capabilities. Toys at this age should be interactive and offer visual, auditory, and tactile stimulation that also explore cause and effect (Jessee & Gaynard, 2018). Examples of these types of toys are: shape sorters, stacking blocks, pop-up toys, and squishy balls. It is important to give children at this age the freedom to explore these toys without adult influence, as they are learning their own capabilities.



### ***Preschool-Aged Children***

Preschoolers' primary mode of play are simple imitations of adults and fantasy play. Rough-and-tumble play is also seen throughout this stage. During this period, children play out more intense themes that reflect real-life roles, home relationships, expression of physical and emotional needs, role reversals, and forbidden impulses (Jessee and Gaynard, 2018). Through the use of fantasy play, children project and enact behaviors that may be forbidden to them to act out in real life. This is important in the play therapy setting because it is during this type of play that children can reconstruct frightening or painful situations that are unbearable to them in reality and conceptualize them into a manageable form (Jessee and Gaynard, 2018). Pretend play allows children to come to terms with difficult situations that they experience in a safe and familiar environment, such as a playroom.

Play is fundamentally important as it teaches children the skills and tools utilized during adulthood. During this phase of a child's life, it is important for adults to scaffold activities for children in a group setting because it assists in the development of decision-making and problem-solving skills, provides opportunities to share and negotiate, and allows for the discovery of personal interests (Yogman, Garner, Hutchinson, Hirsh-Pasek, & Golinkoff, 2018). Play is intrinsically motivated and allows children to engage with the materials, their peers, and the world around them. The natural curiosity found in play promotes memory and learning, among other critical aspects of brain development during this age (Yogman, et. al., 2018). Through children's natural desire to play, they learn to make sense of the world around them, while also learning life skills that will allow them to experience success as they continue to mature.

This multiple-child case study will explore the emerging play patterns and themes of three 4-year-old children who present with Attention-Deficit Hyperactivity Disorder, Autism Spectrum Disorder, and Developmental Delay of Speech and Language. Additionally, all of the children presented in the study have all experienced some form of trauma in their lifetime.

## CHAPTER TWO

### LITERATURE REVIEW

#### **Play Therapy**

Play therapy is an evidence-based, mental health intervention that uses play and various toys for children with varying developmental needs or who experience multiple presenting concerns (Parker, Hergenrather, Smelser, & Kelly, 2021). Play therapy allows children to learn, process their emotions, make sense of their world, and attain mastery of any given situation. Play therapy utilizes theoretical models to establish an interpersonal process where play therapists use the therapeutic powers of play to help children prevent or resolve psychosocial difficulties and achieve optimal growth and development (Malchiodi, 2013). The therapy allows for the symbolic expression of inner conflict. For children, play is a safer form of communicating about threatening parts of their world. It is especially significant for children because oftentimes, children do not have the language to communicate their inner thoughts and feelings so playing out their internal conflicts comes more naturally at these developmental levels. Preschool children, especially, rely heavily on play to express their feelings and perceptions of the world (Crenshaw & Tillman, 2015). Play therapy is significant because children are in charge and in control of the play and the events that they are playing out. Giving children the space to play out distressing feelings or events allows the child to work through the emotions linked to these experiences, while also giving children full control of the situation where they can dictate the ending of the overwhelming scenario in order to experience closure. When children get too anxious, they will typically end or break off the play into something else that feels safer to them

at the time. This process helps children to learn how to pace themselves and self-regulate (Crenshaw & Tillman, 2015).

In order for children to express themselves through play, the environment and the play therapist needs to be intentional. The room is an environment where children can feel safe to process their experiences (Parker, et al., 2021). The play therapist needs to act differently than a parent, teacher, authority figure, or than any other adults in the child's life. The play therapist must respond with empathy, be open and engaging, and convey the message, "I am here, I hear you, and I care" (Parker, et al., 2021, p. 4). Taking the time to build a trusting therapeutic relationship and strong sense of rapport is the most important step of achieving success with a child in play therapy.

### ***Child-Centered Play Therapy***

There are many different models, methods, techniques, and foundational theories in play therapy. The main foundational theory that was utilized in this exploratory case study is known as Child-Centered Play Therapy.

The Child-Centered Play Therapy (CCPT) approach was created by Virginia Axline in 1947. This non-directive, child-centered method carries the belief that play therapy is most effective when the therapist is non-directive and allows the child to take responsibility for the direction of the session. The CCPT approach comes from the understanding that all children have the innate capacity to strive toward growth and maturity if provided a nurturing environment (Guerney, 2001). The goal of CCPT is for the child to achieve self-actualization through allowing them to play out their feelings and bring them to the surface where the child can learn to face them, control them, or abandon them. Through this process a child begins to realize the power within themselves to be an individual in their own right, to think for themselves,

make their own decisions, and become more psychologically mature (Guerney, 2001). The security established in the playroom allows the child to be the most important person in the room, where they are in full command of the situation and of themselves, where no one tells them what to do, judges them, makes any suggestions, or pries with questions. The child is in full control of the therapeutic process.

Child-Centered Play Therapy meets the child at their developmental level and strictly follows the child's lead as a way to enter into the child's inner, emotional world. The focus in CCPT remains on the inner self of the child with no external orientations. The therapist's role and interactions with the child, through play, are unique within the context of CCPT.

### ***The Role of the Therapist***

In Child-Centered Play Therapy, the therapist is specifically trained in this approach and does not deviate from the model. In order for CCPT to be successful, the therapist cannot alter the techniques behind the theory, as this approach needs to be accepted in its totality (Guerney, 2001). The therapist's main role is to reflect and mirror the child. Axline (1974) details the role of the therapist in CCPT in eight principles and within them she stresses the importance that the therapist remain permissive and accepting at all times so that the child feels safe to express themselves without fear of judgment (Axline, 1974). The CCPT approach believes that the child is capable, dependable, and can be trusted with responsibility for themselves. In order for the child to have this confidence, the therapist must have a deep respect and understanding for the child. The therapist must refrain from injecting any suggestions or insinuations and never hurries the child, as this implies a lack of confidence that the child has the ability to take care of themselves (Axline, 1974). It is important for the therapist to remain confident and steady while also being relaxed and sensitive. The therapist must remain alert so that they can recognize the feelings that the

child is reflecting and be able to mirror those feelings back to the child. This allows the child to gain insight into their own behavior and through the trusting relationship the child does not feel judgment over these revelations.

Within this model, the relationship between the therapist and the child is one of the most important contributing factors in achieving success. The Child-Centered Play therapist relies on the strength of the relationship and its associated safety to aid in the child's therapeutic process.

### ***The Role of the Parent***

Within the Child-Centered Therapy approach parents are not present in the therapy sessions. The therapist includes parents/caregivers by informing them about the process and provides general information about goals, attitudes, and remaining issues but details remain confidential between the therapist and the child. Axline (1974) even maintained that it is not necessary for other adults to be involved in order to assure successful outcomes. With that said, parent involvement is more desirable and helpful but participation in the process cannot be forced. Regardless, the child will still be able to benefit from the therapeutic process and achieve success in self-realization and self-regulation (Axline, 1974). If parents want to be involved, Axline says that they, too, can receive therapy and can be offered some education and suggestions about techniques for becoming more effective with their child.

While parents are not directly involved in the play sessions, CCPT enhances parent and child connections and interactions. Through self-realization and learning to recognize internal feelings, acquired through CCPT, children are able to regulate their emotions and not act on them. This benefits the parent-child relationship because as the child becomes more responsible and mature, parents feel less agitated and less of a need to pester the child, resulting in healthier interactions (Axline, 1974).

In the following subsections, I will define a key term that is relevant to the population of the students served in the therapeutic preschool setting, as well as, discuss play therapy with specific populations that are relevant to the case studies in this paper.

### **Defining Neurodiversity**

The term “neurodiversity” is a relatively new term that is mainly used in academia. Judy Singer, an Australian sociologist, coined the term in 1998 and since then, there have been many modifications to the meaning behind the word. Today, “neurodiversity” is used as an umbrella term for Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Alzheimer’s Disease, Bipolar Disease, depression, dyspraxia, dyslexia, Tourette syndrome and any number of other psychiatric and neurological classifications (Clouder, et. al., 2020; McGee, 2012). Neurodiversity is also used as a term for anyone with learning differences. This term focuses on differences in individual brain function and behavioral traits, regarded as a part of normal development (Clouder, et. al., 2020). It is important to note that neurodiversity is *not* a diagnosis, rather an umbrella term used to classify any individual with psychiatric or neurological diagnoses.

In order to be accepted into the therapeutic preschool program in this study, the student must have a mental health diagnosis, however, a majority of the children are also under the umbrella of neurodiversity, as many are diagnosed with Autism Spectrum Disorder. As the case studies are introduced and discussed, the diagnosis that fits under the realm of neurodiversity will be identified.

## **School-Based Play Therapy**

School-based play therapy is unique because the mental health providers are constantly surrounded by the students; whereas in any other setting, the children would come in for a play therapy session and then leave the office after. The benefit of this is that play therapists in school settings have many opportunities to observe their caseload of students throughout the school day.

Another unique benefit of school-based play therapy is that therapists can work collaboratively with school administration and staff. Building working relationships with the teachers and administration is beneficial in creating a holistic approach to meeting each student's needs. Play therapists or social workers who provide play therapy within the school setting have the distinct opportunity to work collaboratively with administrators, teachers, staff, and parents on a daily basis (Sheeley-Moore and Ceballos, 2015). There is a shared accountability in order to address all of the student's needs. It is common to discuss cases with teachers and other therapists in the school setting, while still respecting the confidentiality of each student, in order to identify different strategies that other providers find helpful while working with specific students. Lastly, there are also increased opportunities for whole team meetings in order to collaborate with each other and discuss next steps for each student. The school-based setting provides several chances to work collaboratively with other school professionals in order to best meet the needs of the child, as well as various moments to observe the student's throughout the day.

