

5-1-2015

Transcendence through Play: Child-Centered Play Therapy and Young Children with Autism

Katherine Elizabeth Carrizales

Follow this and additional works at: <http://digscholarship.unco.edu/dissertations>

Recommended Citation

Carrizales, Katherine Elizabeth, "Transcendence through Play: Child-Centered Play Therapy and Young Children with Autism" (2015). *Dissertations*. Paper 13.

This Text is brought to you for free and open access by the Student Research at Scholarship & Creative Works @ Digital UNC. It has been accepted for inclusion in Dissertations by an authorized administrator of Scholarship & Creative Works @ Digital UNC. For more information, please contact Jane.Monson@unco.edu.

© 2015

KATHERINE ELIZABETH CARRIZALES

ALL RIGHTS RESERVED

UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

TRANSCENDENCE THROUGH PLAY: CHILD-CENTERED PLAY
THERAPY AND YOUNG CHILDREN WITH AUTISM

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

Katherine Elizabeth Carrizales

College of Education and Behavioral Sciences
Department of School Psychology

May 2015

This Dissertation by: Katherine Elizabeth Carrizales

Entitled: *Transcendence Through Play: Child-Centered Play Therapy and Young Children with Autism*

has been approved as meeting the requirements for the Degree of Doctor of Philosophy in
College of Education and Behavioral Sciences in Department of School Psychology

Accepted by the Doctoral Committee

Robyn S. Hess, Ph.D., Research Advisor

John Mark Froiland, Ph.D., Committee Member

Robin D. Brewer, Ed.D., Committee Member

Tracy Gershwin Mueller, Ph.D., Faculty Representative

Date of Dissertation Defense _____

Accepted by the Graduate School

Linda L. Black, Ed.D.
Associate Provost and Dean

ABSTRACT

Carrizales, Katherine Elizabeth. *Transcendence Through Play: Child-Centered Play Therapy and Young Children with Autism*. Published Doctor of Philosophy dissertation, University of Northern Colorado, 2015.

This qualitative study was designed to explore the impact of child-centered play therapy on young children identified as having autism spectrum disorder (ASD).

Children with autism often experience difficulties in social, communication, behavioral, and relational domains. Often the treatment protocol for these children is an intense schedule of behavioral interventions designed to decrease problematic and increase desired behaviors. However, little emphasis has been placed on the child's core deficits in relational skills and even less importance has been placed on his/her adequate emotional development. The current study sought to understand the impact of participation in play therapy on emotional and relational skills in young children with ASD.

Using qualitative methods including parent interviews, participant observation, weekly parent probes, and expert check-in/supervision, the progress of three children ages six- to seven-years-old was monitored as they participated in 16 bi-weekly (twice per week) child-centered play therapy (CPPT) sessions. The play of all three participants was coded and analyzed. A mobile play therapy room stocked with toys appropriate for children with ASD was utilized for each session. Transcripts of video-recorded sessions, field notes, parent interviews, and responses to weekly parent probes that occurred

throughout the duration of the CCPT intervention were analyzed for themes. A subsequent within and cross case analysis was completed. Expert check-in and supervision occurred on a weekly basis to ensure adherence to CCPT intervention. Member checks, multiple reviews of videos, and transcribed interviews were completed by the researcher. To enhance trustworthiness, trained reviewers coded a sample of videos and transcriptions.

Results from this study suggested young children with ASD experienced positive growth in a range of areas throughout their participation in CCPT. While the progress and growth noted was varied in the degree of improvement between individuals, results indicated participants displayed improvement in the areas of social engagement, autonomy, academic participation, emotional state, and sensory/repetitive behaviors. Study results also indicated varying degrees of change with regard to play skills in all three participants; two participants advanced through the play stages while one participant displayed fewer play skill changes. For all three participants, emergence of improved skills within CCPT sessions included more natural play, increased communicative behaviors, and enhanced social engagement. These skills occurred in tandem with the reduction of self-soothing behaviors within the play room, providing support to the theory that when provided a safe, accepting environment, children with ASD can display increased motivation and ability to interact more naturally, intimately, and freely with their external world and experience a forward moving state of self-healing power.

ACKNOWLEDGEMENTS

If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth and change, and personal development will occur. (Carl Rogers, 1961)

Looking back over the course of this marathon, I am infinitely grateful for the incredible support, encouragement, and guidance I have received from numerous individuals along the way. I am most grateful to the members of my committee, Dr. Tracy Gershwin Mueller, Dr. Robin D. Brewer, and Dr. John Mark Froiland for their time, encouragement, and expertise throughout this project. Thank you also to Dr. Heather Helm for sharing your kindness and intense knowledge of CCPT as you instilled in me a passion for play therapy.

I am especially grateful for and extend a special thank you to the chair of my committee and advisor, Dr. Robyn S. Hess. Thank you for your exquisite attention to detail, your pursuit for excellence within me, your guidance and inspiration, as well as your unending patience throughout not just this project but the duration of my educational journey. This has been my greatest marathon and I am grateful for your guidance through the finish!

Thank you to Dr. Mark Hald and Dr. Anne Talbot at Options in Psychology LLC, for their support and use of their clinic for portions of this study. Dr. Hald, I am particularly grateful for your reassurance and understanding. Your expertise, guidance, and supervision throughout this study made this journey not only enlightening but most

enjoyable and sparked my excitement for future research! Thank you for taking the time to be with me and helping me grow as a therapist and professional throughout the duration of this process!

I would like to also extend my gratitude to the Graham Fund through the University of Northern Colorado for providing funds to cover the cost of the traveling play therapy kit used within this study and to Educational Service Unit #13 for their allowance of time to pursue this degree.

Finally, thank you, thank you to all of my family--Jennifer, Joey, Su, Dan, Susan, Doug, Robert, Kay, Bob, Juan, Karen and Rachel--who served as unrelenting cheerleaders throughout my education. Mom and Dad, somehow you instilled within me a sense of tenacity that kept me on course throughout this marathon. Thank you for always believing in me! To my husband, Aaron, who matched me stride for stride in the ups and downs of this marathon and who made sure to always remind me that the finish line was near, I would not have had the endurance to run this race this without you! And last but not least, to my little boy, Gavin, my most prized accomplishment, thank you for reminding me daily of life's little excitements even as this journey became overwhelming. Now that this race is finished "Let's Play!"

TABLE OF CONTENTS

CHAPTER I. INTRODUCTION.....	1
Significance of the Problem.....	5
Purpose of the Study	7
Statement of the Problem.....	9
Guiding Questions	12
Delimitations.....	12
Definition of Terms.....	14
CHAPTER II. LITERATURE REVIEW	19
What Is Play?	21
Deficient Versus Different in Play.....	23
Play and Child Development	24
Stages of Neuro-typical Play	28
Play Therapy	34
Types of Play Therapy	38
Child-Centered Play Therapy Effectiveness	45
Autism Spectrum Disorders.....	47
Children with Autism Spectrum Disorder and Play	66
Autism Spectrum Disorder and Child-Centered Play Therapy.....	71
Summary	75
CHAPTER III. RESEARCH METHODOLOGY	76
Epistemological and Theoretical Foundations.....	76
Researcher as Instrument	80
Methodology	85
Participants.....	90
Procedures.....	94
Supervision Plan	102
Data Collection	103
Data Analysis.....	111
Trustworthiness.....	113

CHAPTER IV. FINDINGS	116
Participants.....	117
Collective Themes Cross Case Analysis.....	186
Balancing the Role of Therapist/Researcher.....	205
CHAPTER V. DISCUSSION.....	207
Findings.....	207
Limitations	215
Researcher Reflections.....	217
Implications.....	220
Future Research	224
Conclusion	227
REFERENCES	229
APPENDIX A. PROPOSITIONS.....	245
APPENDIX B. INSTITUTIONAL REVIEW BOARD APPROVAL	248
APPENDIX C. RECRUITMENT FLYER.....	251
APPENDIX D. CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH.....	253
APPENDIX E. ASSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH.....	256
APPENDIX F. SUPERVISION CONTRACT	259
APPENDIX G. PLAY THERAPY SESSION SUMMARY NOTES	261
APPENDIX H. OBSERVATION FORM	265
APPENDIX I. INTERVIEW FORM.....	268

LIST OF TABLES

1.	Developmental Benefits of Play	26
2.	Stages of Play.....	33
3.	Eight Basic Principles	96
4.	Therapist Responses Used in Child-Centered Play Therapy	97
5.	Play Therapy Toys in Mobile Play Therapy Kit.....	99
6.	Timeline of Child-Centered Play Therapy Sessions	106
7.	Marley’s Therapy Progression.....	135
8.	Micah’s Therapy Progression	162
9.	Joshua’s Therapy Progression.....	186
10.	Post-Intervention Cross Case Themes	196

LIST OF FIGURES

1.	Research paradigm.....	77
2.	Convergence of evidence.....	104
3.	Social engagement with therapist	197

CHAPTER I

INTRODUCTION

Each year, a growing number of children are identified with autism spectrum disorders (ASD). In 2008, the Centers for Disease Control and Prevention (CDC; 2010) estimated that 1 in 88 children were affected by this disorder. Experts agree that early intervention results in the most successful outcomes for this population by remediating current difficulties, preventing development of future problems, and reducing the likelihood of skill regression (Koegel, Koegel, Harrower, & Carter, 1999; Lord, Luyster, Guthrie, & Pickles, 2012; Sigman, Dijamco, Gratier & Rozga, 2004). The National Autism Center (NAC; 2009), the National Research Council (NRC; Strain, Schwartz, & Barton, 2011), and most recently Wong et al. (2014) support the value of early intervention and have all released guidelines regarding the ensured quality and appropriate intensity of these interventions.

Many of the empirically supported early interventions reported within the autism literature targeted skill improvement over time and focused on antecedent-based and behavioral-based interventions. These interventions were based on the premise that either positive reinforcement or antecedent manipulation was necessary for children with ASD to change atypical behaviors and build observable, developmentally appropriate skills (Jones & Carr, 2004; Levy, Ae-Hwa, & Olive, 2006; Lovaas, 1977; Odom et al., 2003; Schilling & Schwartz, 2004; Schwartz & McBride, 2008; Stahmer, Ingersoll, &

Carter, 2003). These behavioral-based interventions were designed to target a variety of social, communication, behavioral, and academic skills under the premise that as basic skills were mastered, the level of skill difficulty could be increased.

Additionally, researchers recognized the importance of identifying and enhancing specific pivotal skills for children with ASD, noting the importance these explicit skills have to future skill development (Jones, Carr, & Feeley, 2006; Koegel & Koegel, 2006). These skills or “identified markers may, in turn, unlock other developmental domains for children with autism and may lead to broader changes in a range of abnormal behaviors associated with this condition” (Josefi & Ryan, 2004, p. 534). While the National Research Council (2001) established a broad recommendation that early intervention should incorporate treatments focused on core or pivotal skills that are socially important and functional, joint attention was specifically suggested by Mundy and Crowson (1997) as the most crucial pivotal skill in preschool age children.

Furthermore, while often the behavioral symptoms of ASD (i.e., lack of eye contact, rigidity, echolalia, stereotypy, or self-stimulation) are blatantly apparent, these are secondary symptoms to the underlying core problem areas of ASD (Ray, Stulmaker, & Lee, 2012). The more pervasive, underlying core relational problems identified by Greenspan and Wieder (2006) are skills such as establishing closeness, exchanging emotional gestures in a continuous way, and using words or symbols with emotional intent. Badenoch and Bogdan (2012) further supported the importance of addressing these core relational skills, noting that “as attachment-seeking human beings, our nervous systems preferred way of finding and maintaining safety is through connection with others”(p. 6). Ironically, the difficulty individuals with ASD experience in their

relationships to others often further contributes to their increased perception of danger and their fight or flight response by taking over their ability to connect, self-regulate, and learn new information. In essence, due to their difficulty connecting with others and thus maintaining a sense of safety, these individuals can be thought of as in a continual state of hyper arousal, leading to many of the atypical behavioral symptoms often displayed (Badenoch & Bogdan, 2012). Moreover, the difficulty individuals with ASD experience (e.g., difficulty with emotional regulation, lack of interpersonal connection) can lead to an increased vulnerability to the development of comorbid diagnoses including anxiety or depression (Attwood, 2006).

Evidence-based interventions designed to target various skill deficits associated with ASD include treatments most often stemming from the behavioral literature (e.g., applied behavioral analysis, behavioral psychology, and positive behavioral supports; NAC, 2009; Wong et al., 2014). Treatments most often reported as effective include those of antecedent-based interventions (Neitzal, 2009), behavioral interventions (including strategies of applied behavior analysis, token economies, reinforcement, shaping, and discrete trial training; Ryan, Hughes, Katsiyannis, McDaniel, & Sprinkle, 2011), joint attention interventions, modeling, naturalistic teaching, peer training, pivotal response treatment (PRT), schedules, self-management, and story-based interventions (NAC, 2009).

While the literature supporting these behaviorally based interventions is extensive, few interventions addressing the core relational skills deficits or mental health of young children with ASD have been studied (Wieder & Greenspan, 2001). Even fewer studies have specifically examined the use of child-centered play therapy (CCPT)

with children diagnosed with ASD (Josefi & Ryan, 2004; Ray et al., 2012). Yet several researchers have advocated for the addition of child-centered interventions to the treatment protocol for children with ASD (Getz, 1996; Josefi & Ryan, 2004; Mittedorf, Hendricks, & Landreth, 2001; Ray et al., 2012).

Child-centered interventions have at their crux the goal of helping children build reciprocal relationships in more authentic settings (Josefi & Ryan, 2004; Landreth, 2012; Ray, Sullivan, & Carlson, 2011). It is within these accepting relationships that children are freed to create their own course for progressing toward their full potential. Josefi and Ryan (2004) indicated that the allowance of children to guide their own healing at their own pace endorses their enhancement and initiation of various developmentally appropriate skills including specific target skills of many behavioral-based interventions (e.g., joint attention). This interpersonal interaction creates a more authentically based foundation of skills rather than the more superficial use of skills based purely on external reinforcement.

Moreover, unlike some behavioral interventions in which the effect might dissipate once the reinforcement is removed (Kohn, 1999), changes that occur throughout the course of CCPT are thought to be quite stable. The therapeutic condition of unconditional positive regard, a fundamental key to CCPT, centers on accepting children as they are and thus produces more enduring and fulfilling changes stemming from within the individual (Landreth, 2012; Ray & Bratton, 2010; VanFleet, Sywulak, & Caparosa Sniscak., 2010).