## **Trauma and Play Therapy**

“Trauma” is one of those buzzwords that creates an emotional response in people upon hearing it. It is most often viewed as an extreme occurrence that negatively impacts a person's



life. However, sometimes trauma can also mean multiple smaller life stressors or daily challenges that play a role in a person's overall emotional and mental health. According to Parker, et al., (2021), trauma can be defined as:

An emotionally painful event that overwhelms a person's ability to cope, and this event or culmination of many of these events can have significant negative impacts on physical and mental health long into adulthood. With children simply feeling out of control can create a trauma response. (p. 2)

Considering Adverse Childhood Experiences (ACE's), which are defined as, "potentially traumatic events that occur in childhood," and include: poverty, abuse, attachment disruption, chronic medical issues, parental incarceration, and natural disasters (Jones, et. al., 2020; Parker, et. al., 2021). Childhood trauma can also include physical or sexual abuse, neglect, and household dysfunction. More specifically, household dysfunction comprises of parental divorce, witnessing domestic violence, and parental mental illness or substance abuse (Parker, et. al., 2021). When children experience more than one ACE, they are more likely to present with disruptive behaviors that negatively impact their social, emotional, and cognitive development; as well as, having difficulty with long-term discipline and conduct problems. Children who have experienced trauma often have trouble with self-regulation and can have anxiety and depression. Other clear symptoms of trauma in children are hyperarousal, re-experiencing the event(s), or avoidance. Oftentimes, children get stuck in a state of hyperarousal, which manifests in either externalizing or internalizing behaviors, or sometimes both. Play therapy helps to meet the needs of children who have experienced trauma because through the use of various techniques, the emotions linked to the trauma are worked through and reconstructed in a way that allows the child to feel a sense of control and mastery over the situation(s).

Trauma-based play is a specific type of play therapy that helps children bring their traumatic experiences to their conscious mind and works through the triggers in order to gain mastery over the experience and move on in a healthy way. Trauma does not get better by itself, “it burrows down further under the child’s defenses and coping strategies,” which is why addressing the trauma through play is critical for children’s immediate and long-term health outcomes (Malchiodi, 2013, p. 3). However, children who experience trauma automatically mistrust adults due to the fact that they develop a “blocked trust,” meaning that there is an “unconscious inability to trust others to provide care” (Parker, et. al., 2021, p. 3). Due to this, the play therapist needs to build a strong foundation of trust in a non-judgemental environment. This takes time and patience for the play therapist but it is absolutely critical that the trust is established before conducting any trauma work. Once the trust is established, the play therapist can utilize different intervention strategies to allow the child to work through the trauma.

Children experience their trauma in play by playing in repetitive, abreactive, and corrective actions. Through action-oriented activities, they can tap into the limbic system’s sensory memory of the event(s) and help bridge implicit and explicit memories. This allows children to help shift traumatic events from the present to the past and gives them an opportunity to master the situation, change the outcome of the event in their play, thus viewing themselves differently and allowing them to move on in a healthy way (Malchiodi, 2013). Giving the children the safe space to play out these traumatic experiences allows them to externalize their experiences, work through the complex emotions, and gain mastery over their experiences so that they continue to develop in a healthy state of mind.

## *Homelessness*

Experiencing homelessness is a form of trauma and needs to be highlighted as it is relevant to this research study. Homelessness is defined as, “those living on the streets or in shelters without a permanent address” (Sturm and Hill, 2015, p. 276). While working with children in this demographic, it is important to view these children and families in a “risk and resiliency framework” meaning that while there are many stressors, there are also significant strengths and protective factors that likely exist. It has been found that children who are experiencing homelessness have high cortisol levels, which is the stress hormone. High levels of cortisol for long periods of time begin to affect overall health and it has been found that homeless children often experience poorer health outcomes over children in stable households (Sturm & Hill, 2015). Another common theme among this demographic is that family separation is common. The extreme stress and separation affects children’s executive functioning and cognitive abilities. Cognitive tasks like paying close attention, remembering details and instructions, transitioning from one task to another, and delivering expected responses are compromised and often performed slower (Sturm and Hill, 2015). The disorganized and stressful living environment often results in more immature, stubborn, and hyperactive behavior, along with higher levels of anxiety and depression.

The goal of play therapy for children who are experiencing homelessness is to allow the children to play out and work through their anxieties and stressors in a safe and consistent environment. Conducting Child-Centered Play Therapy with children experiencing homelessness has been shown to increase self-control, especially in the classroom, and ability to internalize control. This means that as these children feel more emotionally secure, they begin to respond more positively to limit-setting and respond more constructively to others. Research has also

shown that children who participate in Child-Centered Play Therapy show more positive trends in reducing avoidance or rejection of attachment, less negativity towards self and others, and a more developed sense of self (Sturm and Hill, 2015).

### **Attention-Deficit Hyperactivity Disorder and Play Therapy**

According to the American Psychiatric Association's (2013), the Diagnostic and Statistical Manual of Mental Disorders: Fifth edition, more commonly referred to as the DSM-5, defines Attention-Deficit Hyperactivity Disorder (ADHD) as, "a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (p. 59).

Attention-Deficit Hyperactivity Disorder is the most prevalent disorder diagnosed in children (Kaduson, 2015). Children who are diagnosed with ADHD are primarily characterized as being "overactive and [having] inattentive behavior," and have "deficits in executive functioning and motivation" (Kaduson, 2015). Hyperactivity and impulsivity can manifest in forms of frequent fidgeting, running around at inappropriate times, talking excessively, and trouble waiting for their turn. Another common characteristic of ADHD is disruptive behavior that often presents through anger. It is important to note that children with ADHD are about one-third behind their peers in social-emotional growth (Kaduson, 2015).

Play therapy can be incredibly beneficial for children who are diagnosed with ADHD. Individual play therapy helps children with ADHD understand the characteristics of the diagnosis and learn adaptive coping strategies and satisfying play skills in order to help them thrive (Kaduson, 2015). The focus of play therapy for these children is on remediation of skill deficits, while also allowing the child to work through any related psychological issues such as self-esteem and anxiety. This is done by keeping the therapy child-centered and focused on his or

her play. The goal of the play therapy should be increasing attention span, self-control, and releasing frustrations (Kaduson, 2015). It is also essential to make sure that the child is actively engaged, practicing and developing needed skills in treatment.

With that being said the most important aspect to remember is that these children need to feel *successful* in the play therapy room. Children with ADHD rarely get positive feedback from others due to their hyperactivity so it is critical that the play therapy environment is a space where they are free to be who they are, without judgment. This is the beginning of the healing process. Then, through the therapeutic powers of play, children with ADHD learn problem-solving and self-regulation skills.

Research shows that a combination of theories and techniques works best for children with ADHD (Kaduson, 2015). Through both direct and indirect teaching, these children can begin to identify and communicate their problems. During the structured portion of play therapy, children are given the opportunity to release anger and verbalize feelings with help from the therapist's strategies. During non-directive time, children are able to play out difficulties in their emotional life. However, it is difficult for children with ADHD to maintain focus in a thematic form of play so the therapist needs to assist with focus by verbally tracking their play (Kaduson, 2015). It is challenging for children with ADHD, especially preschooler age, to work through their problems and find solutions on their own so it is important for the play therapist to provide some structure and teaching strategies during play sessions. Regardless of the play being directive or non-directive, it is important to keep the therapy child-centered.

A study conducted to see the effectiveness of Child-Centered Play Therapy on the behavioral performance of three first grade students diagnosed with ADHD, found that there were in fact significant changes in academic success and behavior in the classroom (Robison,

Simpson, & Hott, 2017). The research proved that as a result of receiving Child-Centered Play Therapy, the students in the study had a decrease in oppositional and intrusive behaviors and a decrease in “sluggish cognitive tempo,” meaning that there was less daydreaming and more time spent on the academic tasks at hand (Robison, Simpson, & Hott, 2017). Utilizing different play techniques helps children to learn self-control and increases their attention span which gives them the chance to achieve academic success.

Lastly, another key element to play therapy work with children with ADHD is parent education and involvement. Research shows that incorporating parent training and education, especially for preschoolers, is the best treatment of choice for these children (Kaduson, 2015). In order to facilitate the healing of these children, parents need to be trained in how to understand and manage their child’s behavior, as well as becoming an advocate for their child’s needs. Educating and collaborating with parents about the child’s strengths along with tools and strategies utilized in the play therapy room to help the children cope is important because it keeps consistency and routine in their daily lives. Parent involvement and understanding help children with ADHD to feel seen and heard and will allow the child to thrive.

### **Autism Spectrum Disorder and Play Therapy**

According to the American Psychiatric Association’s (2013), the DSM-5 describes Autism Spectrum Disorder (ASD) as, “persistent impairment in reciprocal social communication, and social interaction, and restricted, repetitive patterns of behavior, interests or activities... [the] symptoms are present from early childhood and limit or impair everyday functioning” (p. 53).

Conducting play therapy with children with Autism is unique in that the idea of the sessions are simplistic in their modalities. The therapist must be intentional in all aspects, from

the way the room is set up to the ways in which they interact with the child. The rigid and repetitive behaviors of children with Autism are their ways of trying to self-soothe and allow them to feel safe. When children with Autism walk into a big and bright room full of toys, they can easily become overwhelmed by all of the choices. Children may react to these overwhelming feelings and cause them to feel unsafe so they may refuse to move about the room. On the other hand, a child may react to overstimulation by moving around the room, bouncing from toy to toy, energized by the sights and sounds, leaving them eager to explore. It is also common for children with Autism to become fixated on one type of toy or game and refuse to participate in anything else. It is recommended that the therapist meet with the parent or caregiver, before meeting with the child to discuss the child's interests and what they like to play and set those types of toys out so that the child feels comfortable and safe upon entering the room (Hull, 2015).

The attitudes of the play therapist require intentionality while working with children with Autism Spectrum Disorder. There are three main attitudes that are required of the therapist: "just be," being comfortable with silence, and bringing their own imagination to the process (Hull, 2015). The idea of "just being" with the child means that the therapist forgets about their own agenda as the goal of therapy is not to try and "fix" or "change" the child. It requires unconditional acceptance and waiting patiently without rushing the child to an end goal. The second aspect of this type of therapy is that the therapist must be comfortable with silence as it allows for a trusting relationship. The silence that the therapist embraces allows the child to explore freely and interact with space. This is especially important for non-verbal Autistic children because they feel the sense of acceptance and lack of pressure to try and communicate verbally; which also creates a therapeutic alliance. The last aspect that is required of the therapist is that they be imaginative. Children's imaginations are limitless and it is important that

therapists resist the urge to interpret something based on their own interpretations of the world and instead “surrender their imagination to the world that the child is creating” (Hull, 2015, p. 403). Entering into the child’s imaginative world will allow the therapist to meet the child where they are and begin to create a strong therapeutic relationship.

Utilizing Child-Centered Play Therapy (CCPT) while working with children with Autism is beneficial because the non-verbal approach emphasizes the importance of the therapist’s full acceptance and allows the child to not feel forced to verbally communicate with the therapist. Children with ASD can have a difficult time forming and sustaining relationships, however this does not mean that they are incapable of exhibiting empathy. Child-Centered Play Therapy focuses on fostering a positive sense of self and providing children with a space to feel completely accepted for who they are. Simply being with children in a therapeutic setting, allows the child to practice being in an interactive relationship with others while also learning how to express empathy and communicate with the world around them.



## CHAPTER FOUR

### METHODS

#### **Case Study Design**

The study design utilized in this research is known as an exploratory case study. An exploratory case study is an in-depth approach to developing an initial understanding of a phenomenon of interest (Yin, 2012). In this case, the phenomenon is the themes and patterns that emerge during preschoolers play therapy sessions in a therapeutic preschool setting. The exploratory case study design was the best method for this type of research because it explored emerging patterns and themes of each play therapy session without having a direct goal in mind, aligning with the non-directive approach of the Child-Centered Play Therapy intervention. While I am not formally trained in Child-Centered Play Therapy, I have spent the last three years studying and applying the theory into my work with children and have realized that the exploratory case study design is best aligned with the model since it did not interfere with the child's therapeutic process.

Before conducting the study, each parent of the children studied signed a consent form and it was made clear that the study would not influence or dictate my work with the children. The therapeutic process could still be completed without the pressure of achieving a certain goal that other research designs require. The goal of the study was to simply observe children's play during therapy sessions and make note of patterns and themes that emerge in their play with an understanding of home life, as this influences what the children play out during sessions.

## **The Setting**

I had the privilege of acting as a social work intern, in a therapeutic preschool program located in an urban city. The preschool was created to meet the needs of neurodiverse children who have mental health challenges within the community. The preschool is dually funded by the Department of Education and the Office of Mental Health and serves children ages three to five. They attend the program from nine o'clock in the morning to two o'clock in the afternoon. The preschool has three classrooms and each with one teacher and two teacher assistants. However, each classroom has specific criteria. Classroom 1 was physically the largest classroom and held up to 12 students. The children in this classroom were the highest developing children in the program, were able to manage some independence, and did not require one-to-one attention. Classroom 2 was smaller and held up to eight students. The students in this classroom required more attention from the teachers. Classroom 3 was the smallest room in size and held up to six students. The students in this classroom typically required para-professionals, as they needed one-to-one assistance and attention. Along with the three classrooms, the preschool had a sensory gym where occupational and physical therapies took place. The sensory gym was filled with cushioned equipment that includes a swing, trampoline, tunnel, seesaw, tricycles and wagons. In this space, lined along the walls were the student's cubbies where their belongings were kept. There was also a small kitchen where a food service delivered breakfast and lunch daily.

The preschool also had a large play therapy room. In the room, there was a shelf of toys that included Legos, blocks, trains/train tracks, cars, animal miniatures, puppets, a dress up bin, Play-Doh, board games, books, musical instruments, and a farmhouse. The room also had a seesaw, rocking horse, and a rocking chair where children utilized the movement-based toys in

order to regulate their bodies. The playroom also had a big dollhouse, a play kitchen, a child-size table with two chairs, and a white board. The school offered physical, occupational, and speech therapies, as well as, all the students received play therapy in order to meet the individual's social, emotional, and behavioral needs. The play therapy piece of the preschool is funded by the Office of Mental Health, while all other services are funded by the Department of Education.

The preschool ran a typical preschool program while also utilizing play-based, sensory-based, and movement-based learning. Outside of the therapies that the children received, they spent a small amount of time each day in the sensory gym where they could swing, jump, crawl, rock, and climb on the cushioned equipment in order to meet their sensory needs. During the warmer months, the children spent around 30-minutes outside either in the gated playground or on community walks where they sometimes got to stop at the local market to buy fruit or a special snack for the day.

### **Play Therapy Procedure**

As the social work intern, my role was to provide 30-minute weekly play therapy sessions to an assigned caseload of students. My role during these sessions was as a participant observer, meaning that not only was I conducting research, I was also participating in the therapeutic process, which is common in exploratory case study research (Yin, 2012). Another critical task of the intern role was providing weekly psychoeducation telehealth phone calls with families. The families that were served were low-income families, some of whom had immigrated to the United States within several months prior to the time the study was conducted. It was common for these families to only speak Spanish, so the use of translating services was utilized during phone calls with those parents. It is also important to note that many of these

families had caseworkers that advocated for family needs and it was common to have phone conversations with the assigned workers in order to best meet the needs of the students.

The sessions took place in the play therapy room located in the preschool. The children were not given any specific instructions, they were free to explore and decide what they wanted to play during their sessions. At the beginning of each session, some children initiated play upon entry and some children took a few minutes to explore the room until they picked a specific activity. The sessions were strictly child-led, meaning that the therapist/researcher did not influence any of the play and followed the child's direction and initiatives. Therapeutic techniques of tracking the child's non-verbal actions and mirroring and reflecting the child's verbal communication and non-verbal play actions were utilized to interact with the student's in a non-directive way. The children were free to initiate as many activities as they felt comfortable doing. With 10-minutes left in the session, a 5-minute timer was utilized to let the children have a visual reminder that they and the therapist had to clean up in 5 minutes. The idea of cleaning up the toys and crafts at the end of the session helped the child feel a sense of accomplishment and closure as they transitioned back into the classroom. If the child became dysregulated during transitions, the use of a transitional object was utilized to allow the child to feel safe during transitions.

### **Data Collection**

The exploratory method is an emerging method of collecting data. Data was collected through a "Thesis Session Progress Notes" Microsoft Word document that was created by the researcher, clinical note documentation forms, and records of collateral meetings with parents. The clinical notes and collateral records were recorded on an electronic database as required by

the Office of Mental Health. Both of the files are password protected, requiring the researcher's personal username and password in order to access the files. The “Thesis Session Progress Notes” consisted of six categories:

Date	Duration	Mood/Affect	Types of Play	Notable Observations	Relevant Outside Information
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After each session, the researcher would record the date and length of session. All of the sessions over the course of treatment were in person and typically 30 minutes long. Some sessions were less than 30-minutes due to the student’s attention span. The “Mood and Affect” of the child was recorded in order to track their social-emotional development. The “Types of Play” lended to tracking different play themes and patterns that the child initiated throughout the course of therapy. “Notable Observations” included how the children played with each toy, phrases they said, noting common toys utilized, boundaries set by the therapist for safety, and other aspects of the play that have become consistent in the child’s play. The “Relevant Outside Information” section became crucial because it noted parent contact and reports from parents, contact with other service providers working with the children and/or their families, current events or news at home, teacher reports, and classroom observations. The “Relevant Outside Information” section allowed the researcher to make sense of the child’s mood and affect during the session, as it can easily be influenced by what is going on at home or in the classroom.

The second data tracker came from the electronic database that the Office of Mental Health requires all therapists conducting mental health therapies to use. Clinical notes and collateral meetings with parents were recorded on the database. After each session, the researcher wrote clinical notes into the electronic database. The information includes:

- Goal Addressed in Session (related to treatment plan)
- Subjective/Complaint
- Objective/Mental Status/Theme
- Assessment/Comment
- Plan
- Diagnosis

The form that was completed after collateral meetings with parents included:

- Organization and Program Name
- Date Service
- Start and End Time
- Modality (In Person or Phone Conversation)
- Contact Type (Onsite or Offsite)
- Individuals Present
- Explanation of Service
- Mini Mental Health Status: Appearance and Behavior; Mood and Affect; Speech; Thought Process; Thought Content; Cognition (check box format)
- Risk Assessment (check box format)
- Goals(s)/Objective(s) Addressed As Per Individualized Action Plan
- Intervention: Intervention(s)/Method(s) provided; Response to Intervention(s) and Progress toward goals and objectives
- Plan/Additional Information

After weekly phone calls with parents, the collateral form was completed and signed by the social work intern and a clinical supervisor. The discussions focused on progress of the child's

behavior at home, concerns that the parents had regarding the student's social-emotional well-being, and psychoeducation. The psychoeducation provided was based on therapy techniques and coping strategies that were found useful during sessions and school hours in order for the parents to utilize the findings at home. Psychoeducation also included basic information about specific diagnoses and allowed parents to share their worries and concerns.

All of the information that was tracked was a part of basic social work practice within the preschool's setting and the same data collection aided in evidence to support this exploratory case study.