Furthermore, CCPT has been demonstrated to be effective in significantly improving children's levels of internalizing behaviors such as anxiety and depression

(Baggerly, 2004; Ray, Schottelkorb, & Tsai, 2007; Reyes & Asbrand, 2005; Tyndall-Lind, Landreth, & Giordano, 2001) as well as decreasing negative externalizing behaviors (Fall, Navelski, & Welch, 2002; Garza & Bratton, 2005). It follows that CCPT could be successful in effectively addressing the needs of commonly diagnosed comorbid mood disorders among individuals with ASD. Similarly, the core relational deficits of young children with ASD (as noted by Wieder & Greenspan, 2001) are the very areas CCPT has noted to enhance (Ray et al., 2011). Badenoch and Bogdan (2012) suggested that through relational interventions such as CCPT, which offers a space full of safety, interpersonal warmth, and resonance, children with ASD can move from a dysregulated emotional and nervous system to a more fully integrated state. The therapeutic setting of CCPT allows for co-regulation between the child and the setting (including the play therapist).

Child-centered play therapy (CPPT) has demonstrated effectiveness in addressing the key areas of need identified in early intervention efforts for children who have ASD. Thus, it would seem an ideal treatment to address the emotional, relational, and identified pivotal skills of young children with ASD. The purpose of the current study was to explore the effectiveness of CCPT in young children diagnosed with ASD.

Significance of the Problem

The swiftly skyrocketing rates of ASD have been met by an equally intense search for answers. Top medical researchers have joined the hunt for an explanation of the etiology of ASD, while those in the psychological and educational fields have sought evidence for the most effective treatments. Both groups share the common goal of

learning more about this disorder to provide enhanced outcomes for individuals of all ages who have been diagnosed with ASD.

However, the statistics surrounding ASD remain somewhat disheartening with ever growing numbers of newly diagnosed individuals and limited quality support available for these individuals and their families. While the number of individuals with ASD spans all ages, child development specialists are becoming more adept at accurately diagnosing children earlier. Accurate diagnosis can be made in children as young as one year (Lord et al., 2012), an achievement that has allowed for improved outcomes as it makes early intervention possible. Although it is believed ASD is a lifelong disorder, the effectiveness of early and intense interventions has shown to greatly reduce the number of problem symptoms, skill regression, and the occurrence of future problematic behaviors (Koegel et al., 1999; Lord et al., 2012; Sigman et al., 2004).

Diagnostic criteria for ASD include social deficits, repetitive behaviors or obsessive interests, and communication differences (American Psychiatric Association, 2013). In addition to these core symptoms of ASD, several other areas of development might be affected and could produce further behaviors and symptoms of concern (Aspy & Grossman, 2012). These areas often include sensory and motor domains, cognitive abilities, relational skills, and mental health disorders (Aspy & Grossman, 2012; Attwood, 2006).

Many early interventions have been designed to intensively target observable behaviors such as engaging in the use of language/communication systems or learning specific skills (e.g., saying hello, waving goodbye, responding to one's name, and making eye contact on request). However, the core underlying relational deficits and emotional

vulnerability from which individuals with ASD often suffer frequently appear to be overlooked. Greenspan and Wieder (2006) identified three core problems associated with ASD not easily addressed through behavioral interventions: (a) establishing closeness, (b) exchanging emotional gestures in a continuous way (e.g., engaging in emotional signaling with significant others in the form of smiles or frowns), and (c) using words or symbols with emotional intent. “When conceptualizing ASD according to these three core problems, it can be clearly observed that children who are correctly diagnosed with ASD are challenged in relationships” (Ray et al., 2012, p.166). Consequently, relational interventions such as CCPT might be an appropriate and necessary addition to the treatment protocol for individuals with ASD.

Child-centered play therapy has been shown to successfully address a variety of difficulties that might inhibit a young child’s optimal development and functioning, one of which is relational difficulty. Through understanding and acceptance of the child’s world, a CCPT therapist conveys an environment in which the child can move toward self-enhanced ways of being. The growth experienced through CCPT aids in the reduction of the child’s maladaptive ways of interacting and allows for an increase in the child’s sense of responsibility regarding his or her own behavior, ultimately leading to enhanced relationships, development, and functioning (Landreth, 2012; Ray, 2011; Ray et al., 2012).

Purpose of the Study

Child-centered play therapy (CCPT), sometimes referred to as non-directive play therapy, has been identified as a beneficial treatment for children and adolescents with a wide array of emotional, social, and behavioral difficulties (Ray & Bratton, 2010). Ray

(2011) reported that 60 years of CCPT research has provided strong evidence of its effectiveness across a range of ages, ethnicities, settings, and presenting problems. In a review of recent play therapy research, Ray and Bratton (2010) and Ray (2011) reported CCPT research studies addressing the effectiveness of CCPT with a variety of presenting problems (e.g., externalizing/disrupting behaviors, internalizing problems, self-concept/self-esteem, social behavior, sexual abuse, homelessness, identified disability/medical condition, academic achievement/intelligence and speech/language skills). Some of the areas where CCPT has been found to be effective are the very areas that have often proved to be the most difficult for young children with ASD: internalizing and externalizing behavioral problems (Fall et al., 2002; Garza & Bratton, 2005; Tyndall-Lind et al., 2001), development of empathy (Ray et al., 2012), enhanced attachment behaviors with both the therapist and parents (Josefi & Ryan, 2004), and improvement of relationships including peers and teachers (Ray et al., 2012). Furthermore, Ray et al. (2012) found that through the use of CCPT and its enhancement of empathy and emotional regulation, a child's overall level of clinical functional impairment could be reduced, leading to more optimal functioning and development.

Numerous studies have determined the effectiveness of skill acquisition in young children with ASD using behavioral-based interventions (NAC, 2009; Wong et al., 2014). However, less research has been conducted examining the experiences of young children with ASD in a play therapy setting. Studies examining outcomes for children with ASD who have received non-directive/child-centered play therapy, such as CCPT, are even more limited.

A thorough review of the published literature revealed only one study specifically examining the experience of a child with ASD participating in non-directive or child-centered play therapy. This single subject case study indicated that with increasing sessions (i.e., two per week), the child participant began to display increased autonomy and pretend play in the therapy sessions while increased empathy and independence were reported by the child's mother in the home settings. Furthermore, this study found the child demonstrated accelerated growth of key pivotal skills such as joint attention as well as in social and emotional development (Josefi & Ryan, 2004).

Because of the preliminary nature of the previous research, the current study served to further add to play therapy and ASD literature. This study might help mental health professionals be better prepared to intervene in the social/emotional health of young children with ASD and might aid parents, educators, and service providers in their understanding regarding the play stages and therapeutic benefit of play for young children with ASD. Furthermore, while behavioral interventions are effective for direct skill building, non-directive therapies might be more suited to assisting young children in developing those less tangible outcomes such as initiating social interactions and maintaining an emotional connection. This study examined the utility of CCPT as a complementary treatment option to more commonly used behaviorally driven intervention protocols.

Statement of the Problem

Early intervention has been shown to be ideal if not essential in creating an improved prognosis for young children with ASD. Those who receive early intervention services often experience a reduction in current symptomology, less skill regression, have

fewer future complications, and have an increased success in meeting future developmental milestones (Koegel & Koegel, 2006; Lord et al., 2012; Sigman et al., 2004). However, the majority of the comprehensive treatment protocols utilized for early intervention have included intensive behavioral programs designed to specifically address skills or behavior. These intensive programs (up to 40 hours per week) are created, guided, and monitored by adults (Levy et al., 2006). The child (the very individual with the most insight) has little to no input.

While in the traditional sense young children might be thought of as incapable of possessing such insight, in the realm of a humanistic or child-centered philosophy, all individuals are seen as instinctively striving toward self-growth--even children. Young children might not be explicitly cognizant of what or how their actions lead to their self-growth; however, Rogers (1961) maintained that all organisms (regardless of age) exhibit the innate tendency to continually strive toward their full potential. Landreth (2012) further emphasized that “what is most important about children can be learned only from children” (p. 45). Due to the rigid nature of many behavioral approaches, the voice of the child is often ignored. Thus, the key toward growth within these young children is perhaps overlooked or undetected as the child is pushed from the outside to make changes that might best emanate from within the individual.

The child-centered play therapist, however, is tuned in to the messages children might communicate through their play. Within the play room, the children chart their own course of treatment as the therapist listens, notices, and responds to all the child offers. This experience of being noticed, heard, and given the chance for autonomy allows a child to draw on his or her own inner resources for growth toward problem

resolutions. “The acceptance, safety, and permissiveness experienced in the playroom allow children to express the fullness of their personalities” (Landreth, 2012, p. 47). In the playroom, there is no right, wrong, good, or bad way to play. Children and their play are fully accepted without conditions. Children are allowed and encouraged to engage in genuine play that is not adult directed (i.e., what many children might consider work) but instead intrinsically motivated and self-directed.

Adding CCPT to the treatment plan for children with ASD would allow them to experience acceptance regardless of their symptomology. This unconditional acceptance would not only be a novel contrast to the otherwise intense behavioral treatment often prescribed but would also serve to provide an environment in which safety and acceptance resonates, both of which could act as a catalyst for individuals with ASD to make progress toward more fulfilling and functional behaviors. Thus, CCPT and all of its residual benefits might contribute a missing piece to the optimal development of individual growth, perhaps providing the perfect complement to the traditional treatment protocol for young children with ASD.

Using a collective case study design, the experiences of young children with ASD (and their parents) were observed and described as they participated in child-centered play therapy. Of particular interest was the observation of how children’s autonomy and initiation in the playroom and home settings, interaction/attachment with the therapist, and progression through neuro-typical developmental play stages changed over the course of CCPT. Additionally, attention was given to the type/themes of play exhibited during this process. These behaviors and patterns were compared to the child’s play across sessions. Additionally, the findings were compared to those of previous

researchers of typical social/emotional development and play behaviors as well as those of children with ASD.

Guiding Questions

- Q1 What changes do young children with autism spectrum disorders experience in their interpersonal and social interactions across 16 sessions of child-centered play therapy?
 - Q1a How does the child's level of autonomy/initiation change in the playroom and home settings over the course of play therapy sessions?
 - Q1b How does the child's social interaction with the therapist change over the course of play therapy sessions?
 - Q1c How does the child's interaction with their parents change over the course of play therapy sessions?
 - Q1d How does the child's play change over the course of play therapy sessions?

Delimitations

Because I was the main investigator and therapist delivering CCPT, my influence was present in this study. Thus, my biases, life experiences, and therapeutic assumptions were likely evident in all aspects of this study. To better structure my perspective and examine its impact on the study as well as track and explain my thought processes throughout the study, I kept field notes and analyzed this information to identify researcher biases. Additional information regarding my stance as a researcher is provided in Chapter III.

The focus of this study was to provide an in-depth examination of the experiences of young children who have been diagnosed or identified as they participate in 16 sessions of bi-weekly CCPT. This study was designed to provide a rich description of each child throughout this process. Consistent with a case study research design, the

achievement of such an in depth examination required a limitation on the number of study participants.

The study participants included young children who were identified as having an autism spectrum disorder (ASD). The Nebraska educational verification requirements for an autism spectrum disorder as identified through the schools (Rule 51 Special Education Standards) were closely aligned with the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; APA, 2013) criteria for autism. Therefore, in this study either a Nebraska state department educational verification of ASD or a clinical diagnosis of ASD was used to determine whether a child was eligible for participation in this study and were considered interchangeable. The minute differences in diagnostic criteria were not thought significant to the results of this study. Furthermore, recent changes to the DSM-V have resulted in the merging of all ASD into one classification rather than the historical identification of pervasive developmental disorders (PDD that were divided into five different types. For the purposes of this study, a diagnosis of Asperger's, autism, or pervasive developmental disorders not otherwise specified (PDD-NOS) was acceptable as it was likely those individuals who met the criteria for any of these diagnostic categories would demonstrate similar patterns of difficulty in their social exchanges and interactions. Participants with any diagnosis or educational verification of ASD were assumed to have the symptoms most often associated with ASD including social communication differences and repetitive or restricted interests.

Participation in this study was limited to children ages 3-7 of families living in Western Nebraska. Children who participated in the study received sixteen 50-minute biweekly (twice per week) CCPT sessions. Play therapy was provided in the child's

home school district. The category of toys was similar across setting and the mobile play therapy toys were arranged in a similar fashion in each room used for the play therapy sessions. The specific room utilized in each setting was chosen to ensure privacy of the child and therapy session and thus had different physical qualities. The physical makeup of the room was not thought to affect the treatment outcome of this study.

Definition of Terms

Aggression. Aggressive play that occurs between characters in play or aggressive content in the child's behavior out of roles.

Allorepresentational play. The fifth play stage in Sheridan, Foley and Radlinski's (1995) theory of play development. This stage begins around 18 months and continues to develop through age two. The play developing in this stage includes continued use and development of deferred imitation and decentration of play.

Art and drawing. When the child is drawing, painting, or writing in the play room.

Autorepresentational play. The fourth play stage in Sheridan et al.'s (1995) theory of play development. This stage begins around the child's second year and includes the child's emerging ability to engage in pretend use of objects for play.

Boundary setting. Whenever the child establishes a boundary between two people (or characters in play) including putting a physical barrier between the characters in play.

Broken play. Play when some character is broken or sick, hurt or otherwise needs to be fixed--also includes the tearing down or falling down of a house.

Burying or drowning. Objects or toys buried under the sand (if there is a sandbox) or under piles of toys or bean bags, etc.

Case study. In qualitative research, this is the study of a “bounded system,” with the focus being either the case or an issue that is illustrated by the case (or cases). A qualitative case study provides an in-depth study of this “system,” based on a diverse array of data collection materials, and the researcher situates this system or case within its larger “context” or setting (Creswell, 2007, p. 244).

Child-centered play therapy. A method of play therapy based on Rogers’s (1957) theory of personality development as applied to children. Within an unconditionally accepting and genuine relationship, all individuals have within them the capacity to make progress toward self-direction, maturity, and healing (Axline, 1974; Landreth, 2012).

Cleaning play. Play about cleaning things up.

Collective case study. This type of case study consists of several cases with the defining feature of the researcher examining several cases as part of the research study (Creswell, 2007).

Constancy play. The child wants assurance that things will remain the same as they have been, e.g., looking to see if the toys are in the same place, naming activities, checking for things from a previous session to see if still there, etc.

Collaboration or cooperation. When the child initiates or invites the therapist to join the child in solving a problem or completing a task.

Constructive play. The third play stage in Sheridan et al.’s (1995) theory of play development. This stage occurs during the second year of a child’s life. Play in this

stage consists of children using objects in the way intended and the beginning of their discovering novel compositions and elaborations of use for these objects.

Exploration. When the child is looking and checking out or asking questions about what is available or how things work within the play room.

Failed nurturance. Any time in which the nurturance activities are negative or the child or baby character is being hurt by the traditional caregiver in play.

Fixing play. Play that includes the fixing of anything that is broken through repair, doctoring, etc.

Functional-combinatory play. The second play stage in Sheridan et al.'s (1995) theory of play development. This stage occurs in the later months of the first year of an infant's life. Play in this stage consists of a baby's ability to begin to apply information about objects and discover purposeful actions with these objects.

Good guy versus bad guy. Overt designation of goodness or badness of the characters in play.

Joint attention. When one shows or engages in gaze monitoring in an attempt to direct or monitor the attention of another individual to an object or event of interest (Koegel & Koegel, 2006).

Mastery play. When the child builds something or masters a challenge within their play.

Messing play. Play that includes the child messing in the play, i.e., the smearing of paint or deliberately play outs "being messy."

Neuro-typical play. Refers to the play of typically developing children. This type of play is traditionally conceptualized as being pleasurable, voluntary, flexible, and

changing as well as an increasingly symbolic activity progressing from simple to complex, literal to abstract, and external to internal (Wolfberg, 1999).

Nurturing play. Positive nurturing activities such as one character feeding, holding, or taking care of another; it also includes fixing food for another or giving objects of value to another.

Pivotal skills. Improvement of skills in these areas result in improvement across a large number of behaviors. Joint attention is thought to be one of the most critically important pivotal skills in typically developing children as it is closely tied to theory of mind and language acquisition (Twachtman-Cullen, 2008).

Play therapy. "The systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association of Play Therapy [APT], 2015).

Sensorimotor play. The first play stage in Sheridan et al.'s (1995) theory of play development. This stage occurs in the early months of a child's first year. Play within this stage begins as actions evoking pleasure that are repeated and refined.

Separation-reunion. Whenever someone leaves or separates from someone else, e.g., a mother going shopping, and then a reunion or return from separation occurs in the child's play.

Sleeping. Whenever the play includes one character or more sleeping or preparing to go to sleep.

Sorting play. Whenever the child lines up things or sorts things into categories.

Stage mix. Mix of developmental stages in play, i.e., when a baby or child is also playing an adult role, or when the patient is then the one helping the doctor, etc.

Symbolic play. The sixth and final play stage in Sheridan et al.'s (1995) theory of play development. This stage occurs when a child's play begins to reflect deferred imitation and freedom from concrete use of objects. There are three levels of progressively more abstract abilities of play within this stage: object-centered, sociodramatic, and imaginative.

Theory of mind. The "ability to understand mental states, including beliefs, thoughts, desires, perceptions, intentions, and feelings, and to apply this understanding to predict the actions of others" (Aspy & Grossman, 2012).

CHAPTER II

LITERATURE REVIEW

Play is an activity that dates as far back as the history of mankind. It is an experience to which we are all exposed growing up regardless of our culture, race, social status, or geographical location:

The remarkable endurance of play and games across centuries, generations, cultures and countries is quite a story. Both natural and man-made playgrounds change with geography, time, and necessity. Technology, culture and interest change children's toy choices, but their games, laws, and seasons for playing them endure in modified fashion. (Frost, 2010, p. 61)

We play particular games and use certain toys as part of our cultural experience, we engage in give and take social exchanges, we adapt our play based on our environmental surroundings, and we practice social interactions as part of our play experience. Play activities are integrated into our life in such a way that play behaviors become automatic responses as if they are pre-programed into our behavioral repertoire (such as the way we are instinctually inclined to say "peek a boo" when a young toddler pops out from around the corner--we all laugh and enjoy this natural, fun exchange regardless of our age, gender or culture). Play is, in fact, such a natural part of our everyday lives that it becomes easy to overlook its value and take for granted the importance of play in children's optimal development.

Certainly in this era of accountability and emphasis on achievement, it seems much of today's general public underestimates the extensive significance genuine play

has on a child's development. True play is often devalued; goal-oriented adults view it as mere luxury, ignoring its widespread value. Within the Western world, our society is currently inundated with what seems to be endless play opportunities beginning at such an early age that many preschoolers are scheduled for "play" every day of the week. However, numerous and often overwhelming opportunities for youth to engage in scheduled, structured, "pay for play" type activities overlook the importance of spontaneous self-directed play in our children's development. Although many adults view play as synonymous with childhood, this assumption might in fact inhibit the opportunities provided for true play among young children in today's outcome-driven culture. Yet the necessity of play in a child's life is not only identified by researchers as critical for optimal development but has been declared an indisputable right of childhood. The *Declaration of the Rights of the Child* (United Nations, Human Rights Division, 1959) noted that all children should be provided the complete opportunity for play and recreation and society and public authorities should work to support children's enjoyment of this right.

The idea that true play should be thought of as more than a mere indulgence of childhood is by no means new. Throughout history, prominent researchers have discussed the importance of play in children's development. In fact, this perspective can be traced to the very beginnings of the history of psychology and was a topic of philosophical discourse during the time of ancient Greeks. Some of the world's greatest thinkers explored the meaning of play such as Plato (427-347 B.C.), Socrates (470-399 B.C.), Aristotle (384-322 B.C.), and Xenophanes (6th Century B.C.), all of whom

considered the true meaning of play in an effort to better understand human expression and thought (Frost, Worthman, & Reifel, 2012).

It was Plato who noted the importance of play in a child's acquisition of skills by specifically mentioning the significance of play in learning while simultaneously cautioning against too much adult supervision or direct interference in children's play (Hughes, 2010; Smith, 2010). Since Plato's time, many well-known researchers (Frost et al., 2012; Landreth, 2012; Panksepp, 2010; Ray, 2011) have studied play, what it entails, its crucial role in a child's development, its effect on brain development (neuroscience of play), and the benefits of play in therapeutic environments.

What Is Play?

There is a vast array of academic approaches to understanding play, its definition, and importance. Although most professionals have agreed upon the significance of play in children's development, there is less agreement on what exactly constitutes play. A variety of theories have guided what we see and what we look for when observing and thinking about the impact of play. The definition of play is not clear; on the contrary, it is unexpectedly complex and the creation of one precise definition perhaps impossible. While sifting through the vast amount of literature on the topic of play, it was quite clear that the diverse views of play were driven by a wide range of scholarly disciplines (Frost et al., 2012; Sutton-Smith, 1997).

Descriptions of play from a child developmental perspective suggested it is pleasurable, spontaneously occurring, and dictated by the child. Play, from this perspective, was thought to lead to discovery, expression, mastery of feelings, and a social negotiation among those involved. Play was also viewed as flexible, changing, and

included a nonliteral orientation (Garvey, 1977; Rubin, Fein, & Vandenberg, 1983; Sheridan et al., 1995; Smith & Vollstedt, 1985).

While researchers might deliberate over the exact definition of play, Garza, Briley, and Reifel (1985) found children were much more confident in their own explanations of what constituted play. When asked, most children agreed that play is unplanned, a choice, fun, and includes the freedom to do what one wants such as pretend at will, create, or construct. When working with children, it is clear that the single most important criterion for play is whether or not it is chosen by the child or directed by an outsider. This one factor completely changes not only the dynamic of the play but transforms the type of the activity: “One *must* work. One *can* play” (Frost et al., 2012, p. 82). Therefore, it seems that play must be perceived through the eyes of the player--its value and purpose trusted as necessary for the child and not assumed on the part of the observer.

Regardless of the exact definition, the most salient features of play appear to include intrinsic motivation (play purely for the sake of play), internal control (the child’s own determination of the “rules”), and internal reality (the child determines what is real and make believe; Hughes, 1999; Rubin et al., 1983; Sponseller, 1982; Wolfberg, 1999). It appears play is an act that cannot be dictated or directed by outsiders but must be driven from within the player. Once direction occurs, play turns from intrinsically controlled and motivated to outwardly dictated, changing the position of the activity from “can” to “must,” and thus evoking the transformation from “play” to “work.”

Deficient Versus Different in Play

If play is genuine only when dictated from within the individual, should it be classified as right or wrong, good or bad? What about those who engage in play behaviors veering from the typical play most often seen among children--play that perhaps looks unusual to the outside observer? Rubin (2012) addressed atypical play and raised the question of deficient versus different when it comes to play. The advantages of neuro-typical play are quite salient as it “frees children from physical, temporal, and spatial constraints, providing them with limitless as-if possibilities” (Rubin, 2012, p. 27). This freedom along with the child’s ability to engage in perspective taking and their ability to engage in make believe play allows them to enter into reciprocal and creative play relationships with other children. Because play allows children to “try out” different roles, to practice language, and build their social skills, this type of typical play might also be considered adaptive.

However, not all children play the same. It is well known that many children with developmental disorders and especially children with ASD have difficulty in the aforementioned areas of typical play and instead often engage in rigid, repetitive, stereotypical, unimaginative, and isolated play. Yet, should this play be considered deficient with interventions put in place to remediate these atypical play behaviors? Or as Rubin (2012) questioned, should these atypical yet intrinsically motivated and controlled play behaviors simply be considered different? Is it in some way addressing the child’s internal needs? Perhaps, like neuro-typical play, this type of play could be considered adaptive as well--just in ways outsiders might not understand.

A long history of research has examined behaviors that might be labeled “atypical” in terms of children’s play. In fact, Evans (1992) noted a wide range of play behaviors among even neuro-typical children. From these observations, he questioned the natural evolution of play, inquiring whether children are playing less or simply playing differently from their predecessors. Palmer (1986) indicated that children and their play should be viewed as naturally and continually evolving, playing differently over time. He noted that while play behaviors might look different to the observer, the play itself continued to meet children’s developmental needs, indicating that this process simply transpires in varied, creative ways of which adults are not always aware and supporting the idea that play should be seen as beneficial regardless of whether it looks typical.

Play and Child Development

Innate to childhood, play is not only internally motivated and self-satisfying by providing recreation and escape but also serves to enhance children’s development. In fact, neuroscientists have discovered that play is not only essential to brain development but is now also thought to represent a biological need (Frost et al., 2012). Play, it seems, is as important in one’s life as other basic drives such as sleep and food. Johnson (2004) suggested actual circuitry within the brain structure is dedicated to play and is similar to the circuitry of fear and love. Other researchers (Bekoff, 2001; Panksepp, 2005; Smith, 2005) indicated a positive correlation between brain growth and amount of play, supporting the long-held belief that the rate of development in children is directly related to the variety and quality of stimulation during infancy and early childhood. On the contrary, a lack of pure, internally motivated, and internally controlled play (i.e., play

deprivation) is related to developmental deficits including declines in health, fitness, and overall well-being (Frost et al., 2012). Play deprivation is also thought to contribute to the growing numbers of hyperkinetic children and thought by some researchers to possibly contribute to the overwhelming number of children diagnosed with various mental health disorders (Panksepp, 2010). “Deprivation of spontaneous, creative play, whatever the cause, may result in stunted or aberrant development, learning, and behavior, but normal, healthy play builds brains, enhances learning, and supports healthy development” (Frost et al., 2012, p. 62).

While play deprivation leads to negative outcomes, genuine self-driven play is credited as the main mode for childhood learning and optimal development. Play reinforces the growth and development of nearly every skill learned in childhood. The connection between play and development occurs in the areas of physical/sensory motor development, communicative/linguistic development, cognitive skills, academic development, social skills, and self/emotional development (Frost et al., 2012; Wolfberg, 2003). Several of the developmental benefits of play are outlined in Table 1.

Table 1

Developmental Benefits of Play

Developmental Domain	Developmental Skill Acquisition
Physical/Sensory Motor	Fine and gross motor skills, Sensory regulation, Body/spatial awareness
Cognitive	Vocabulary, rules of conversations, language structure, metalinguistic awareness
Academic	Spatial skill, categorical relationships, problem solving, mental planning, thought organization, cause and effect, memory, abstract and flexibly thought process
Social	Interest in stories, knowledge of story structure and comprehension, separation and understanding of fantasy versus reality
Emotional	Turn taking, boundaries, teamwork, competition, perspective taking, exploration of various social roles, and issues intimacy, trust, negotiation, friendship, verbal and nonverbal communication, unwritten social rules Emotional regulation, expression of thoughts and feelings, working through social, emotional or peer conflicts, control aggressive behavior, respect others feelings, charitable traits kindness

Several contemporary theories have helped to explain the benefits of play across various developmental domains (Frost et al., 2012; Sheridan et al., 1995).

Communication, cognitive, social, and psychodynamic theories provide us with varying ways for understanding and viewing play. Through these different perspectives, we are able to better appreciate the work of and importance of play in children's development (Frost et al., 2012).

The communication theory of play was fueled by the work of Bateson (as cited in Frost et al., 2012) from the mid-1950s. This theory viewed play as an important component for increasing children's developing communication skills by viewing play as a method to enhance communication. When viewing play from this perspective, it is thought that children are able to experience and practice numerous essential communication skills through various common interactions of typical play. Specifically, these activities include those of establishing communicative signal systems, discovering methods to indicate frames of reference for play scenarios, and enhancing social communication knowledge through the need to flexibly move in and out of various play roles (Frost et al., 2012).

Cognitive theories of play were influenced by the work of Vygotsky and Piaget (as cited in Frost et al., 2012) from the late 1970s who suggested that play is key in the role of mental development. Vygotsky described play behaviors as the expression of progressive developmental stages while Piaget described play experiences as a means from which mental schemes are constructed (Frost et al., 2012; Sheridan et al., 1995). Piaget (as cited in Frost et al., 2012) viewed cognitive development as a progressive reorganization of mental processes resulting from the combination of biological maturation and environmental experience. Piaget proposed that children construct a basic understanding of the world around them and then experience various discrepancies between what they already know and what they discover/experience within their environment. The main vehicle for these experiences is through play and the interaction of their play behaviors with the world around them (Frost et al., 2012). Similarly, Vygotsky (as cited in Frost et al., 2012) viewed children's cognitive development as

stemming from their interactions with their environments but he further emphasized the role of social relationships within this experience (Frost et al., 2012).

When viewed through a predominantly social lens, Mildred Parten's studies (as cited in Frost et al., 2012) in the early 1930s regarding peer play made significant contributions to our understanding of the role of play in social development. From her perspective, play was seen as an innate process for generating social structure or social meaning within a peer culture. Today, play is viewed as a means through which children are exposed to unwritten social rules, allowed to try on various social roles, and provided the opportunity to engage in peer negotiation (Frost et al., 2012).

Regardless of the theory of development, a child's attainment of developmental skills follows a progression of increasing complexity and is typically seen as taking place in a certain order. While it is not always a clear cut step-by-step progress toward skill acquisition, the general pattern of progression remains similar across individuals. Similarly, it makes sense that children's play behaviors also progress through a consistent pattern of stages with increasing complexity at each step.