## CHAPTER FIVE

### CASE STUDIES

#### **CASE I: Meet J**

J was a Hispanic, four-year-old male diagnosed with Attention-Deficit Hyperactivity Disorder. J was one of five children, the second youngest child, and the only male. Over the course of play therapy, J's Mom was pregnant with her sixth child and gave birth in March of 2023. J's oldest sister lived with his maternal grandmother, while the four other children lived with their 35-year-old mother. J's mom was single and unemployed. The family was a low income family that solely relied on government support. J's mom had some support from her own mother but the two did not live near each other. J's Mom also got some support from one of the three biological father's among her children. One of the biological fathers was not a part of the family's life. The biological father of two of the older children spent time with the family and acted as a paternal figure for the four children living in the home. He was not in a romantic relationship with J's Mom but the two had a supportive friendship. J's father was in and out of the picture and Mom reported that the two did not have any sort of relationship and were not in communication. Mom had an order of protection against J's father due to domestic violence and sexual abuse that occurred when J was between two and three years old. J's father had partial custody of the children that he had with J's Mom and toward the end of the play therapy sessions, J's Mom began working with a case worker to get full custody of those children. It is important to note that J's biological father was also the father of the youngest and newborn child. He did not know that J's Mom was pregnant with one of his children and this caused severe anxiety and stress for J's Mom that also affected J's emotional and mental health as well.



In school, J was in Classroom 1, which was the highest functioning of the students in the preschool. J tended to be absent from school at least one to three times per week, and on days that he did come, he showed up 30 to 60 minutes late. On a few occasions, J walked into the school holding and eating a bag of candy. J refused to take the school bus that was provided to all of the children at the school so his Mom and at least two of his sister's dropped him off. In the fall, J would become upset and cry while saying goodbye to his Mom for the day. However, over the course of the school year, J had shown great improvement in staying regulated when his Mom left.

J was friendly to the other students in his class and encompassed a nurturing nature. He was a good listener and was often seen organizing, cleaning, and picking up toys after his peers, even if it was not time to clean up. J had a clear understanding of school routines, even if he did not want to partake in some of them.

Sometimes J engaged in aggressive types of play in the classroom and liked to throw balls in the classroom. He responded well to clear and calm directions from his teachers when boundaries were set within his play. J preferred one-on-one attention from his teachers and thrived off of verbal praise after completing an activity. J often asked to go to the play therapy room and became easily frustrated and angry when it was not his time to go.

J always ate the breakfast and lunch that was provided by the school and was often told to "slow down" from his teachers as he ate his meals in a hurried fashion. J was often in a regulated and happy state while in the classroom. He liked to play tag outside on the playground with his teachers and therapists. J had a difficult time engaging in interactive play with his peers but enjoyed engaging with adults.

Based on reports from J's Mom's, J was aggressive, disruptive, and dysregulated at home, while also reporting that he could be helpful with chores and could be very loving and affectionate towards his mother. J's Mom reported that he liked to help with laundry and cleaning up toys. She also stated that she and J had a close relationship and that he was very attached to his mother. J's Mom reported that J was always the last child to go to sleep at night because he enjoyed having alone time with his mother while they watched TV together. On the other hand, J's Mom also shared that J threw objects and clothing out of their window, broke technology and toys, drew on and hit walls, screamed and fought with his sisters, and hit and scratched his mother. Mom often reported feeling that she had lost any sort of control over him. She also reported that J tantrums often and did not respond well to discipline or follow any boundaries that are set. In January, J's psychiatrist prescribed Adderall for his ADHD. After that, J's Mom reported that the disruptive and destructive behavior subsided and that he had become more mellow and quieter in the home.

Throughout the course of play therapy, there were two Child Protective Service (CPS) cases opened with the family: one in the fall and one in the winter. The CPS worker who conducted the home visit after the second report stated that the home was in "hazardous condition." At the time of the second CPS case, Mom was well into her third trimester and tried to move into a domestic violence shelter based on her history with J's father and a constant fear that he was going to show up at the family home. During this time, there was an all-team meeting hosted by CPS that included J's Mom, the assigned CPS worker and her supervisor, two case workers and their supervisor, J's teacher, myself, J's psychiatrist who was also my task supervisor, and a mediator. During the two and a half hour meeting, many action steps were taken which included: changing the lock on the family's current home door, assisting J's Mom in

getting legal custody of the children that she shares with J's biological father, reigniting the Order of Protection that she had against J's father, getting a health home aide that could assist Mom in the home, and try to accelerate the process of moving the family to a new home.

The insight gained from the all-team meeting allowed for deeper understanding into the themes and patterns that emerged in J's play therapy sessions.

### **An Inside Look into the Play Therapy Sessions**

J's play therapy sessions were by far the most complex and challenging sessions. J frequently presented in a dysregulated and escalated state. J exemplified a higher level of thinking because when he felt dysregulated in the classroom, he would seek me out and ask to go to the play therapy room. Due to high caseloads, it was likely that J would not be able to go to the playroom until his allotted time. However, on days where J had play therapy sessions, it was clear that he understood the uniqueness of the play therapy room and the therapeutic relationship. He would work through a variety of emotions in his play, and occasionally ended sessions early once he felt that he had worked through his inner emotional conflicts.

Like many of the students, J grew excited when it was his turn to go to play therapy. He would wave and tell his teachers, "goodbye" and attempt to run down the hall to the playroom. Once in the play therapy room, J initiated play immediately but had difficulty regulating his emotions. Every session, J would take multiple bins and board games off of the shelf and dump everything on the floor without settling into the activity. Ironically enough, at the end of each session, J adamantly refused to clean up the playroom; however, in every other area of his life, especially in the classroom and at home, J was observed or reported to be constantly cleaning up after others. J cleaned in a hurried manner and was often told by his teachers that it is not time to

clean up, as the activity is still in progress. On the contrary, when J was in the play therapy room, he refused to clean up and yelled, “no” when the session was wrapping up.

Another noteworthy aspect of J’s play sessions is his push back on one of the main components of Child-Centered Play Therapy. In CCPT, it is common for the therapist to use mirroring and reflective language with the client as they follow the child’s lead. When J would play in solitary play, I would often play similarly alongside him and reflect and mirror back what he would say. During the second session he turned to me and said, “Stop copying me!” Throughout the course of therapy, I would catch myself mirroring and reflecting on his language or play and before I shifted my approach, J would say, “stop copying me!”

### **Themes and Patterns**

Over the course of intervention, J played out many different themes and patterns. These included medical play, playing in the toy kitchen and in the dollhouse all while expressing dysregulation throughout many different forms of play.

#### ***Medical Play***

During J’s first play therapy session in October, he initiated medical play. At this time, he did not incorporate me in the play other than telling me to retrieve the boy and girl baby dolls and to sit in the chair across from him at the table. J put a stethoscope around his neck, and while standing up, he undressed the baby girl doll and placed the doll on her back. J took out the play syringe and started poking the doll in her vagina area. He played out the poking repetitively and looked at me with no expression in his face while he continued the action. After this, he directed me to dress the doll again while he took the boy doll, undressed it, and laid it on its back. He repeated the poking action, this time on the doll’s stomach. Again, J looked at me expressionless

while he did this. After he finished, he put the medical kit away and moved on to initiate a new form of play in the kitchen area.

Over the course of the play therapy, J included me in the medical play and we switched playing out the role of doctor and parent bringing both baby dolls to the doctor's office. J directed the play and gave specific instructions for my role in each scenario. When J played the role of the doctor, he was consistently trying to "fix" the baby and make the baby feel better. He always had the baby girl go first. At the end of the "doctor visit," J would give the baby a bottle of milk in order to console the baby. When J played the role of the parent, he would hand me the girl babydoll and sit in the rocking chair with the boy doll, feeding the doll a bottle, while he waited for me to finish playing the role of a doctor with the baby girl, then he would switch and repeat the pattern.

J did not initiate medical play every session but he played out this scene 75% of the time. Over the course of the play therapy sessions, the medical play with the same two baby dolls became less aggressive and more nurturing. J began using the medical play tools in a realistic manner and used the same two baby dolls each time. Once J played out themes of "fixing" the babies, he would place the dolls back in their designated spot in the room and continue on to the next activity.

### ***Play Kitchen***

Beginning during J's initial play therapy session and in every session over the course of intervention, J spent a portion of his time playing in the toy kitchen. The play kitchen was the first area where J engaged in interactive play. J instructed that he and I would take turns cooking meals for each other. While J acted as the chef, he would dump the bins of food onto the floor and shuffle through until he found what he was looking for.

When J instructed that it was my turn to cook for him, he would become easily frustrated when the meal took too long to come to him. He would express that he was angry with me and physically turn his body away and avoid eye contact with me. During these moments, it was difficult for J to regulate his frustration and would remain upset with me for the remainder of the session.

### ***Dollhouse***

Another pattern that J initiated was pretend play in the dollhouse. J played out forms of aggression, domestic violence, and dangerous behaviors. Whenever J played in the dollhouse, I assumed the role of an observer, rather than an active participant. Unlike the play in the kitchen, J did not invite me into this play; instead, he remained focused and concentrated on what he was doing. Half of the sessions, J would play within the dollhouse, while the other half of the time, J would bring certain pieces of furniture and dolls to the floor in front of the dollhouse and set up the furniture in a smaller space and in a more particular way.

During the times when J would play within the dollhouse, there was a common theme of having one of the dolls, typically a boy, fall off of the roof or from the top floor. In these moments, J would look at me for a reaction but quickly revert his attention back to the play. He would replay the scenario two more times before shifting his attention to another area of the dollhouse that he designated as the bedroom. J put all of the beds in one room and would put each doll to sleep before closing out the play and transitioning to another activity in the room.

When J would create a smaller environment on the floor in front of the dollhouse, J took his time to set up the dollhouse in a specific way. He was also particular in which dolls he would include in the play. Typically it included an older woman, a boy, and a young girl. In these scenarios, J would put the little girl in the top bunk bed and sometimes have the young boy sit on

top of the girl before moving him to the kitchen area where the older woman was. Then in the kitchen/bathroom area, J would play out scenes of fighting and hitting between the boy and older woman until one of them removed themselves from the scene. Once one of the characters was removed from the scene, J would stand up and initiate a non-related form of play in a different area of the therapy room.

J's demeanor and affect during this play was more serious, focused, and quieter. However, once J ended the play, he quickly transitioned back into his typical escalated state. While the activities initiated after the play in the dollhouse changed, J always engaged in interactive play for the remainder of the session.

### **Dysregulation and Self-Regulation**

J's normal state of being was escalated and dysregulated. One of J's play therapy goals was to engage in safe behaviors while playing with the toys in the therapy room. J needed frequent reminders and consistent boundaries set in order to keep himself and me safe. J became defiant and more escalated when boundaries were put into place. During non-directive sessions, J would become the most dysregulated due to the lack of structure.

Due to J's dysregulation, the sessions needed to be more structured than a typical non-directive approach seen in Child-Centered Play Therapy. While J resisted more structure, it was observed to help him redirect his escalated behaviors into more productive coping strategies.

An area of strength that emerged from the more directive sessions, was J's ability to identify and initiate two different coping strategies when he became dysregulated. The first coping strategy was sitting either on the seesaw or in the rocking chair and rock back and forth in order to regulate all of the big feelings he was experiencing. However, even during this particular

self-regulation strategy, boundaries still needed to be set since J would attempt to stand on the rocking chair or rock back and forth in the seesaw with such force as he tried to tip it over.

Another form of self-regulation that J engaged in was manipulating PlayDoh and punching a mound of PlayDoh until he began to sweat. After several minutes of manipulating the PlayDoh and working through it in a hurried and rushed manner, J would physically calm down. Once J was able to regulate himself, he was able to remain regulated until the end of the session, as transitioning out of the session was particularly difficult for him.



## **Case II: Meet G**

G was a Hispanic, four-year-old female diagnosed with Autism Spectrum Disorder. G lived with her biological mother and older brother, who was diagnosed with Autism and ADHD. G's mother was a 39-year-old, single mother, who was unemployed. The family was low income and relied solely on government support. G was close with her maternal grandmother and spent time with her often, especially on the weekends. G's Mom reported that they were a faith-filled family and that prayers and practices were an important part of their daily lives.

The family had a history of mental illness. G's Mom was diagnosed with Bipolar Disorder and G's maternal grandmother was diagnosed with Schizophrenia. Mom reported that suffering from these mental health conditions impacted her and her mother's ability to care for the children at times. G's Mom reported that when she was in an episode, she dropped the children off at the maternal grandmother's apartment. However, Mom said that there are often times when dropping the children off at her own mother's apartment was not always an option due to the grandmother's schizophrenia.

When G's Mom was three-months pregnant with G, G's father left the family as he decided he did not want to be a part of their lives. G's mother relied on her own mother to help raise the two children. G's Mom shared that when G was born, the family was living in a homeless shelter and when G turned 1-years-old, the family was relocated to permanent housing. When G was 13-months old, G's Mom noticed a regression in her child and at 19-months old, G was diagnosed with Autism Spectrum Disorder. G received early intervention services but Mom reported still feeling that G was regressing, specifically in sleep.

In school, G was in Classroom 3, which consists of the students who need the most one-on-one attention. G was a leader in her classroom and her teachers often relied on her to

engage in classroom activities and routines as she was one of two verbal children in the classroom. G was enthusiastic and full of joy for most of the school day. She enjoyed singing the morning songs, dancing during movement time, and could be heard throughout the halls from her high-pitched voice as she participated in classroom activities. G was nurturing and always made sure that her peers were feeling okay, sometimes even notifying them when it was their turn for therapy. G loved unicorns and stickers and responded well to praise, especially when it involved getting a sticker put on her forehead for her good work. G had a vast imagination and loved to engage in dramatic play while in school. G loved animals, specifically cats and dogs, and often acted as one of the two animals. G's teachers reported that the animal-like behavior was to gain attention from her teachers and was often participating in attention-seeking behaviors. G had trouble transitioning in and out of the classroom. In moments of transition, G would become limp, refuse to walk, and bark like a dog or meow like a cat, while trying to lick the arms of the adult trying to help her.

During mealtimes, G had little appetite and would often only eat crackers. She also refused to drink water or milk during the school day. G's teachers had been working with her for a year and a half on potty training and Mom reported that this was a major issue at home, as well.

At home, G's Mom reported that she was nurturing and that the two had a close relationship. G's Mom said that the two of them bonded over their love of music and dancing. G's Mom reported that she spent time playing with her daughter when G was not in school.

G's Mom also reported that, at home, G could also be very difficult. Mom stated that G often tantrumed by screaming and flailing her arms and legs. Whenever G's Mom took her out in public, G often threw a tantrum when she did not get what she wanted and refused to walk on her own, requiring Mom to bring a stroller with them. Mom reported that G could be aggressive

towards her brother and the family dog. It was also reported that G threw objects and clothing out of the windows and drew on the walls. Mom reported that her most prevalent challenges with G were: separation anxiety from her mother, tantruming behaviors, lack of appetite, toilet training, and sleep. G's Mom also expressed her frustration and concern over G's animal-like behavior and often demanded that she would like the habit to stop.

G's Mom was very attentive to her children and was a strong advocate while getting her children the services they needed. G's Mom was always open to feedback and attended all meetings regarding her children. G's Mom was also a strong advocate for herself and did not shy away from asking for help.

### **An Inside Look into the Play Therapy Sessions**

G began play therapy at the beginning of October. During her first session, G expressed a level of comfort and ease while entering into the play therapy room. She engaged with me in a repetitive manner. The conversation on the first day looked like:

G: Do you like bubbles?

CG: Yes, I do! Do you like bubbles?

G: Yes!

*Silence*

G: Do you like bubbles?

*Repeat*

If G was not asking whether or not I liked bubbles, she would mirror my language. Her mood and affect during the first session were observed to be happy and regulated. G entered into the play therapy room and after scanning the shelf, G chose to blow bubbles for the remainder of the

session. Transitioning out of the room came with ease and G took my hand and walked back to the room without any difficulty.

Throughout G's play therapy sessions, she always grew excited when it was her time to go to the playroom. She always made sure she said "goodbye" to her teachers while waving to her class. G was typically excited when entering into the room and participated in interactive play, while also making sure that I had a clear role within her scenes and activities. During play sessions, G was drawn to pretend play, water-based play, and engage in animal-like behavior.

G showed an interest in incorporating feelings into her play and participated in a "Feelings Check-In" at the beginning of each session. The "Feelings Check-In" took place at the mirror in the room. Next to the mirror, there was a list of feelings with pictures of facial expressions above the word. Taped on the mirror was the question, "How are you feeling today?", with a Spanish translation under it. The higher developing students typically led the check in on their own. They picked a feeling, posted it on the velcro attached to the mirror, then together, the child and I made a facial expression that was linked to the feeling that they chose.

Throughout her pretend play, G incorporated different feelings with her characters and was always sure to share how my character was feeling too. Mom reported that she noticed a difference in her language and expression of feelings since the play therapy sessions began. At home, G often shared how she was feeling and incorporated them into her play at home with her Mom and brother.

At the time of her second session, transitioning out of the play therapy sessions was an area of difficulty for G. Typically at the end of the sessions, G began to throw a tantrum and became limp, refusing to walk back to the classroom. It was during those times that G often

acted as either a dog or a cat and tried to lick my arms or scratch my legs. This theme and pattern will be further discussed below.

### **Themes and Patterns**

Starting during G's second play therapy session, there were specific themes and patterns that had emerged. G often played out themes of nurturance and protection, sleeping, and patterns of engaging in animal-like behaviors while transitioning out of the therapy room.

#### ***Nurturing and Protective Play***

During G's second session, she initiated an introductory theme that would later expand in future sessions. At the time of the second session, G took two stretchy fidget strings that were kept in the sensory bin for children to utilize as a self-regulation tool and identified them as snakes. Then G took the shark and alligator puppets off of the shelf, which were the only two puppets in the room, and played out the puppets chasing after the snakes. G initially played the role of the snake and assigned my role as either the shark or alligator. After chasing the snake around in circles a few times, G switched roles and acted as the shark or alligator and I played the role of the snake being chased.

After this scene, G initiated another activity. However, over the course of G's sessions, the theme of nurturing and protective play was incorporated into the chasing scene. The next time G played out the scenario, she utilized the stretchy fidget strings, the shark puppet, and incorporated a plastic shark miniature in the play. Again, we took turns playing both roles. G typically assumed the role of the character being chased before switching roles. During these scenes, the shark puppet, "mom shark," protects the "baby shark" from the snake. The nurturing

and protective behavior played out as the “mom shark” put the “baby shark” in her mouth as she moved around the room.

During a session in mid-November, G was playing out the same scene with the mom and baby sharks, but this time, there was a small male doll from the dollhouse incorporated into the play. G assigned herself the role of both mom and baby shark and handed me the male doll. During the scene, G played out aggression through the mom shark for the first time. G began chasing and eventually eating the male doll. Upon further inquiry, G labeled the male doll as “dad”. G did not switch roles during this episode. That was the last time G mentioned the role of a “dad” figure in her play. However, after that session, G continued to play out the nurturing and protective scene with the sharks and a theme of aggression had been incorporated into the play.

Sometimes the aggression was towards the snake, while other times the aggression was towards the baby shark. G regularly placed the baby shark inside the mom’s mouth but never identified the reason. There were scenes where the aggression was focused on the mom shark eating the baby shark, and the baby shark tried to get out; while other times the baby shark was put inside the mom’s mouth to protect from the snake that was chasing them around.

The scenarios of nurturing and protecting were played out at different points in the sessions and once the episode was played out, G smoothly transitioned to initiate another activity.

### ***Sleep***

The theme of sleep and putting babies to sleep was played out during G’s sessions, as well. The scene was quick but occurred in almost every session. G either chose a baby doll or a doll from the dollhouse and took the bed from the dollhouse, placed the babies in the bed, put a pillow under the head, covered the dolls with a blanket, then moved on to the next activity.

Sometimes G played the scene out in the beginning, while other times she played the scene out before it was time to clean up.