Stages of Neuro-typical Play

Sheridan et al. (1995) outlined a progression of neuro-typical play stages that served as a very basic framework from which to view the increasing complexity of children's play skills and development. This model of play development incorporated Bergen's work from the 1980s regarding the essential themes of play and allowed for the definition of prominent changes in play behaviors over the course of a child's development.

The general progression of play skills and development as proposed by Sheridan et al. (1995) progresses from sensorimotor play to functional-combinatory, constructive, auto representational, allorepresentation, symbolic, object-centered, sociodramatic, and, finally, imaginative play. Each of these stages is not isolated but instead overlaps significantly with one another. Viewing play through this developmental framework allows practitioners to predict the types of behaviors that will emerge during play, to create a context that helps children move to the next level of play, and to choose appropriate toys to facilitate this progression.

Sensorimotor

The sensorimotor stage of play occurs during the first few months of a child's life. Most of the play during this stage is reflex mediated and not differentiated from infants' feeding responses and reactions to physical care. "This protoplay begins as pleasure experiences through sensory activation of the whole body and then, more specifically, the mouth" (Sheridan et al., 1995, p. 3). During this stage, play becomes progressively more cultivated and planned around simple visual-sensory-motor manipulations (e.g., reaching, touching, tasting, banging, etc.), allowing children to explore not only the quality of the objects they manipulate but also discover the actions and capabilities of their own bodies (Sheridan et al., 1995).

Functional-Combinatory

Functional-combinatory play is the second stage of play within this model. This stage of play typically occurs in the latter part of the child's first year. This play is thought to be initially accidental and becomes intentionally more repetitive, ultimately leading to an infant's emerging ability to anticipate the cause and effect properties of

his/her actions. With the progressing ability of infants to connect the information learned through these actions to their outcomes, they become increasingly more purposeful in their actions. Eventually they begin to apply this knowledge of cause and effect to novel situations and thus begin to purposefully use objects in the ways intended (e.g., pushing a toy car versus putting it in their mouth; Sheridan et al., 1995).

Constructive

Throughout the constructive play stage, typically occurring during the child's second year of life, the child has begun to more consistently use objects in the way intended. Furthermore, with trial and error experiences, children within this stage begin to discover novel elaborations and new possibilities of use with objects. This type of play (such as building towers of various heights or hosting an imaginary tea party with the use of unrelated materials as the tea set) facilitates development of an emerging ability to discriminate, categorize, and recognize shared and unique attributes of various objects. These activities aid in the development of children's inner schemes and expanding knowledge base (Sheridan et al., 1995).

Autorepresentational

Autorepresentational play is the fourth stage of play in this theory and is also thought to emerge during the second year of a child's life. This type of play includes play activities of pretend use of various objects and toys on oneself (e.g., washing one's own face with a wooden block used as a bar of soap and a washcloth). Deferred imitation, the utilization of an object in a way previously observed by the child (e.g., a child's pretend use of a phone), is also thought to emerge during this stage. While it is believed that within this stage have the emerging ability to engage in mental

representations of objects, they are still somewhat tied to the one-to-one correspondence of the physical object (Sheridan et al., 1995).

Allorepresentational

Allorepresentational play also includes deferred imitation to re-create observed scenes; yet within this stage, these actions are carried out in novel settings and directed toward new individuals or objects. The shift in focus from autorepresentational to allorepresentational (self to others) begins around 18 months and becomes more developed within the second year of a child's life. In subsequent years, a child's play becomes gradually de-centered and increasingly directed toward others. Furthermore, play behaviors become progressively more integrated and connected as they begin to form schemes, themes, and scripts (Sheridan et al., 1995).

Symbolic Play

Symbolic play is the final and most advanced stage of play within the Sheridan et al. (1995) model of play development. This stage typically occurs after age two and follows a child's progression through prior play stages. A child's play is described as symbolic when it begins to encompass deferred imitation and incorporates the use of objects in ways not limited solely to their concrete use. This evolution of symbolic play tends to follow a hierarchy of abstraction--the first step begins with the child's ability to engage in object substitution such as pretending a block is a boat. This progression then evolves into sociodramatic play in which the child expands on ideas and actions on a personal level. The final level within symbolic play is that of imaginative play. This type of play consists of children using play to create ideas beyond their personal level of experience either through the themes of their play or their use toys/objects in ways that

differ from their conventional use. This type of play reflects children's creativity and liberation from conformity of object use. It is at this stage of play that children experience the "ongoing opportunity for creative transformation and problem solving through an evolving capacity for divergent thinking" (Sheridan et al., 1995, p. 4). A summary of this theory of play progression and the types of play represented at each developmental level are presented in Table 2.

The connection between development and children's play is quite clear as each stage of play corresponds with the development of various cognitive, social, and linguistic skills. It appears play is clearly a necessary vehicle for the ideal progression of nearly all aspects of childhood development and skills. Correspondingly, the innate capacity for children to engage in and the natural benefits of play suggest it might be the most natural modality to utilize when addressing children's problems.

Table 2

Stages of Play

Play Stage	Behaviors Observed	Development of Skills Related to Play Stages	Social Complexity
Sensorimotor	Reaching, touching, tasting, swiping, grasping inspecting, banging, dropping	Recognize qualities of objects, assimilate sensory information, regulate tension, discover the setting and action properties of the body	Solitary
Functional-Combinatory	Pushing a car, bouncing a ball	Purposeful use of objects, use of objects in the way intended (emerging)	Interactive (synchronous and reflective)
Constructive	Building towers to various heights, fabricating tea time from various materials	Expand knowledge of different types of relations among objects Construct/revise: inner cognitive maps, working models of the world Increased problem solving	Interactive (synchronous and reflective)
Autorepresentational	Conventional use of object (e.g., bottle to feed baby doll) Deferred imitation (e.g. talking on a toy phone) Naming Labeling	Deferred imitation Mimicry Naming and Labeling	Onlooker
Allorepresentational	Feeding the doll with a toy cup and spoon Play increasingly directed to others (decentration)	Shift of focus from self to others (decentration)	Parallel
Symbolic	Pretend play Expanding actions based on personal experience Creating/combining ideas beyond personal experience	Preliminary expressive imagination and creativity Symbolic play (allows for ongoing creative transformation and problem solving) Evolving capacity for divergent thinking	Associative

Note. Adapted from Sheridan et al. (1995).

The psychodynamic framework views play as serving an important developmental role in resolving past conflicts that might compel an individual to act in certain ways. This framework also views play as serving a therapeutic role as it creates a safe context where one can obtain what is desired in the world of make believe. Through this lens, play is seen as an avenue for children to take charge of their difficulties and find individual routes for healing and mastery. This view of play was greatly influenced by the work Axline and Erickson published in the late 1960s (cited in Frost et al., 2012) and built upon the earlier writings of Freud. In fact, the first published report of the therapeutic use of play was traced back to the work of Sigmund Freud in 1909 in which he described the case of “Little Hans,” a young boy with a phobia (Kottman, 2001). Although Freud did not work directly with this child, he attributed the child’s difficulty to emotional causes and advised the boy’s father about how to respond to the boy based on the child’s play (Kottman, 2001; Landreth, 2012). Freud believed that play served as a repetition of unconscious concerns and conflicts (Kottman, 2001). From this framework, the field of play therapy emerged.

Play Therapy

Because play is such an integral part of children’s lives, it is considered a natural modality for working with those struggling with a variety of difficulties. The use of play in a therapeutic setting (play therapy) is a commonly used intervention for young children (Ray, 2011). The Association of Play Therapy (APT, 2015) defines play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (para. 4). The

long history of play used within therapeutic settings dating as far back as 45 years has prompted extensive research examining the effectiveness of this modality.

Two meta-analytic reviews of play therapy research have revealed the effectiveness of play therapy (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001). The first meta-analysis to focus exclusively on play therapy was carried out by LeBlanc and Ritchie (2001). This meta-analysis included 42 play therapy studies and revealed a moderate effective size ($SD = .66$). This finding indicated positive results for those who received play therapy versus those who did not.

More recently, Bratton et al. (2005) conducted a meta-analysis of play therapy outcomes using a larger number of studies and reported a large treatment effect size ($SD = .80$ above those who did not receive play therapy). This meta-analysis included 93 studies spanning the years of 1942 to 2000. The results revealed moderate to large treatment effects for internalizing ($SD = .81$), externalizing ($SD = .72$), and combined problem types ($SD = .93$). Moreover, play therapy treatment effects within the moderate to large range were also noted in the areas of self-concept, social adjustment, personality, anxiety, adaptive functioning, and family functioning. With regard to play therapy approaches utilized, humanistic play therapy interventions (defined as child-centered and nondirective play therapy) revealed an effect size falling within the large effect category ($SD = .92$). However, non-humanistic play therapy approaches were still found to be effective and reported to fall within the moderate category ($SD = .71$).

Ray and Bratton (2010) examined more recent research in play therapy in their review of 25 play therapy studies spanning the years of 2000 to 2009. Results from this review reported positive outcomes of play therapy with a wide range of mental health

issues including social maladjustment, withdrawn behavior, conduct disorder or aggression, maladaptive school behavior, emotional maladjustment, anxiety, fear, autism and schizophrenia, multiculturalism, self-concept, intelligence, reading, physical or learning disability, speech or language problems, sexual abuse and domestic violence, depression, post-traumatic stress, ADHD and locus of control, divorce, and alcohol or drug abuse. While earlier play therapy studies largely reported on single cases or a small number of individuals, this most recent effort to evaluate the effectiveness of play therapy included more diverse methodology. For example, of the 25 studies reviewed by Ray and Bratton, 13 met pre-determined criteria as experimental, 4 as quasi-experimental, and 8 as evidentiary.

Ray and Bratton (2010) found that play therapy resulted in statistically significant improvements in reducing a number of problematic presenting problems in all but one of the 25 studies. Ten studies focusing on the effectiveness of play therapy in reducing externalizing and disruptive behavior showed significant, positive results in the reduction of these problems in students from ages of 2 to 17 years. Child-parent and child-teacher relationship stress was the second most frequently researched problem area. Studies examining this area resulted in significantly reduced levels of relationship stress through the child's participation in play therapy. This stress reduction was exhibited in six studies (five utilized CCPT and one Gestalt play therapy), which also demonstrated a statistically significant improvement in the total behavior problems exhibited by the child (Dougherty & Ray, 2007; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Ray, 2007, 2008; Ray, Henson, Schottelkorb, Brown, & Muro, 2008).

Internalizing problems, anxiety, sexual abuse, and trauma were addressed in five separate studies. The findings of each study indicated significant improvement in participants' functioning including reduction of levels of anxiety/withdrawal (Baggerly, 2004; Ray et al., 2007; Reyes & Asbrand, 2005), significant improvement in self-concept, reduction in negative self-esteem (Baggerly, 2004), and lower levels of post-traumatic stress (Reyes & Asbrand, 2005).

Although other areas of concern included limited studies, Ray and Bratton's (2010) review suggested that individuals with speech impairments who participated in CCPT treatment demonstrated increased receptive and expressive language skills (Danger & Landreth, 2005). Individuals identified as requiring special education services who participated in CCPT were subsequently rated by their teachers as having significantly reduced social problems (Fall et al., 2002) and children diagnosed with insulin-dependent diabetes who participated in play therapy experienced statistically significant increases in their adaptation to diabetes over the control group (Jones & Landreth, 2002). Furthermore, in their study with children who had ADHD, Ray et al. (2007) found that children who participated in play therapy sessions experienced significant improvement in the areas of emotional ability and anxiety/withdrawal. The effectiveness of play therapy sessions was noteworthy as all research studies (aside from sexual abuse, which provided mixed results in two studies) reported positive effects of play therapy (Ray & Bratton, 2010). Of these studies, CCPT treatment proved the most often utilized method of intervention as 18 of the 25 studies identified CCPT as the therapeutic approach (Ray & Bratton, 2010).

Types of Play Therapy

Numerous play therapy methods are available, many of which have been derived from theoretical approaches originally used to understand and work with adults.

VanFleet et al. (2010) suggested that most types of play therapy fall into three main categories: directive or structured play therapy, nondirective play therapy, and family play therapy. While family play therapy including filial therapy and theraplay is an important, effective modality, a detailed description was beyond the scope of this study.

Directed Models of Play Therapy

Directive play therapy consists of the therapist leading the child in the session while providing structure, direction, and interpretation of the child's play. Within the framework of directive play therapy, the therapist determines the focus and goal of the therapy and operates from the belief that children are capable of resolving problems through catharsis when provided the appropriate setting and toys (Kottman, 2001; Landreth, 2012; Ray, 2011; VanFleet et al., 2010). Various types of expressive play-based therapy was also thought by some to fall into the directive play therapy category (e.g., storytelling, music therapy, art therapy, role playing, bibliotherapy, and other modalities that include playful interaction; VanFleet et al., 2010). Of those various models and approaches, cognitive-behavioral play therapy was the most widely known directive play therapy.

Cognitive behavioral play therapy (CBT), which is directed, structured, and goal-oriented (Knell, 1998; Kottman, 2001; VanFleet et al., 2010), is based on the cognitive theory originally developed for use with adults. Knell (1998) adapted traditional CBT and incorporated it into a play therapy setting for children. This approach to play therapy

utilized behavioral techniques and cognitive strategies embedded in play approaches to help children learn about themselves, their relationships, and their environment.

Cognitive behavioral play therapy employs playroom toys and the child's play to directly change the thoughts and behaviors of children. Through this use of play, cognitive change is communicated indirectly and more adaptive behaviors can be introduced to the child (Knell, 1998). In this approach, the play therapist directs the play either directly by structuring the activities or in a slightly more indirect way by selecting the goals for therapy and the types of toys or activities to be used to meet those goals. While cognitive behavioral play therapy has demonstrated effectiveness for certain presenting concerns, by far the most commonly used therapeutic modalities used within play therapy are those that align with nondirective approaches.

Nondirective Play Therapy

Nondirective play therapy was built on the work of Carl Rogers (1951) who was the founder of a client-centered/person-centered counseling approach. A former student and colleague of Rogers, Virginia Axline (1974), applied Rogers's principles to her work with children by integrating the person-centered approach into the most developmentally appropriate and natural communication style of children--play (Landreth, 2012).

VanFleet et al. (2010) noted that several types of play therapy fell close to the nondirective end of the play therapy continuum. These approaches included Gestalt, Jungian, and Adlerian play therapy but as noted, CCPT was the most widely utilized, researched, and well known nondirective play therapy approach. Because therapists who endorse a CCPT approach might sometimes incorporate strategies from these other nondirective models, a brief discussion of each is provided.

Gestalt play therapy. Gestalt play therapy was founded by Violet Oaklander in the late 1970s based her work with children on the principles of Gestalt psychology as introduced by Fritz Perls. Gestalt play therapy includes both directive and nondirective approaches to working with children. Techniques aligned with this method are typically directed toward helping children get in touch with their feelings and experiences in the “here and now.” The therapist at times guides the child and, at other times, allows the child to take the lead in therapy sessions (Kottman, 2001; VanFleet et al., 2010).