It should be noted that during weekly calls with G's Mom, a common report was that G did not sleep well the night before. Mom reported that G had regressed in her sleeping patterns and typically woke up between the hours of 1:00 and 4:00 AM and was typically awake for 30-minutes to 2-hours. After hearing the reports, there were attempts during sessions to expand the play and inquire more about G's feelings towards this play. However, when further inquiry was attempted, G ended the play by saying, "baby is asleep" and she moved on to the next activity.

### ***Animal Play Acting***

As previously mentioned, G had consistently struggled with transitioning out of the play therapy room and back into the classroom. After a few time queues, indicating that the end of the session was near, G was prompted to clean up the toys she played with that day. Wrapping up the play sessions triggered G and she immediately screamed "no!", fell to the floor, and became limp and a dead weight. G grew quiet and then adopted the role of an animal. Typically she became a cat or a dog. She would give a high-pitched "meow" or "woof" and flail her legs and arms around the floor when I tried to take her hand. G would then lick the air and my arms and while on all fours, as she scratched my legs and feet.

Due to the unique nature of play therapy, my role was not to stop G from assuming this role, rather meet her where she was and proceed from there. During transitions, G was made aware that she was able to walk back to the classroom acting as an animal, however, when she re-entered the classroom, she needed to go back to acting as a "big girl". Over the course of play

therapy, G became more familiar with the boundaries set and while transitions remained a challenge, G was able to stand back up when she was inside the classroom.

Based on reports from her teachers and her Mom, G assumed the role of an animal when she faced a scenario that challenged or overwhelmed her. Her teacher reported that the behavior was a “negative attention-seeking behavior,” while Mom felt an immense amount of concern. During an in-person meeting in mid-January, Mom shared that she felt genuinely nervous that G really believed she was an animal. Mom stated that she found the behavior “very annoying” and that she “just wants it to stop”. During school hours, G’s teachers had learned to either redirect the behavior by stating, “we would like to hear your beautiful big girl voice” or they would purposely ignore the efforts until G realized that she was not gaining attention from it. At home, Mom stated that she got frustrated with G and told her to “stop,” which only perpetuated the behavior.

Over the course of the school year, the behavior decreased both in school and at home. G remained consistent with acting as an animal while transitioning out of the play therapy session and back into the classroom but that was the few times that the behavior was reported.



### **Case III: Meet D**

D was a biracial four-year-old, diagnosed with a speech and language delay. D's mother was a hispanic, twenty-three year old single mother. D's father was black and his age was unknown. Mom reported that while she and D's dad were not romantically together, he was involved in D's life. D spent time with her father a few weekends per month. D and her Mom lived in a homeless shelter and had experienced many sudden changes in housing throughout the academic school year. The sudden changes caused immense stress in their lives and could be seen throughout D's play therapy sessions.

In school, D was in Classroom 1 and was a busy student who liked to move around the room. D was either a hyper child with lots of energy or she was napping in a cot in the classroom. D formed attachments with many different but specific small toys. Some of the toys included: arts and crafts pom pom balls, a plastic spider, a paint brush, a microscope, a Pete the Cat stuffed animal, a dinosaur, and a small plastic gem. She escalated in behavior if she did not have a toy in her hand, specifically certain toys that she had grown an attachment to. D could not regulate herself unless she had one of the toys listed above in her hand. D had a hard time listening to directions, especially when she could not have the toy until the class activity was finished. It was also common for D to hide her favorite toys around the classroom and retrieve them at a later time in the day.

Both in the classroom and on the playground, D typically played by herself and had difficulty engaging in parallel play, meaning that she struggled when other students played alongside or at the same table as her. D often took toys out of other student's hands with little to no awareness of their emotional response. She liked to play alone, not even with an adult.

D loved going to play therapy, so much so that she tried to run down the hall as fast as she could to get to the room. D always yelled, “goodbye” to her teachers while jumping up and down when I picked her up from the classroom to go to the playroom. D’s play sessions were thematic and her behavior in the play therapy room was influenced by what is going on in her life outside of school.

### **An Inside Look into the Play Therapy Sessions**

D’s play therapy sessions began in November of 2022. During the first few sessions, D remained in a regulated and calm state. D would take 2 to 3 minutes to initiate play and she would often walk around the room looking at her options. She engaged in water color or Play-Doh for the first few sessions. D had difficulty engaging with the therapist and only engaged in solitary play, however D allowed me to play alongside her. D remained aware of the type of play that I was engaging in and by the end of the sessions, D would mirror my play. D’s play was sensory-based as she sought out the feelings of different textures, especially water, paint brushes, Play-Doh, and sensory bins with fake snow inside. She often played with the different materials with her hands and enjoyed covering her arms and face with the different sensory crafts.

From November to January, D would escalate in behavior and cry when it was time to clean up and walk back to the classroom. She would begin to run around the room, crying and screaming, and refusing to clean up. In order for D to become regulated and walk back to the classroom, she would need to use a transitional object, which was typically a toy gemstone.

As the sessions progressed and D became more comfortable with both me and the setting, D engaged in interactive play. D initiated play upon entering the play therapy room and

incorporated me into every aspect of play. It was during the middle of the school year that D's regulated and calmer state transitioned into an escalated and energetic state in the therapeutic setting. D would enter the playroom in an escalated state and immediately initiate play. Over the course of the 30-minute session, D's body would calm down and she would be able to focus on the activity of her choice, sometimes for the entirety of the session. Other times, D initiated two to three play activities but would remain regulated.

By the end of January, at the end of the play therapy sessions, D was able to clean up the play therapy room, say goodbye to all of the toys she played with, and walk back to the classroom with a transitional object that she brought from the classroom in her hand. D still escalated in behavior, but more so in an excited state as she understood that she would be able to go back to the play therapy room again.

Over the course of play therapy and reviewing the "Thesis Progress Notes" tracker, it was clear that D's play had become thematic with similar patterns emerging during each session. There was also a clear shift from the themes and patterns when the sudden changes occurred within D's home environment.

### **Themes and Patterns**

Between the months of November to April, D had the weekly opportunity to attend Child-Centered Play Therapy and spend 30-minutes to play, say, and do whatever she wanted, within the limits of safety. D gravitated towards a few options for the entirety of the five months. The themes and patterns that emerge during D's play session all began during the fourth play therapy session that took place at the end of November.

### ***Attachment and Self-Regulation***

During D's third play therapy session, she found a small plastic, yellow starfish and incorporated the toy into her play. At that moment in time, it appeared as though the starfish's role in the play did not carry any unique meaning and was observed to simply act as one of the many miniatures in D's play. When D cleaned up at the end of the session, the starfish was put back in a bin without any emotional response.

On D's fourth session, she entered into the play therapy room and immediately said, "Starfish! Where's the starfish!" Her body became frenzied and D grew escalated until she found the starfish in one of the bins on the shelf. For the remainder of that session, she held the starfish in her hand while playing with PlayDoh. Occasionally she would place the starfish on the ground next to her so she could manage the PlayDoh with both hands but after about 30 seconds, she would frantically say, "Starfish! Where's the starfish!" She would desperately move around the room until she found the starfish, which immediately regulated her body. Over the course of D's play therapy sessions, D would enter the playroom and say, "starfish! Where's the starfish!" or "Starfish! Starfish, where are you, starfish?" Some sessions, the starfish was simply used as a tool to regulate herself, while other times, the starfish would be utilized in the play. No matter the starfish's role, D had to know where the specific toy was.

Another notable pattern that emerged over the course of the sessions was that D began rotating the toy that she would look for upon entry. The toys rotated between the starfish, a dinosaur, and a shiny gold musical egg shaker. Similar to the starfish, D played with either the dinosaur and the egg shaker during the session before, but each toy appeared to hold little to no significance in her play. Then, during her next session, while walking to the play therapy room,

D would say, “Dinosaur (or gold egg)! Let’s go get the dinosaur (or gold egg)!”, which would indicate which toy she wanted to find in order to regulate her body that day.

As previously mentioned, D had difficulty at the end of the play sessions and she became dysregulated. When “clean-up time” was initiated, D would grab ahold of either the starfish, dinosaur, or gold egg and either run around the room or redirect her attention to the toys on the shelf and begin initiating play with her free hand. However, when prompted to have her starfish help her clean up, she transitioned into a regulated state. Here is what happened during our fourth session together when it was the first time D was prompted to have the starfish help her clean up:

CG: Oop, the timer went off, that means it’s time to clean up

*No response.*

*I start singing the “Do you know what time it is” and “clean up” songs, like they do in the classroom. D picks up one Play-Doh tool and puts it back in the bin.*

D: Ooh!

*D looks up, walks to the shelf, and grabs a new bin of toys*

CG: It’s not time to play D, it’s time to clean up.

*I take her hand and she sits in my lap. Then she picks up the star stamp and places it on the starfish in her hand. Her face lights up and she looks up at me.*

CG: They match, don’t they!

D: A star!

CG: Yup, you matched the two stars!

*Silence*

*With a sea turtle in my hand, I point and talk to the starfish in D’s hand.*

CG: Starfish, will you please put the star stamp in the bin and help us clean up?

*D looks at the sea turtle in my hand and watches the sea turtle putting a toy back in the bin. Then D looks at the starfish in her hand and begins to clean up the rest of the toys using the starfish.*

D: Bye squish! Bye starfish!

*D places the starfish behind the drums on the shelf, takes my hand, and walks out of the play therapy room.*

D was able to say “goodbye” to either of the three significant toys at the end of the play therapy session and walk back to the classroom in a regulated state. However, when D entered the classroom she would call out for one of the toys that holds a unique meaning to D that can only be found in her classroom.

It was clear that D used specific toys to regulate herself when she felt overwhelmed. Due to D’s diagnosis of Developmental Delay of Speech and Language, it was challenging for D to express her inner emotions and feelings and relied on consistent toys to help her feel safe and regulated. While D had a difficult time cleaning up, the starfish, dinosaur, or golden egg enabled her to accomplish the task in a regulated state, allowing D to feel safe completing what may be considered a daunting task for her.

### ***Hiding***

Hiding toys was a theme that D did in the classroom, play therapy room, and at home - as reported by her Mom. Since the fourth play therapy session, D’s play encompassed themes of hiding. At the end of her fourth session, D hid the starfish behind the drums on the shelf, instead of placing it in the bin with the other sea creatures, where she found it.

Over the course of play therapy, D found different places to put the toy of choice at the end of each session. D hid the starfish behind the drums, inside puppets, in a school bus that she

parked under the table in the room, in the toy kitchen cabinet, or in the dollhouse - either under the covers in a bed, or in or behind a cabinet or piece of furniture. Interestingly enough, when D entered the room for the following session, she immediately went to the shelf and found the bin that the toy belonged in.

During a session in February, D spent the entire 30-minutes hiding the gold egg, along with other smaller toys, in Play-Doh. She remained quiet, calm, and focused for the whole session while she took turns covering different toys in PlayDoh. At the end of the session, D became upset and dysregulated when she was prompted to take the toys out of the PlayDoh so that the PlayDoh could go back in the containers to keep them from drying out. D had the most difficult time uncovering the gold egg. Her behavior during this session was notable because typically D engaged in interactive play and while she remained regulated for most of the sessions, she was still a lively 4-year-old. During this session, D's demeanor and affect were subdued and she did not want to engage in interactive play. She simply sat on the carpet and hid objects in PlayDoh. While the theme of hiding her favorite toys was common, D had not spent an entire session playing out the theme of hiding, she simply hid items around the room when she left.

### **Life Events that Influenced Play Therapy Sessions**

As previously mentioned, D and her Mom lived in a homeless shelter. Towards the end of January 2023, I received a call from D's Mom who sounded like she was in distress. D was absent from school the day of the call and Mom shared that the day before our call, she was told that she and D were being relocated. D's Mom did not know when the move was happening or where they were being relocated. The morning that she called me, she just learned that the two

would be moving that afternoon to a location that was two hours away from the preschool. D's Mom stated that until she advocated for them to be moved closer to the preschool, D would be unable to attend school. Over the course of the next 7 days, the family was relocated four different times, with two of the placements in a shared living space with two to three other families living in the same quarters. Finally, on the seventh day, Mom's insistent advocacy placed the family in a shelter closer to the preschool.

During D's first play therapy session back, after the traumatic experience, D remained secluded in her play. She did not make eye contact and was more focused on her play than she had been to date. The most notable aspect of the session was that it was the first time that D did not look for the starfish, dinosaur, or gold egg at the beginning of her session. D also initiated activities that she had never shown interest in before like building and playing with the trains and train tracks, as well as bowling.

During the second play therapy session, after all of the moves, D's behavior was completely different. D was dysregulated and could not settle into play like she typically had. She ran around the room, taking toys and games off the shelf, poured the games on the floor, then would repeat the behavior with other bins and games. During the second half of the session, I had to initiate some direction in order to calm her body down. I introduced D to a sensory bin full of fake snow with different tools and toys within the texture. It took D about 5 minutes to settle into play for the remainder of the session. D's body physically calmed down and her breathing slowed. However, at the end of the session, D quickly re-entered into an escalated state and began running around the room. It was clear that the sudden changes in moving and the uncertainty of life that she experienced influenced her inner emotional world and she needed to stray away from the typical patterns and themes that she usually played out. In the third session



after all of the sudden changes, D was back to her regular routine, finding the gold egg upon arrival and spending the session playing out themes of hiding.

It was evident that from the fourth play therapy session on, D created a routine for herself and would consistently engage in thematic play in order to feel safe and regulate her body. When she experienced sudden change and loss of a familiar home, D's play routine became inconsistent and dysregulated, which was a clear indication that there was something happening in her personal life that was out of her control.

## CHAPTER SIX

### DISCUSSION AND REFLECTION

#### **Discussion**

Over the course of the case study, each child played out consistent themes and patterns that were unique to them. After analyzing the data collected, it was clear that each child has their own specific types of thematic play that can be viewed within the context of their diagnosis and traumatic experiences. While it is never the purpose to make sense of the children's play, within the context of Child-Centered Play Therapy, identifying themes and patterns can assist in informing practice interventions and allow the therapist to gain insight into the child's inner emotional world.

Exploring J's thematic play while accounting for his ADHD diagnosis and his multiple traumatic experiences, gives insight into his dysregulation and need for control within his play. During both medical and kitchen play, J established a need for control. In both of these repetitive scenarios, J initiated turn-taking but left little room for error when it came to my role. J always made sure to tell me exactly what he envisioned my role to be and became easily frustrated and dysregulated if the scene did not play out as planned. During medical play, J always tried "fixing" the dolls and correcting their illness. Knowing that J often visited the doctors office for his own illnesses and poor living conditions, gave insight into his need to "fix" the dolls in the doctor's office.

Another pattern that emerged over the course of the study were the aggressive and dangerous scenes that J played out in the dollhouse. Knowing that J had witnessed domestic violence in his home allowed for a deeper understanding of the reason for his dysregulation and

his desire to control the scenario. With every theme and pattern that J played out, he always looked for my reaction, studying my face while he kept his expressions stoic, as if trying to figure out his understanding of the situation through my feedback. Due to this, it was crucial that my body language remained open and non-judgemental in order to give J the space to safely play out a mature concept for his age.

J's Attention-Deficit Hyperactivity Disorder diagnosis also gave meaning to the reasons behind his dysregulated play. J externalized his internal hyperactive feelings by creating a disorganized and chaotic environment within the therapy room. At the end of every session, J's dysregulation could visually be observed by the state in which the room was in. Almost every toy bin was dumped out onto the floor and when boundaries were attempted to be put into place, J would become even more escalated. He would put himself in danger by forcefully rocking his body back and forth on the rocking chair almost tipping the chair over each time. A clinical interpretation for J's negative reaction at the attempted boundaries to keep the room more organized could be that he did not feel fully accepted for his feelings and emotions. He may not feel that a clean and organized therapy environment is authentic to how he felt or how his living conditions were at home. Due to J's chaotic home environment and past traumatic experiences, it was clear that his dysregulation, aggressive and dangerous play patterns, and the need for constant control was his way of expressing how he felt internally. During these sessions, J was trying to make sense of the chaos he experienced, which led to the externalized behaviors of creating the disorganization in the play therapy room.

While analyzing G's play themes and patterns within the context of her diagnosis and experienced trauma, it can be argued that due to her overly attached relationship with her mom her play consisted of nurturing and protective scenarios. During the chase and protect scenes

with the sharks and snakes, there were themes of aggression that emerged between the characters. The aggression was two-sided, meaning that it did not only come from the snake who was chasing the mom and baby shark. The aggression could be interpreted as overprotection since G's mom had reported that this was the nature of her relationship with her daughter.

The theme of sleep emerged as a consistent pattern over the course of the study, as well as the animal play acting behaviors. These two areas of G's play were a point of contention with her mom. G's mom often spoke about her frustrations with these two patterns, even while her daughter was in the vicinity. Due to G's mom's Bipolar diagnosis, she would often snap at G while on the phone with me in regards to the lack of sleep and the animal-like behaviors. G's mom reported that when G began acting as an animal, mom would go into her bedroom and lock the door until G was finished with the play scene. Considering G's attachment to her mom, being separated created an escalated response, which exasperated the animal-like behaviors. This could lend to the insight into how G utilized the animal play acting as a way to cope with feelings of uncertainty or abandonment when her mom refused to acknowledge her. Additionally, the uncertainty of how her mom would present each day could lend to the reasons why G struggles to sleep at night. Stress can hinder sleep patterns and playing out patterns of sleep during therapy sessions could be G's way of playing out the nighttime routines that made her feel anxious.

However, over the course of therapy, G's sleep patterns improved and the animal acting subsided. During the play therapy sessions, it was made clear that G could act as any animal she felt compelled to be in the room, however once she got back to her classroom, she had to act like a "big girl". Giving G the space to freely act as an animal resulted in a decrease in the same behaviors in all other areas of her life. With G acting less as an animal around her mom, gave her

mom little reason to avoid her daughter. Mom reported that her attachment with G felt “healthier” and G slept better throughout the night.

Understanding D’s Developmental Delay of Speech and Language diagnosis and her experience with homelessness lended to a deeper insight into her attachment behaviors in order to self-regulate and the theme of hiding that emerged in her play. As was previously mentioned, children lack the vocabulary to express themselves, which is why play is considered children’s natural language. However, for a child like D, who had a clinical barrier behind the challenges of vocalizing her emotions, analyzing her play patterns and themes helped decipher what she was trying to communicate with the outside world. It was clear that D formed attachments to physical objects due to the inconsistency of her home environment. D was unable to regulate her emotions or initiate any sort of play until the specific object she was looking for was in her hand.

Furthermore, D’s pattern of hiding objects, especially the toys she grew an attachment to, can be analyzed within the context of her experience with homelessness. During the winter months, D and her mom were relocated four times within a seven-day timeframe and given little to no notice before each move. At this time, D consistently played out themes of hiding while utilizing PlayDoh to hide small objects or furniture or books to hide toys behind. Remarkably, D could recall where she hid specific toys at a later date. The theme of hiding and forming attachment to specific toys in order to regulate herself was her way of externalizing and communicating her need for consistency and control at a time where she had very little of either outside of the therapy room.

When working with young children, especially neurodiverse children who have experienced trauma, identifying the different themes and patterns that emerge in their play provides insight into their inner emotional state and efforts to communicate with the outside

world. Utilizing information shared by their parents about their familial relationships and living situations allows clinical therapists to gain a more holistic understanding of the themes and patterns that emerge as well.