Unlike CCPT, Gestalt therapists do not utilize play therapy techniques such as reflecting feeling, restating content, or tracking. Instead, each session is structured to have predetermined goals and plans for guiding the session. Often the therapist preselects play and art materials and specifically designs activities to provide children with specific experiences. However, the Gestalt therapist, even with his/her predetermined structure, should have no expectation of the child or his/her behaviors and allow the child to determine the pace of the session (Kottman, 2001).

Jungian play therapy. Jungian play therapy is based on Jungian principles of counseling where the emphasis is on identifying broad themes. Within play therapy, this approach has been adapted to children’s needs by utilizing miniatures and sand trays to evoke these themes. The goal of these efforts is to work toward understanding the child’s collective unconscious through the use of these materials (Kottman, 2001; VanFleet et al., 2010). Some therapists who use this approach emphasize the child’s verbalizations while others look for patterns and themes in the chosen play activities as a window to the child’s worldview. In addition, some Jungian therapists have expanded their use of techniques to include art to help children further explore their ego, self, and collective

unconscious. These methods, combined with the nondirective relationship between the child and the therapist, are thought to prove the necessary combination of safety and security to allow the child to progress along the path of healing (Kottman, 2001).

Adlerian play therapy. Adlerian play therapy is based on the principles of individual psychology by integrating nondirective and directive interactions with clients. In this modality, the therapist not only works with the child but also with the adults within that child's life to help them learn more effective ways of interacting with the child (Kottman, 2001). Adlerian play therapists employ their therapy based on the belief that all people are unique and creative and born with an innate capacity to connect with others. However, Adlerian therapists believe that individuals must learn and be guided in how to make social connections (Kottman, 2001). The therapist's role within Adlerian play therapy changes with regard to the phase of counseling.

The first phase of counseling is marked by the therapist's nondirective demeanor and positive encouragement of the client's progress toward self-confidence. The second phase includes the therapist's use of more directive techniques and interventions while the third phase includes the therapist again taking the role of a partner through the use of nondirective and supportive techniques. The final phase of Adlerian is marked by the therapist providing training and experience in assertiveness skills, social skills, or other useful strategies for coping with problems outside of the therapeutic setting (Kottman, 2001).

Each of these therapeutic models represents a distinct approach that aligns with a nondirective orientation. Over time, many therapists have integrated techniques from these different models into their work, often employing them in tandem with their

endorsement of and basic foundational use of CCPT. For example, many playrooms are set up to include a sand tray or table and multiple small figures (consistent with a Jungian approach). Most therapists see the value in collaborating with parents and, at times, help them change certain patterns of behavior in their interactions with their child (as might be expected from an Adlerian perspective). Despite this commonly applied integration of theories, CCPT in its purest form stands alone as a unique and effective model of treatment for addressing the needs of children.

Child-centered play therapy. Child-centered play therapy was first described by Virginia Axline (1974) and continues to remain one of the most widely used child interventions and features some of the strongest research support (Landreth, 2012; Ray et al., 2012). Child-centered play therapy is built on the three central constructs of Rogers's (1951) person-centered theory: (a) the person--the child; (b) the phenomenal field--everything the child experiences, consciously or subconsciously; and (c) the self--the child exists in a continually changing world of experiences of which he or she is the center. Based on this idea, the child's behavior is consistent with the child's concept of self. "A child whose parents react to him as stupid and incapable comes to view himself as stupid and incapable. How can a child feel capable if no one responds to her as capable?" (Landreth, 2012, p. 58). The child-centered perspective views children as growing and changing based on their phenomenological field (Landreth, 2012). Thus, it is necessary to view a children's experience within this phenomenological field as their true reality regardless of actual (factual) reality.

Building on the work of Virginia Axline (1974), Guerney (2001) and Landreth (2002) continued the development of this nondirective approach, now referred to as

CCPT. This method of play therapy highlights the client-centered therapist's conditions of unconditional positive regard, empathic understanding, and congruence (Landreth, 2012; Ray, 2011). The relationship between the therapist and child is considered to be the main vehicle for children's progress toward healing and facing challenges. Child-centered play therapy incorporates the use of a playroom with specifically selected, developmentally appropriate toys that allow children to use their play as the main method of communication. The premise of CCPT is the full potential of a child is unlocked and becomes accessible to the child through a therapist's warmth, understanding, and unconditional acceptance of the child and the child's world.

As noted, the theoretical rationale for CCPT is centered on the philosophy and principles of Carl Rogers's (1951) person-centered theory from the mid-1940s. Rogers introduced 19 propositions (see Appendix A) that served as a framework from which to view human development as well as providing a premise for the human response to life problems and how progress toward resolution could occur (Landreth, 2012; Ray, 2011). By incorporating these propositions into one's child-centered practice, therapists are able to provide consistency in their approach with children and enhance their sensitivity to the child's inner world of experiences (Landreth, 2012; Ray, 2011).

The essential concept for growth and change is that personality development lies in the phenomenological experience of the organism. The propositions emphasize that persons are the center of their own perceived phenomenological field... One eventually comes to evaluate self-worth based on the perceived expectations and acceptance of others (termed condition of worth). Conditions of worth eventually integrate into the developing self, so that subsequent experiences represent individuals' internalized representation of how they are valued. Thus, peoples valuing process may or may not contribute to optimal growth based on how internalized representations of being valued relate to the self-construct. (Ray et al., 2011, p. 161)

The CCPT therapist makes no effort to change or control the child and maintains the foundational belief that children are equipped with an innate capacity to resolve the problems they are experiencing, increase their self-mastery, and naturally gravitate toward complete self-realization (Landreth, 2002). The relationship between the therapist and the child, key for healing within this intervention, is based on 10 basic tenants about children. These 10 basic tenants serve as a context for the therapist to utilize in constructing an experiential, self-projecting attitude about children (Landreth, 2012). These tenants emphasize the necessity of the therapist in recognizing and respecting the uniqueness of children, their natural language of play, their resiliency, their ability to innately progress toward positive growth and healing, and their right to guide and dictate the timelines of this process.

Child-centered play therapists understand that it is not the skill set utilized but the person behind the skills, the nondirective attitude, and the practitioner's way of thinking about and accepting of individuals that promotes the client's self-sufficiency (Landreth, 2012). By not assuming responsibility but by believing that clients can and should take responsibility for their own direction or goals, the therapist permits each to progress in his/her own unique way toward individual self-fulfillment (Landreth, 2012; Ray, 2011). Through this genuine, warm, and empathic climate, the child will come to rely on his or her own resources for self-growth. The therapist's ability to convey his/her consistent acceptance of the child and believe that all individuals have within themselves everything they need to change serves to liberate children from meeting others' demands for external change. Instead, they allow children to accept responsibility and discover their own

strengths. As a result, CCPT culminates in children experiencing more fulfilling and enduring internal change (Landreth, 2002).

Child-Centered Play Therapy Effectiveness

Unconditional acceptance of the child, meeting the child at his or her developmental level, and allowing the child to communicate through the most developmentally appropriate mode makes this intervention an appropriate choice for use with all children regardless of their developmental level. Even very young children, those who have less developed verbal skills, and children with a variety of disabilities can benefit from this approach. A growing body of empirical evidence suggests that CCPT is effective for the resolution of a number of mental health difficulties, presenting problems, as well as for enhancing overall child functioning.

Most notably, several studies have shown CCPT to lead to significant improvement in both internalizing and externalizing behaviors. With regard to internalizing behaviors, the areas of self-concept and self-esteem were found to significantly improve, while symptoms of depression, withdrawal, and anxiety were reduced among children who participated in CCPT (Baggerly, 2004; Ray et al., 2007; Reyes & Asbrand, 2005; Tyndall-Lind et al., 2001). Garza and Bratton (2005) found similar results in their study of children receiving CCPT once per week for five weeks. These participants displayed statistically significant reductions in externalizing problems and moderate improvement in internalizing behavior as reported by their parents. Furthermore, Fall et al. (2002) found CCPT to be effective in reducing social problems in the school setting in their study of CCPT with 66 children in special education.

While many specific areas of difficulty and specific problematic behaviors have been shown to improve with the facilitation of CCPT (i.e., internalizing, externalizing, social, and academic behaviors), it is also noted to be effective in the improvement of children's overall optimal functioning. Ray et al. (2012) conducted a study to explore whether CCPT had a positive impact as an intervention for broad-based functional impairment. The researchers wanted to determine whether CCPT affected children's ability to perform at developmentally expected levels and reduce difficulties they experienced in daily life activities such as lack of adaptive emotional, psychological, social, or academic skills. Results from this study indicated that children identified as having severe functional impairment displayed significant improvement. Specifically, significant improvement was identified in peer relationships and classroom problems while large effect sizes were found for all subscales (i.e., overall impairment, peer relationships, teacher relationship, academic progress, classroom problems) except in the area of self-esteem in which a medium effect size was noted.

This study provided further support for the use of CCPT and confirmed earlier work supporting the effectiveness of this approach in addressing a number of specific developmental and emotional problems. Based on their findings, Ray et al. (2012) concluded that because CCPT was so comprehensive, it should be viewed as more beneficial than simply an intervention to address specific areas of difficulty, indicating the potentially more global positive effects of CCPT were based on its core methods, which closely align with the overarching constructs of functional skills such as empathy and self-regulation (a lack of which have been previously noted as indicative of clinical impairment; Ray et al., 2012).

The effectiveness of CCPT and the power of typical play in the remediation of specific conditions as well as overall child impairment is clear. However, not all children play the same and often children with disabilities display great difficulty engaging in typical play behavior, particularly children with ASD. Children with ASD often display play characterized by a lack of spontaneity and imagination as well as certain social, emotional, and cognitive differences that result in their play looking quite different from their neuro-typical peers. Therefore, the question can be raised: Does this lack of typical play affect the therapeutic benefits of play or can these young children still benefit from therapeutic play-based approaches? In other words, can their atypical play still serve as a vehicle to meet their own unique social, emotional, and developmental needs through the use of play therapy?

Autism Spectrum Disorders

Autism spectrum disorders (ASD) are characterized by an individual's severe impairment in reciprocal social communication skills and a restricted range of activities and interests (APA, 2013). This neuro-developmental disorder was first described in 1943 by Leo Kanner (APA, 2013). Previously, autism spectrum disorders consisted of five subgroups (autism, disorder, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified, and Asperger's syndrome) that were thought to vary in the severity and intensity of the symptoms associated with ASD. However, the newest DSM-V (APA, 2013) has grouped these disorders together under one term: autism spectrum disorder.

The current DSM-V (APA, 2013) diagnostic classification of ASD consists of two primary diagnostic indicators: difficulty in social communication and restricted or

repetitive behaviors and interests. These features are considered to be present regardless of the individual's level of functioning; however, symptoms may fall along a continuum of severity and often appear quite different based on individual characteristics.

Additionally, within the autism spectrum, children often exhibit different combinations of specific behaviors ranging from mild to severe (Wolfberg, 2003). Some of the more commonly reported areas of difficulty include social interaction, communication, imagination, repetitive behaviors, sensory differences, and theory of mind (Wolfberg, 2003).

Identified Areas of Difficulty in Autism Spectrum Disorder

Social differences. Perhaps one of the most prevalent misunderstandings of the general public is individuals with ASD do not want to interact, socialize, or do not desire to engage in interpersonal connection with others (Aspy & Grossman, 2012). On the contrary, individuals with ASD often not only express a desire to connect and have friends but experience enhanced outcomes when provided opportunities for interpersonal connections (Badenoch & Bogdan, 2012). However, children with ASD often experience great deficiencies with regard to their social and relational skills. Greenspan and Wieder (2006) argued that these relational skills are in fact the root cause of more obvious behavioral symptoms (though it is the skill deficiencies and inappropriate behaviors that often receive more attention and interventions). Children with ASD were reported by Greenspan and Wieder (2006) to have specific difficulty in the areas of establishing closeness, exchanging emotional gestures in a continuous way, and using words or symbols with emotional intent. These three areas of difficulty are noted to be core

deficits--the source from which most other symptomatic behaviors stem (Greenspan & Wieder, 2006).

Specifically, very young children with ASD often display difficulty in nonverbal initiation such as protodeclarative pointing (i.e., the use of their index finger to indicate an object of interest to another person) and joint attention (when one engages in gaze monitoring in an attempt to direct or monitor the attention of another individual to an object or event of interest; Koegel & Koegel, 2006). Young children with ASD also have lower levels of prelinguistic initiation (less use of babbling for communicative intent or social initiation) and display difficulty with initiation of attention seeking (often showing fewer or no attempts to attract attention to themselves through initiation such as showing, giving, or pointing than their neuro-typical peers). Furthermore, young children with ASD often do not initiate eye contact, do not respond to their name, and do not engage in the imitation of others. All of these behaviors can be interpreted as a child's lack of interest in reciprocal communication as well as novel social situations (Koegel, Vernon, Koegel, Koegel, & Paullin, 2012).

Older children with ASD might experience difficulty understanding unwritten social codes and experience discomfort in social settings, which often proves a barrier to forming relationships.

While other children learn through experience that certain behaviors are “gross” or “babyish” by their peers, children with ASD may miss these lessons and persist in behaviors such as picking their noses, carrying cartoon lunch boxes, or wanting to sit on their teachers' laps beyond an age where such behaviors are typical. (Aspy & Grossman, 2012, p. 13)

Thus, individuals with ASD are at risk of not only experiencing difficulty making connections with family and friends but might often be targets for bullying or teasing, thereby increasing their emotional vulnerability.

Social differences experienced by children with ASD present distinct variations in their development of play. Older children might have limited play partners due to their lack of social understanding and rigidity with regard to the types of play in which they choose to engage. As previously noted, young children with ASD often have fundamental deficits in the area of joint attention. This delayed skill often leads to increased difficulty in the areas of language and social interactions, both of which affect their ability to optimally engage in shared play (Charman et al., 1997). These young children also often have difficulty in the areas of spontaneous imitation and emotional responsiveness; these impact their ability to engage in reciprocal interactions with peers and adults (Wolfberg, 2003) and result in isolated play and, consequently, fewer opportunities to experience interpersonal connection.

Communication differences. Individuals with ASD often have limited ability to understand nonverbal cues and experience deficits in their understanding of social language. Furthermore, many young children with ASD have delayed or no spoken language development and no attempts to compensate through alternative modes of communication such as gestures (Wolfberg, 2003). In addition, individuals with ASD often use idiosyncratic and repetitive language patterns, further contributing to their difficulty engaging in and sustaining conversations with others (Wolfberg, 2003). These communication difficulties can result in extreme difficulty for children with ASD when navigating their social world and often lead to their preference in avoiding social

interactions or to their non-acceptance among peers (Aspy & Grossman, 2012). These communication difficulties can also lead to continued hindrance of developmentally appropriate play and relational skills (Wolfberg, 2003).