## **Reflection**

My time interning at this specific therapeutic preschool was a critical experience for me in my professional development. The internship is a required component of my graduate school program and when asked where I would like to be placed for my final year, I thought about two areas of children's development that I had not yet explored. I had not worked clinically with preschoolers and the idea of working with neurodiverse children who have also experienced trauma intimidated me. However, I believe that in order to grow and be the best professional that I can be, I need to put myself in challenging situations in order to gain perspective, resilience, and unmatched experiences. Reflecting back on my time at the placement, I am astonished that this was my first time working with children in this demographic, as it has been one of my favorite populations to work with thus far. I love the challenge and new experiences that every day brings and working through the growing pains of the therapeutic relationship with these young children. For me, it keeps the work interesting and keeps me invested in finding new approaches and interventions that will work for each child. No two sessions on my caseload were alike and that made every day exciting.

I have also reflected on multiple aspects of my work there including the benefits of the Child-Centered Play Therapy model, the uniqueness of a school setting, and my specific clinical work with the three children presented in this study. I believe it is important to discuss these

reflections and insights so that professionals working with children can gain a deeper appreciation for working within this demographic and this setting.

### ***The Benefits of CCPT in this Setting***

The Child-Centered Play Therapy model is beneficial for neurodiverse children who have experienced trauma because it gives the children a safe space to assume the role of “actors,” while the therapist acts as the “audience”. There is no other area in the child’s life where they are not given rules or standards to follow. They are free to be who they are and what they want to become in the room where the holding space is safe and the therapist is not judgemental. Within the principles of CCPT, children gain a sense of autonomy and self-confidence as they play out and express whatever themes or activities they feel compelled to do. This is why I believe that Child-Centered Play Therapy is the best approach for working with neurodiverse children who have also experienced trauma.

### ***The Setting***

The school-based setting provided me with advantages and disadvantages to my clinical work with the children and their families. A significant benefit of being in this setting allowed me to be intentional about greeting each parent during drop off and pick up times for those who forgo the bus. Taking the opportunity to have a face-to-face interaction with the parents is beneficial in order to have a continuous working relationship and aid in building a strong rapport with the families. These designated times at the beginning and end of each day provide the chance for a check in to learn about any changes going on in the child’s life, as well as, give an update on play therapy sessions and provide insights that the parents can utilize at home. It is also important to note the children’s attitude when their parents are around. Does this child get excited? Does the child become reserved or anxious? Does the child interact with their parents or

do they pay any attention to them at all? What is the child's body language while their parents are with them? All of these interactions give insight into the child's inner world and how they experience the world around them. Every additional observation adds to the development of a more holistic approach to intervention.

While I loved being in a preschool setting and appreciated the multidisciplinary team approach, I did experience some challenges. Creating clear boundaries with the students, especially at the preschool age, was often challenging. This is due to the fact that in the play therapy room, children can act and do what they need to do in order to work through their inner emotions; however, when in the classroom, there are a different set of rules and norms that the students need to follow. I found that when I was in the classroom, it became difficult to set clear expectations of my role, as I also am expected to assist the teachers in creating a safe learning environment.

Another challenge of school-based play therapy is that social workers are around the students all day, whereas in any other setting, the client only comes in for their scheduled session then leaves. The challenge is that children express a range of behaviors throughout the day and this can sometimes bring my own emotional reaction to the surface. I find that when I am in the classroom for too long, observing the students struggling to follow directions and unable to follow the teacher's rules can feel frustrating for me. Oftentimes I have to step into a classroom situation to help diffuse the challenging behaviors and can find myself growing frustrated with certain students. Then, when I am in the play therapy room with those specific students, my role shifts from helping in the classroom to the therapist in the room and I cannot let the frustrations and feelings from the classroom influence the child's therapeutic process. However, throughout this internship, I have learned to partake in daily critical self-reflection in order to remain clear



mindful and not allow personal reactions and emotions interfere with the therapeutic relationships built with each student. I have reframed the frustrations to be more productive and not look at these challenging behaviors as “misbehaviors,” but rather as “stress behaviors.” This term was coined by Stuart Shanker (2016) and it refers to viewing a child’s behavior as a reaction to stress instead of viewing the child as “misbehaving”. This outlook allowed me to feel more patient while working with the students and ask myself, *what needs are not being met for this child right now that are affecting their focus on learning?* Viewing the student’s challenges in the classroom as an opportunity to work collaboratively with the teachers to meet the student’s needs within the classroom setting is a special part of school-based play therapy.

### ***The Case Studies***

While working with J, G, and D I found myself getting in my own head during the sessions and various emotions arose while conducting the therapy. For all three students, there were many instances where I had to intentionally tell myself to take a step back and not influence their play. It is common for play therapists, or any mental health therapists for that matter, to feel the urge to want to make sense of the child’s play and their patterns. However, over the course of studying play therapy, it has become clearer to me that it is not for adults to make sense of the child’s play or to put our own interpretations on the play. The point of Child-Centered Play Therapy and play therapy, in general, is to give the child a safe space to explore and work through experiences and emotions that feel complicated to them.

There were also numerous times when the characteristics of a non-directive play therapy approach felt so simple that it was actually hard to put into action . In a world that is so fast paced, simply sitting back and letting the child direct the play is less instinctively than one might imagine. There were many sessions where I felt like I was not doing anything of substance or

importance. However, by simply being present and giving the children the space and undivided attention to play out whatever they felt compelled by is a unique and therapeutic experience. During many sessions, it took more intentionality for me to remind myself of the simplicity of the session, rather than being present with the child, especially while working with children with Autism.

Lastly, I mentioned that my sessions with J were the most challenging and this was due, in part, to my own anxiety and desire to keep things organized. At the beginning of J's sessions, I found myself anxious and overwhelmed by the mess he was creating in the play therapy room. I often felt the urge to clean up after him, especially when he transitioned to another activity. In these moments, I intentionally told myself that my urge to clean would place me in the same role as every other adult in his life who is telling him to clean up. However, the purpose of the therapist in this setting is to be *different* from any other adult in the child's life. This does not make therapist's better than anyone else, but it does make therapists unique and aides to the significance of the process and setting.

As J's sessions progressed our rapport became stronger, I had a better sense of who he was, and I gained a clearer insight into his family dynamics which made me feel more confident in my role in the therapy room. As I gained more confidence, I realized that the non-directive approach may be aiding in J's dysregulation since it mirrored his life experiences. While Child-Centered Play Therapy is a non-directive approach, I felt as though in order to assist J in feeling safe and somewhat regulated, it was important to instill boundaries during the sessions. These included, sometimes having shorter sessions, setting time limits on a certain activity, and utilizing a visual timer to give notice that the session was wrapping up. The shorter sessions allowed J to play out his inner thoughts and feelings without growing more escalated with more

free time than he showed he needed. There were many times that J would wrap up his play at the 20-minute mark and over the course of the next 10-minutes, he would initiate multiple activities by taking everything off the shelves, opening the games and toys across the floor, and did not settle into any form of play. In these moments, I felt as though J was becoming more escalated and diminishing the work he had just accomplished during the first 20 minutes of the session. During those weeks, I began ending the sessions after 20-minutes and J was able to maintain a regulated state outside of the therapy room.

While I noticed that, at times, these boundaries were helping J regulate his body, he was adamant about his disapproval of the more directive approach. He did not respond well to limits and sometimes this approach would dysregulate his behavior even more. Some sessions the limits allowed J to regulate, while other weeks it would cause him to escalate into uncontrollable behaviors. My sessions with J were trial and error and there were many times that I felt inadequate and felt as though the sessions were not therapeutic for him. However, when I would engage in critical self-reflection and reflect back on the sessions, it was clear that these sessions were very much meaningful for J. He felt comfortable with me in this space to play out and externalize some significant traumatic experiences in his life. While he may not have been able to verbalize it, J understood the uniqueness of the room based on the types of play he engaged in that were not seen in his play in the classroom or at home, based on reports from his Mom.

Overall, this experience turned out to be one of the most enlightening and enriching of my professional life thus far. Not one session among the cases presented was like another, however, creating the same safe space and engaging with the student at their own individual developmental levels kept the work challenging and exciting. For me, it is what makes the work engaging because it forces me to take a step back in the fast-paced world we live in and simply

be present, in the room, with the child in order to fully see them for who they are without wanting to change or “fix” them.

## CHAPTER SEVEN

### CONCLUSION

This paper explored many different aspects of conducting play therapy sessions with neurodiverse children who have experienced trauma. In order to understand the basics of play therapy, the first component of this paper discussed the importance of children's play across the developmental span. Children's universal language is play and they use toys in order to communicate with the world. The two leading theorists' discussed, Jean Piaget and Erik Erikson, are best known for their work in child development and the importance of play. Children's play in two developmental stages of life were discussed as they are relevant to the three children in this multiple case study.

The next component of this paper reviewed the main principles of play therapy and Child-Centered Play Therapy including the therapists and parents' respective roles, as this was the therapeutic approach that was utilized during sessions in the preschool. Next, the literature review described some key terms related to the topic and several aspects to consider while implementing play therapy in a school setting and among children with various diagnoses. Next, the methods section provided an explanation for the case study design, a description of the setting in which the case studies took place, and details of how data was collected.

The case studies were presented with an overview of the child, including their family dynamics, diagnosis, identity as a student, and their behaviors and attitudes in play therapy. Themes and patterns were discussed based on data collected over the course of four to five months. A discussion and reflection followed as a way to provide better insight into the researcher's outlook on the setting and while conducting play therapy sessions. The purpose of

this thesis is to provide a basis of understanding into the themes and patterns that arise in children's play, who have also experienced trauma and to provide a foundation of play across development and within the context of different diagnoses.

### **Further Research**

While collecting literature for this multiple case study, it is clear that there is limited research on play therapy that incorporates neurodiversity and trauma. There is ample research on Child-Centered Play Therapy with neurodiverse children, as well as, trauma; however, there is little research incorporating both. Additionally, given the significant increase in diagnoses, more research in both neurodiversity and trauma can inform early intervention practices and play therapy modalities. Further research in these areas could help support school-based programming as children are best set up for academic success when they feel regulated and emotionally supported.

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