Imagination. Often young children with ASD lack varied or spontaneous play behaviors. Due to their difficulty with reciprocal communication skills such as imitation, these children also experience difficulty in socially imitative play appropriate to their developmental level. Furthermore, many children with ASD have very black and white thinking and are not able to move from their literal thinking to the more abstract skills needed for make-believe play (Wolfberg, 2003).

Repetitive behaviors/obsessive interests. While individuals who have been diagnosed with ASD have a wide range of symptoms, repetitive behaviors are perhaps one of the most diverse in presentation. Some individuals who experience a more “classic” form of autism might have repetitive behaviors that include hand flapping, rocking, finger flicking, or intense fascination with moving parts or lights (Aspy & Grossman, 2012). For others, however, intense areas of interest or extreme preoccupation with certain topics might be the dominant form of repetitive behavior. These areas of interest might stand out as unusual as the fascination with the topic is incredibly intense and consumes most of the child’s play or conversation. In some instances, the topics of interest might be quite uncommon for the individual’s age. These preoccupations often consume individuals as they guide most conversations and play choices toward engaging in repetitive and inflexible play activities and rituals around these topics of interest (Aspy & Grossman, 2012; O’Brien & Daggett, 2006; Wolfberg, 2003).

Sensory differences. Leekam, Neito, Libby, Wing and Gould (2006) reported that over 90% of children with autism have some degree of sensory abnormalities. While Tomcheck and Dunn (2007) indicated that all people have different thresholds for noticing, responding to, and becoming irritated with sensations, individuals with ASD often experience extreme difficulty with even day-to-day functioning due to their sensory needs. The varied sensitivity thresholds could significantly affect an individual's daily choices, mood, and ability to fully function in their day-to-day lives. Often those with ASD exhibit extreme responses to sensory stimuli such as heightened pain tolerance, tactile defensiveness, exaggerated reactions to light or odors, or intense fascination with certain stimuli.

Often children with ASD alter their behaviors based on their individual sensory differences. This might include a child covering her ears in the lunchroom due to the noise or rocking in her chair when in the classroom. Furthermore, children with ASD often choose to play with specific toys and in specific ways to meet their sensory needs (e.g., tapping a block on her cheek repeatedly to gain sensory input) and explore their environments through these sensory based actions (Wolfberg, 2003).

Theory of mind. Some prominent researchers suggested that the difficulty individuals with ASD experience with theory of mind provides an explanation for their commensurate communication and social challenges (Howlin, Baron-Cohen, & Hadwin, 1999). Many interpersonal skills are dependent on the development of theory of mind such as empathy, self-consciousness, and understanding of unwritten social rules (which guide appropriate social behavior). While many children acquire skills throughout their early years building their theory of mind, children with autism are less likely to acquire

the early pre-requisites such as intention (i.e., acting in a particular way either consciously or unconsciously to elicit a desired outcome) and joint attention (i.e., a form of intentional communication such as pointing to or making an object aware to another in an effort to share enjoyment and shifting eye gaze to share attention with another).

The results of insufficient theory of mind create difficulty or an inability to take into account the social perspective of others. Failure to recognize and understand that others possess their own feelings, desires, and beliefs often leads to difficulty in not only reciprocal social interactions (Howlin et al., 1999) but also the child's ability to engage in symbolic and imaginative play as well as difficulty in collaborative play schemes (Wolfberg, 2003).

Demographic Information

The prevalence of ASD has increased markedly over the past two decades, increasing from 2 per 10,000 in 1990 to between 1 in 50 and 1 in 88 children (Wong et al., 2014), and is noted to be diagnosed three times more frequently in boys than girls. This marked increase in prevalence can be attributed to several factors (Attwood, 2006). First, Atwood (2008) noted that the broadening of the definition of autism has directly resulted in more individuals being diagnosed with ASD. In addition, the now accepted view that children can have more than one disorder (comorbidity) as well as the more accurate diagnosis of children who were previously thought to have only intellectual disabilities has resulted in more children receiving the ASD diagnosis. Finally, professionals have become more adept at diagnosing autism, especially in younger children (Atwood, 2006). In fact, experts are now finding they can reliably diagnose ASD in children as early as 12 to 18 months (Lord et al., 2012).

Early identification of individuals with ASD is thought to be critical as it has allowed for earlier implementation of interventions. Early interventions aimed at minimizing or in some cases even preventing some of the handicapping symptoms of ASD are noted to be especially effective in not only the treatment of current ASD symptoms but also in prevention of developing future symptoms as well as prevention of skill regression (Lord et al., 2012; Sigman et al., 2004).

Current Intervention Approaches

The increase in rates of prevalence of young children diagnosed with ASD has been met with an intensified quest for not only answers as to the etiology of this disorder but also effective interventions for all ages of individuals with ASD with specific emphasis on the importance of early intervention. Most interventions designed for treatment of ASD fall under two broad classifications of either a comprehensive treatment model or focused intervention (Wong et al., 2014).

Comprehensive treatment models (CTMs) are those programs consisting of a set of practices that have been designed to achieve a broad learning goal or positive impact on remediating the core deficits of ASD. These CTMs include programs such as the Learning Experiences and Alternative Program for Preschoolers and Their Parents (LEAP; Hoyson, Jamieson, & Strain, 1984; Strain, 1987; Strain & Hoyson, 2000) and Early Start Denver Model (ESDM; Rogers & Dawson, 2009; Rogers, Hall, Osaki, Reaven, & Herbison, 2000). These programs tend to be more collaborative with an adult/parent or peer teaching and add to the child's play skills in a naturalistic setting.

In contrast, focused intervention practices are designed to more specifically address a particular skill or distinct goal an individual with ASD might be working

toward (Odom, Boyd, Hall, & Hume, 2010). Numerous skills and behaviors might be targeted for improvement with the use of focused interventions; however, most interventions are designed to either increase developmentally appropriate skills or decrease unwanted behaviors. Typically, focused interventions are shorter in duration than comprehensive treatment models (i.e., until the goal has been met) and operationally defined to address specific individual outcomes. Due to their specificity, focused interventions can be tailored to meet the unique needs of individuals and can be utilized in isolation for specific individual goals. However, they can also be included within CTMs (e.g., discrete trial training, pivotal response training, prompting, video modeling; Wong et al., 2014).

The large number of focused interventions and comprehensive programs geared toward the treatment of individuals with ASD makes it essential to discern effective from ineffective treatments. Several focus groups have reviewed large amounts of literature to aid in this task. The National Autism Center (NAC; 2009) completed a review of treatments and wrote the *National Standard Report*, which describes the most effective interventions for ASD. Additionally, Wong et al. (2014) recently released their concurring report of effective treatment practices.

The review conducted by Wong et al. (2014) included 456 studies (most of which focused on ages 3-11) designed to address interfering behaviors and increased skill use (social, communication, joint attention, play, cognitive, school readiness/academic, motor, adaptive, vocational, and emotional wellbeing). The bulk of these studies focused on social (165 studies), communication (182 studies), and interfering behaviors (158 studies) while only one study focused on mental health (Wong et al., 2014).

The NAC (2009) identified 11 effective treatments focusing on similar participant outcomes. Most of 724 studies included in the NAC review corresponded to or combined 27 effective treatments identified by Wong et al. (2014). These treatments were reported within the *National Standards Report* (NAC, 2009) as Established Treatments, a term coined to indicate these interventions were each backed with substantial evidence to support their effectiveness in either increasing wanted skills or decreasing unwanted behaviors. These Established Treatments included antecedent-based interventions, behavioral-based interventions, comprehensive behavioral treatment for young children, joint attention intervention, modeling, naturalistic teaching strategies, peer training, pivotal response treatment, schedules, self-management, and story-based interventions.

Antecedent-based interventions. The antecedent-based interventions, behavioral-based interventions, and comprehensive behavioral treatment for young children all included approaches reflective of the research within the fields of applied behavioral analysis (ABA), behavioral psychology, and positive behavior supports (Wong et al., 2014). Antecedent-based interventions (ABI) have gained substantial support for use with Individuals with ASD and have proven effective for their use in a variety of individualized interventions (Schilling, & Schwartz, 2004). Antecedent-based interventions focus on behavioral supports and strategies that can be put in place before an interfering or problem behavior occurs while simultaneously supporting and teaching the desired behaviors. Behavioral interventions typically employ basic behavioral strategies including reinforcement of desired behaviors and behavioral treatment of young children interventions including a combination of ABA procedures.

The main goal of ABI is to identify factors that reinforce the interfering behavior and then modify the environment or activity so the factor no longer elicits the interfering behavior (Neitzel, 2009). Commonly utilized ABI procedures include increasing individual interest levels by incorporating highly preferred activities and items to the task, implementing a change in the schedule or routine to promote interest and compliance, employing pre-activity interventions such as warnings for upcoming transitions, and offering choices to increase individual buy in and motivation. In addition, altering an individual's environment to ensure the learner's sensory needs are met allows reductions in alternate, interfering behaviors (due to unmet sensory needs; Schilling & Schwartz, 2004). It is important to note that ABI strategies are often used in conjunction with other evidence-based practices such as functional communication training (FCT), extinction, and reinforcement (Neitzel, 2009).

Behavioral-based interventions and comprehensive behavioral treatment.

Behavioral interventions as well as comprehensive behavioral treatment for young children aim to decrease problem behaviors and increase target behaviors through the application of basic behavioral principles. These interventions are often based on the ABA approach advocated by Lovaas (1977), and might include discrete trial training (DTT), sometimes referred to as the Lovaas method. Additional commonly used behaviorally-based strategies include token economies, successive approximation, task analysis and chaining, reinforcement strategies, stimulus pairing with reinforcement, teaching, prompting, differential reinforcement of other/alternative behaviors (DRO, DRA, DRI) and shaping, and extinguishing behaviors (Jones & Carr, 2004; Stahmer et al., 2003).

Joint attention interventions. Joint attention, identified as a core deficit in ASD, is broadly defined as the ability to coordinate attention between an object and a person in a social context. Joint attention interventions aim to increase the use of specific skills involved in regulating others' behaviors and include a training component in which children are taught specific skills such as responding to the nonverbal efforts of others to initiate interaction and following eye gaze or pointing to objects (Jones et al., 2006, Whalen, Schreibman, & Ingersoll, 2006). Jones et al. (2006) reported that following intervention, participants who received joint attention intervention displayed improvements in their responsiveness to joint attention as well as increased child-initiated joint attention.

Modeling interventions. Modeling interventions include a peer or adult providing a demonstration of the optimal target behavior. Modeling interventions are often combined with other interventions to enhance their effectiveness such as reinforcement and prompting. Modeling strategies include both live and video modeling (Bellini, Akullian, & Hopf, 2007).

Naturalistic teaching strategies. Naturalistic teaching strategies or naturalistic interventions include a group of interventions that elicit specific behaviors based on the individual's interests. These interventions aim to increase skill complexity with the idea that the more complex skills are naturally reinforcing and appropriate for the interaction (Franzone, 2009). Naturalistic interventions utilize the techniques of modeling, incidental teaching, and naturalistic time delay. Environmental arrangement, reinforcement of close approximation of the desired behavior, and strategies based on

applied behavior analysis principles are also utilized to increase the likelihood of skill building and maintenance (Franzone, 2009).

Peer training interventions. Peer training packages such as circle of friends (Schlieder, 2007), integrated play group (IPG; Wolfberg, 2003), and peer mediated social interactions are examples of interventions that focus on training, typically developing peers to facilitate social interactions with children with ASD. In addition to training peer models, these interventions often include strategies such as modeling, reinforcement, and prompting. Peer training interventions are designed as a method to increase a number of skills among children with ASD including joint attention and social knowledge and skills.

Pivotal response treatment. Pivotal response treatment (PRT) uses a developmental and ABA approach aimed to decrease symptomology of ASD, increase children's motivation to communicate, and provide learning opportunities and reinforcement of pivotal skills within a child's natural environment (Koegel & Koegel, 2006). By targeting specific pivotal skills (identified as motivation, responsiveness to multiple cues, self-management, and self-initiations), interventions can not only lead to gains in particular areas of interest but also to collateral gains in untargeted areas (Koegel et al., 1999).

Schedule-based interventions. Schedule-based interventions include providing the individual with ASD a list or series of activities or steps required for an activity (words or pictures). Schedules can promote independence and self-regulation by organizing tasks and activities in ways that are comprehensible to individuals with ASD. Visually structured sequences provide opportunities to clearly communicate which and

how many activities to complete, when the work is finished, and what happens after the work is completed (Massey & Wheeler, 2000).

Self-management interventions. Self-management interventions aim to reduce or manage an individual's behaviors. Often these interventions are designed to increase an individual's awareness of his or her behavior and incorporate goal setting as well as reinforcement strategies. Learners are taught to monitor and take data on their own behavior. This method is typically used with older, high-functioning learners who are capable of reflecting on their actions. However, some studies have included self-management strategies adapted for preschool children (Shearer, Kohler, Buchan, & McCullough, 1996). Through self-management strategies, learners are taught to self-monitor a variety of behaviors such as alertness, activity level, concentration, and problematic behaviors (Mithaug & Mithaug, 2003; Newman, Tuntigian, Ryan, & Reinecke, 1997).

Story-based interventions. Story-based interventions, e.g., social stories (Gray, 1995), are interventions aimed at helping the individuals adjust to changes in their routine, adapt their behavior based on the situation, or teach a specific skill. Stories used for this intervention are typically short, describe social situations in detail, and provide an appropriate resolution to the problem or social situation at hand. Story-based interventions or social narratives are appropriate for use with individuals who are preschool age and older and can be utilized to address a variety of social skills, behaviors, and appropriate problem resolution (Collet-Klingenberg & Franzone, 2008).

These 11 treatments were collectively supported by approximately 541 research studies, all of which represented divergent areas of intervention. However, many of these treatments utilized similar treatment strategies.

Approximately two-thirds of the Established Treatments were developed exclusively from the behavioral literature (e.g., applied behavioral analysis, behavioral psychology, and positive behavioral supports). Of the remaining one-third, 75% represent treatment for which research support comes predominately from the behavioral literature. (NAC, 2009, p. 52)

This comprehensive evaluation of numerous interventions for individuals with ASD reinforced the effectiveness of behaviorally-based treatment (NAC, 2009). However, this report also highlighted the scarcity of interventions within the literature designed to address the core relational difficulties and mental health needs of young children with ASD.

Within the *National Standards Report* (NAC, 2009), only 7 of the 541 intervention studies were relationship-based and only three mental health interventions were included (all of which utilized CBT). Furthermore, despite the evidence of increased vulnerability and risk for individuals with ASD developing a variety of co-morbid emotional and psychiatric problems, only one study within the 2014 review conducted by Wong et al. (2014) addressed the emotional wellbeing of individuals with ASD.

Cognitive behavioral therapy. Cognitive behavioral therapy (CBT) was the intervention most cited within the literature for addressing the emotional needs of children with ASD and was the only mental health intervention identified within the *National Standard Report* (NAC, 2009). Cognitive behavioral therapy, which assumes the goal of identifying and modifying negative thinking styles, boasts a robust body of

research touting its effectiveness for teaching skills to address emotional vulnerability with a variety of disorders including ASD (Attwood, 2003). However, CBT utilizes verbal processing requiring well developed expressive and receptive language skills. Often times, individuals with ASD are either nonverbal or have a variety of other types of communication impairments that make verbal processing more difficult (Leyfer et al., 2006). Furthermore, individuals with ASD might also have impairments in theory of mind, complex information processing, and executive functioning. These impairments make it difficult to fully benefit from verbally-based therapy (Baron-Cohen, 1995; Leyfer et al., 2006). Consequently, CBT is most appropriate for children who are eight years and older (Knell & Dasari, 2011) and is not appropriate for nonverbal children or early intervention candidates.

As such, several other notable interventions that veer from the traditional behaviorally-based treatment, are more appropriate for early intervention, and are for use with nonverbal children are discussed: nondirective activity-based interventions (Bricker & Cripe, 1992), relationship development interventions (Gutstein & Sheely, 2002) and DIR/Floortime (Greenspan & Wieder, 2006).

Activity-based intervention. Activity-based intervention (ABI) was developed by Diane Bricker and her colleagues (Bricker & Cripe, 1992) at the University of Oregon. This intervention incorporates a less directive method and is described as a

child-directed, transactional approach that embeds intervention on children's individual goals and objectives in routine, planned, or child-initiated activities, and uses logically occurring antecedents and consequences to develop functional and generative skills. (Bricker & Cripe, 1992, p. 40)

Activity-based intervention studies have shown increases in a variety of target behaviors. For example, Pretti-Frontczak, Barr, Macy, and Carter, (2003) reviewed 16

studies utilizing ABI and reported that all indicated the effectiveness of ABI in targeting a wide variety of skills including social skills, language, self-help skills, transition skills, imitation, counting, play and academic engagement, as well as attending and listening.

Relationship development intervention. Relationship development intervention (RDI) has been touted as the “first systematic intervention program designed specifically to help children born with obstacles that prevent them from attaining relationship competence in the natural environment” (Gutstein & Sheely, 2002, p. 23). This intervention addresses the social relationship based difficulty inherent in individuals with ASD. Relationship development intervention is a parent-based, cognitive-developmental approach designed to build on the self-motivating aspect of relationships and works to provide children with the potential payoffs, enjoyment, and positive excitement they can receive from social encounters.

The overarching goal of RDI is to improve social-emotional, cognitive, and functional abilities. As such, the main intervention agents are parents or caregivers. Primary caregivers are trained to implement specific strategies including those of joint attention, conjoint pretend play skills, social communication, and functional and adaptive behaviors. Through the course of RDI, children pass through six specific levels and 24 stages. Children learn as their parents provide continuous and daily opportunities to use and build on previously acquired social-emotional and social-cognitive skills. While less empirical support is available for this relational intervention, one published study investigated the effectiveness of RDI on 16 children with autism. Over the course of five years, this intervention resulted in the children being more socially engaged, displaying more reciprocal communication, and displaying more adaptive social functioning

(Gutstein, Burgess, & Montfort, 2007). While the research backing this intervention was somewhat limited, the positive results of Gutstein et al. (2007) showed RDI to have potential as a structured relational intervention and indicated a need for further research.

Developmental, individual-differences, and relationship-based/Floortime.

Developmental, individual-differences, and relationship-based (DIR)/Floortime did receive attention in the NAC (2009) report but was listed as an Emerging rather than an Established Treatment. Developmental, individual-differences, and relationship-based/Floortime has the overarching goal of building a foundation for social, emotional, and intellectual growth rather than focusing on specific behaviors as do many behavioral interventions. The primary strategy within DIR/Floortime is teaching adults to support their child in expanding circles of communication. This approach entails the adult meeting the child at his/her developmental level, following the child's lead, and building upon the child's strengths. Six developmental milestones are emphasized in DIR/Floortime: (a) self-regulation and interest in the world, (b) intimacy or a special love for the world of human relationships, (c) two-way communication, (d) complex communication, (e) emotional ideas, and (f) emotional thinking.

The premise of this intervention suggests it is the relationship built between the adult and child diagnosed with ASD that serves as the vehicle through which these children are able to progress toward appropriate developmental milestones. This relationship-based intervention aims to educate parents and intervention providers as they work toward developing enriched relationships with children based on the child's interests and strengths. It is believed that through these rich interactions based on the child's interests, more complex interactions will naturally develop. For example, with

the help of an enhanced relationship, an adult might join a child in his/her play with cars and by doing so might facilitate a more interactive play experience.

The child-centered premise of these relational interventions is quite similar to that of CCPT. However, the goal of CCPT is to provide a relationship for children in which they feel free and secure enough to move toward self-enhancing processes of growth. It proves even less directive than previously mentioned interventions and puts even more emphasis on the relationship between the child and the therapist. Furthermore, CCPT is preliminarily thought to not only increase specific target behaviors but perhaps, even more importantly, address the main core relational deficits of ASD (Josefi & Ryan, 2004; Ray et al., 2012).

Through their relationship and acceptance, CCPT therapists work to increase attachment behaviors, empathy, and emotional regulation, all of which are thought to contribute to the alleviation of core relational and communication challenges and address current and perhaps even aid in the prevention of future developing, co-occurring mental health disorders in children (Josefi & Ryan, 2004; Ray et al., 2012). These qualities make CCPT a worthy consideration for its addition to the treatment protocol of individuals with ASD. “If ASD is conceptualized in part as a relational communication disorder, CCPT is equivocally matched as a relational communication intervention” (Ray et al., 2012, p. 16).

Furthermore, a review of literature revealed that CCPT might prove an ideal intervention for young children with disabilities, especially those with ASD. Child-centered play therapy has been shown to improve many of the areas in which children with ASD have difficulties: relational skills, attachment behaviors, joint attention,

comorbid emotional difficulties such as anxiety, and overall functional impairment (Brandt, 1999; Josefi & Ryan, 2004; Ray et al., 2012; Tyndall-Lind et al., 2001).

Some might question whether or not individuals who display few, if any, neuro-typical play behaviors can benefit from a nondirective play-based intervention. However, Badenoch and Bogdan (2012) proposed that when given the appropriate setting and ideal relational connections, children become capable of engaging in and initiating play. Thus, the question of right versus wrong in play becomes irrelevant.

Badenoch and Bogdan (2012) specifically indicated that when young children are allowed to enter into a play space that resonates with a sense of safety, connectedness, and interpersonal warmth, they are able to engage in co-regulation and an interpersonal connection with the therapist. Due to this synergistic system of play and interpersonal connection, individuals experience a trusting relationship and develop a sense of safety that allows for pure play to become ever more available. “The joyous news about this is that we don’t need to teach children to play but instead need to remove the obstacles so that the natural capacity can emerge” (Badenoch & Bogdan, 2012, p .5).

Children with Autism Spectrum Disorder and Play

Previously noted hallmarks of difficulty for individuals with ASD including social difficulty, communication deficits, repetitive behaviors and restricted interest, as well as their difficulty with imagination, theory of mind, and sensory processing often lead to difficulty engaging in typical play skills. It is thought by some that this lack of typical play results in individuals with ASD never fully progressing through the neuro-typical play stages and instead frequently leads to the development of fragmented play skills (Mastrangelo, 2009): “Children with ASD may show a variety of features in their play

(e.g., inflexibility, concreteness, constrictedness, impulsivity, irrationality, unreliability, and inability to engage in or sustain imaginative play) that are not generally accepted in the definition of play” (p. 35).

While children with ASD routinely engage in self-directed play, the quality of their play is considered different from their neuro-typical peers (Hellendoorn, Van der Kooij, & Sutton-Smith, 1994; Mastrenghelo, 2009). Often children with ASD engage with play objects in a very inflexible manner such as spinning the wheels of a toy car repetitively instead of making the car move or driving this car around the play space. Furthermore, the play of children with autism has often been described as mechanical and lacking exploration or pretend play; they might repetitively line up or organize their toys rather than engaging in imaginative play schemes. Often the play behaviors observed might be dominated by the individual’s special topic of interest or preoccupation such as a child’s desire to only play with dinosaurs and the inability to direct his thoughts or play elsewhere. When symbolic play does occur in individuals with ASD, it is reported to be very stereotypical and rigid as well as indifferent to the suggestion of other children or play partners (Beyer & Gammeltoft, 2000).

The lack of spontaneous pretend play as well as its basic components (e.g., joint attention, turn taking, theory of mind) in children with ASD are often skills targeted in early interventions for these young children. However, due to the many different definitions of play, it seems quite difficult to distinguish particular aspects of play that should be considered essential, healthy, or purposeful from those types of play considered unhealthy, deviant, or non-purposeful, making the justification of interventions implemented with the sole purpose of changing this play difficult.

Some researchers in the area of child development support the idea of normal/good and abnormal/bad play, noting that normal play, such as constructive, creative play serves to enhance development while atypical play, such as narrow and unimaginative play, inhibits optimal development (Frost, 2010; Gitlin-Weiner, 1998; Sutton-Smith, 1985). However, from a therapeutic perspective, all play is accepted and thought to serve a purpose. Even children who engage in what child development specialists might consider bad or destructive play are thought to benefit from expression of this type of play (Frost et al., 2012).

While the play of children with ASD, when viewed through a developmental lens, is greatly varied from what is usually considered typical play, perhaps the self-driven play of children with ASD is still capable of meeting individual developmental and emotional needs in a therapeutic setting. Frost et al. (2012) reported that therapeutic benefit could be gained regardless of the type of play. Despite the differences in the type of play behaviors displayed, perhaps children with ASD still experience benefit from this play since the play behaviors themselves are internally driven. Conceivably this play should be viewed through the therapeutic lens as serving a specific purpose for that individual child.

Additionally, due to the previously noted difficulty for young children with ASD to engage in age appropriate relational skills, perhaps the ideal intervention for individuals with ASD should focus on building an interpersonal connection versus teaching specific play behaviors. A relational intervention could prove to not only increase relational skills but also serve as a vehicle to remove obstacles so developmentally appropriate play behaviors can emerge (Badenoch & Bogdan, 2010).

For this reason, the exploration of how children with ASD change when participating in a relational intervention appears essential.

Despite the large number of interventions available for individuals with ASD, apparent gaps remain within the literature. More research is needed with regard to the mental health needs of individuals with ASD as well as the relationally-based interventions designed for individuals with ASD. Most interventions are currently behavioral-based and have adult-driven goals and timelines. These interventions might result in the loss of the child's voice and investment in the change process. On the contrary, when children are allowed to choose the pace and focus of their treatment, they often experience an increase in autonomy (Josefi & Ryan, 2004). Additionally, some behavioral-based interventions might not produce the long-term results expected by most parents and providers. Kohn (1999) suggested that this lack of longevity with regard to the results of behavioral interventions is linked to the fact that "reinforcements do not generally alter the attitudes and emotional commitments that underlie our behaviors. They do not make deep, lasting changes because they are aimed at affecting only what we do" (p. 41). From this perspective, interventions relying solely on behavioral principles can be viewed as effective in inducing compliance and obedience but perhaps not as effective in producing long-term changes or an internally driven progression toward emotional growth and self-fulfillment. "Change in behavior, if it is to have any lasting value, must come from within the individual as a result of insight that he has achieved" (Axline, 1974, p. 108).

The rudimentary goal of most behavioral-based and skill-focused interventions carries with it the objective of child transformation toward conformity and toward the

norm. This expectation of conformity is perhaps the very aspect that inhibits children's optimal self-fulfillment. When the goal of many skill based interventions is to dictate change within the child either through teaching new skills or modifying existing skills, the focus naturally becomes what is wrong with the child by shining a spotlight on the problem. Landreth (2002) discouraged this tactic, noting that "when we focus on the problem we lose sight of the child" (p. 85).

One might wonder what if any effect the intervention has on a child when the problem and not the child is the focus. If children are continually sent the message that something is wrong with them and they must change to be accepted, does this affect their development? From a child-centered perspective, these messages, or conditions of worth, are the basis from which an individual shapes his or her personality and development.

If I do not feel worthy of receiving love from others based on internalized conditions of worth that I am unlovable unless I am perfect, then love experienced from others may be seen as a threat to self and rejected. This internalized condition is counterproductive to growth and interferes with the development of meaningful relationships. (Ray et al., 2011, p. 160)

Thus, the very same pattern of relational difficulties addressed through behavioral modifications and interventions aimed at "fixing" the child are perhaps the characteristics strengthened as unwanted outcomes of these interventions. For instance, children with ASD are sometimes denied certain experiences due to the unexpected behavior and anxiety this behavior might create in their caretakers despite the child's developmental need for this type of play/activity. Mundy and Crowson (1997) supported this idea, suggesting that symptoms of ASD are perhaps not only the outcome of a neurological disorder but also the result of ongoing environmental processes impacting the development of these children. Ray et al. (2011) further suggested that "a person will

behave and emotionally respond in a way that is consistent with the view of self, even if the view of self does not facilitate optimal growth of the individual” (p. 160). Perhaps the use of an intervention aimed at helping the child obtain self-fulfillment versus observable normalcy would be an effective solution to not only meet the social/emotional needs of individuals with ASD but also enhance their relational capacity.

Child-centered play therapy as a nondirective relational intervention might arguably be the perfect complement to a typically behavior-driven treatment protocol. Child-centered play therapy, similar to DIR/Floortime (Greenspan & Wieder, 2006), is considered a child-directed relational intervention. However, CCPT has been found to result in overall functional improvement (Ray et al., 2012) and focuses on providing a safe and accepting environment, thereby allowing the child to guide the process as he/she works toward self enhancement. Furthermore, Ray et al. (2012) suggested that while many of the behaviorally based interventions developed for individuals with ASD addressed observable skill deficits and behavioral symptoms, the three core relational difficulties associated with ASD identified by Greenspan and Wieder (2006) could best be addressed through a relational intervention such as nondirective play therapy (CCPT).

Autism Spectrum Disorder and Child-Centered Play Therapy

In 2007, the American Academy of Pediatrics (AAP) declared that early intervention (i.e., below six years of age) for individuals with ASD should include at least 25 hours of educational services per week (Meyers & Johnson, 2007). With this declaration, it became ideal, if not necessary, to combine several interventions to create an individualized treatment protocol of adequate duration and intensity. Furthermore, Strain et al. (2011) suggested there needs to be increased attention to the quality of life

for children with ASD by stating, “We need to ensure that the programs we provide to young children teach skills and behaviors that are related to better functioning at home, school and community, rather than those that are easy and convenient to teach” (p. 329). As noted, many of the most commonly used interventions are arguably lacking when it comes to the development of meaningful relationships and inner growth. These safe and accepting relationships are indisputably necessary to not only promote satisfactory quality of life but are also thought to serve as a means for overall enhancement of individuals with ASD, allowing for their progress toward optimal development in all domains.

In his polyvagal theory, Porges (2007) provided yet another layer of support for relational interventions within his neurophysiological explanation of how emotions, attachment, communication, and self-regulation are all coupled with the feeling of safety and connectedness to others. Porges noted, “It appears that autism is associated with autonomic states that remove the individual from direct social contact by supporting the adaptive defensive strategies of mobilization (i.e., fight-or-flight behaviors) or immobilization (i.e., shutdown)” (p. 221). This state of disconnection (which leads to deactivation of the individuals’ neural regulation regarding their social engagement) and corresponding state of fear are thought to contribute to individuals’ limited ability to engage in and decipher facial expressions as well as difficulty separating the human voice from background noise (Porges, 2007)--two hallmarks of difficulty for individuals with ASD. Accordingly, the Polyvagal theory promotes the idea that if individuals with autism can move from the activation and use of their sympathetic nervous system to that of their ventral vagal, the brain circuitry of social engagement naturally emerges. This

movement from the sympathetic to ventral vagal circuitry is thought to be facilitated through the use of safe, accepting relationships.

Concurrently, Badenoch and Bodgen (2012) explicitly encouraged the use of relational interventions with individuals diagnosed with ASD to foster this very type of social engagement. These authors suggested that the provision of an environment full of safety, interpersonal warmth, and resonance with young children allows their brains the chance to become more fully integrated and able to connect, describing play therapy as the ideal catalyst for this connection:

In these few moments of play, this youngster moves from being dominated by his nervous system and emotional circuitry being in severe dysregulation to clear signs that both the social and regulatory systems in his brain are online and in the lead. (Badenoch & Bogden, 2012, p. 4)

Child-centered play therapy is not only a relational intervention that is effective in addressing the needs of interconnectedness between child and therapist, it is also particularly strongest in the very areas where behavioral interventions might fall short: addressing the social needs of individuals (Fall et al., 2002), increasing relational ability (Ray et al., 2011), self-efficacy (Fall, Balvanz, Johnson, & Nelson, 1999; Johnson, McLeod, & Fall, 1997), and emotional regulation (Ray et al., 2007). Further, key pivotal skills among young children with ASD (e.g., joint attention) have preliminary support, demonstrating improvements (Josefi & Ryan, 2004; Ray et al., 2011) and suggesting the use of CCPT might work well with simultaneously focused interventions.

While many CCPT therapists currently report working with children who have been diagnosed with ASD and many leaders within the field of CCPT support its use with this population (Badenoch & Bogdan, 2012; Getz, 1996; Mitteldorf et al., 2001; Ray et al., 2012), research in this area is limited. An initial case study of CCPT with a young

boy diagnosed with ASD supported its use as a complementary addition to his behavioral treatment plan (Josefi & Ryan, 2004). In this case, child-centered play therapy appeared to be “effective in the very areas where behavior therapy is least effective” (Josefi & Ryan, 2004, p. 548). Following the participation of a six-year-old boy diagnosed with ASD in 16 CCPT sessions, Josefi and Ryan (2004) reported positive changes in this young boy’s autonomy, initiation of joint attention, concentration, enjoyment, interaction with the therapist, and in the development of symbolic or pretend play.

Specifically, Josefi and Ryan (2004) reported this child experienced enhanced autonomy and self-reliance. This finding was supported by the boy’s decreased requests for help (which stopped after the first five sessions) and increased time spent independently problem solving. Additionally, this boy’s exploration of the playroom increased as did the repertoire of toys with which he chose to play. Notably, as he expanded his toy use, he also appeared to engage in more laughing and smiling as well as joint attention. From this, the authors surmised that CCPT had served to heighten this child’s autonomy and facilitated his exploration and social engagement (Josefi & Ryan, 2004, p. 539). Additionally, the number of child-initiated physical contacts increased from none during the first session to five during the 14th session. While the child’s initiation of interactive activities with the therapist increased from less than two minutes during the first session to 12 minutes during the 12th session, these did reduce again during the final few sessions. The authors surmised the therapeutic conditions of CCPT created opportunities that instilled in this young child an intrinsic motivation to interact and engage with others (Josefi & Ryan, 2004).

Child-centered play therapists do not seek to fix the observable symptoms of ASD but instead work to counter the core relational and communication challenges (Ray et al., 2012). “Because relationship is a core problem of ASD and relationship is the core focus of CCPT, the effectiveness of therapy serves to help the core issues of the child” (Ray et al., 2012, p.168) and meet the proclaimed challenge of Strain et al. (2011) to address enhanced quality of life versus easily targeted skills.

Summary

Currently, ASD is one of the most common and least understood childhood disorders. Continued research is needed for answers related to etiology as well as effective treatment protocols. Early intervention is touted as not only essential for remediating current symptomology but effective in preventing future problem behaviors and skill regression. What constitutes the best early intervention treatment protocol is less certain. Many of the contemporary early interventions focused on the use of empirically supported, behavioral-based treatment methods to increase skill acquisition. However, these interventions might be less effective in treating core relational difficulties or emotional aspects of ASD. Recently, there has been an increase in support for the use of play therapy as an addition to the treatment protocol for children with ASD. However, research examining the use of play therapy with children with ASD has remained somewhat limited.

CHAPTER III

RESEARCH METHODOLOGY

Qualitative research is based on the idea that “reality is constructed by individuals interacting with their social worlds” (Merriam, 1998, p. 6). Therefore, qualitative research studies have at their core the goal of better understanding the meaning people have constructed in their lives and the way in which these individuals make sense of their world and their experiences (Creswell, 2007; Merriam, 1998; Yin, 2014). The current study examined the essences of the changes young children with ASD experienced with regard to their play and relational skills through their participation in 16 sessions of child-centered play therapy (CCPT).

Epistemological and Theoretical Foundations

Crotty (1998) described four essential elements or levels of research. The broadest level was that of epistemology: “the theory of knowledge embedded in the theoretical perspective and thereby in the methodology” (Crotty, 1998, p. 3). With the primary research questions of this study in mind, I selected constructivism as most appropriate with regard to the aim of this inquiry and the best representation of my own current philosophical orientation toward knowledge acquisition. The second element identified by Crotty was theoretical perspective or the mode for accepting or generating knowledge within a discipline. Interpretivism was utilized to explain the specific research tradition that informed my methodology. Case study was the primary mode of

inquiry or methodology for this study. And finally, several key data collection methods were used including interviews, observations, treatment (CCPT), parent journals, and researcher field notes. The elements from these four levels of research made up the research paradigm of this study (see Figure 1) or the “basic set of beliefs that guides action” (Guba, 1990, p. 17). As I describe each of the levels in the following sections, the assumptions I brought to this inquiry process as the researcher and as the therapist are clarified.

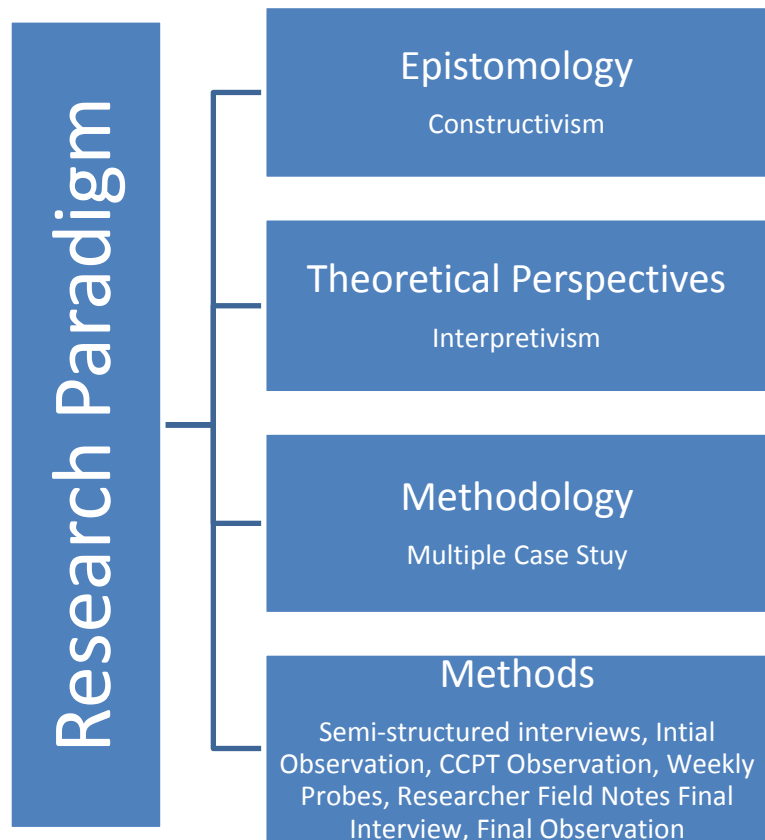


Figure 1. Research paradigm.

Epistemology

My professional and personal theoretical identity is found within the realm of Rogers's (1951) client-centered philosophy; my view of human nature allows for the understanding that our reality is constructed by what we perceive. As humans, we all interact and react within a phenomenal field; our perceptions of our experiences create meaning within our lives. Thus, my epistemological views fit most naturally with that of social constructivism. Schwandt (2001) wrote,

Human beings do not find or discover knowledge so much as they construct or build it. We invent concepts, models, and schemes to make sense of experience, and we continually test and modify these constructions in the light of new experience. Furthermore, there is an inevitable historical and sociocultural dimension to this construction. We do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language, and so forth. (p. 30)

Within this view and often combined with the theoretical perspective of interpretivism, the assumption is that individuals seek to have an understanding of the world in which they live--the subjective meanings of individuals' experiences and the meanings they create and place on certain objects or things (Creswell, 2007) being most valued. Constructivists view the research goal as relying as much as possible on participants' views and understanding of their situations. The subjective experiences of individuals and their construction of meaning regarding the situation rather than purely factual observations and outcomes drove the worldview of this research and provided a more in-depth understanding of the essences of participants' experiences (Creswell, 2007). In this way, I hoped to gain better insight into the contexts and meaning the participants and their families constructed from their experiences throughout the CCPT intervention.

Theoretical Perspective

The theoretical perspective for this study was that of interpretivism. According to Crotty (1998), interpretivism attempts to understand an individual's reality from the participant's perspective. It has at its core the idea that an individual's perceptions of reality are most important for understanding the phenomenon being studied. This social science theory assumes that the actions individuals choose are based on the meaning they perceive (Crotty, 1998). Since no one except the individual can determine what or how he/she experiences various phenomena, within this perspective there is no right or wrong with regard to how each individual encounters the world. This perspective recognizes that all human understanding is unavoidably prejudiced and embedded within the perspectives and experiences of the individual and the event that has occurred (Elliott & Lukes, 2008). The interpretivist perspective for this study respected participants and their perceptions of reality as truth and acknowledged that facts could not be separated from values and views of their experiences. In an effort to control for or at least recognize the effect of all individuals' prior held beliefs or assumptions, I approached this study with a mindset open to the attitudes and values of the participants and was cognizant and mindful of my own prior personal beliefs and perspectives (Mackenzie & Knipe, 2006).

The interpretivist view aligns quite seamlessly with all three central constructs of the child-centered theory of personality structure: the person, the phenomenal field, and the self. In 1951, Rogers first explained this idea by noting the person is part of a continually changing world of experiences. Landreth (2012) expanded this idea to the world of children and play therapy, noting that "as the child reacts to this changing world of experience, the child does so as an organized whole, so that a change in one part

results in changes in other parts” (p. 55). The child changes with regard to his or her cumulative experiences, thoughts, and beliefs regarding the experiences. The phenomenal field consists of all experiences the child encounters (whether consciously or subconsciously) including the child’s perceptions, beliefs, thoughts, feelings, and behaviors. Children’s perceptions of their experiences create their reality.

Similar to the interpretivist researcher’s view, my view as a CCPT therapist was guided by the following basic tenant:

The child’s perception of reality is what must be understood if the child and the behaviors of the child are to be understood. The child’s phenomenal world is the point of focus and must be understood if a significant relationship is to be established with the child...the child’s behavior must always be understood by looking through the child’s eyes. (Landreth, 2012, p. 56)

Finally, the third construct of child-centered theory (the self) assumes that the child is existing in a continually changing world of experiences. As such, the child’s private world gradually becomes recognized by the child and increasingly becomes the sum of the composition of the individual child’s perceptions (Landreth, 2012). The view of the child-centered therapist mirrors that of the interpretivist researcher--it is the individual’s perception and the unique meaning placed on experiences as well as the culmination of these perceptions and experiences that must be honored as truths. Adopting the interpretivist perspective for the current study allowed me, as the researcher, to extend my understanding and view of human behavior throughout all components of this research project including the therapy, observation, and interpretation.

Researcher as Instrument

Regardless of methodology, in qualitative research, the researcher is the primary tool (Merriam, 1998). The voices and experiences of the research participants are heard

and described through the lens of the researcher. One of the philosophical assumptions within this type of qualitative research is reality is not a fixed entity but rather subjective with multiple interpretations. A sensitivity or intuitiveness must be exhibited by qualitative researchers (Merriam, 1998). This sensitivity was not only applied to the observation and collection of data within this study, it was also applied to the subjectivity of my innate individual biases and assumptions inherent to this type of study (Merriam, 1998). Therefore, within the context of this particular study and as the researcher and therapist, I brought my own construction of reality and assumptions. These were built on my prior life experiences, my training in education and school psychology, and my personal and professional views. As the researcher, reflective self-exploration and communication of my own views and assumptions proved essential throughout all phases of the design, development, and interpretation of this study.

Perhaps one of the most salient reasons I chose this research topic was out of a continued interest in and genuine concern regarding the intensely behavioral-driven treatment protocols for young children with ASD. On a personal level, I found the idea of such rigorous behavioral programs disheartening. The constant demands of these programs for young children and the continual message regarding these conditions of worth was dispiriting. The intensity of these programs (up to 40 hours per week) necessitated that children endure contingent praise and rewards for nearly all of their waking hours. The idea of one's entire existence permeated with behavioral requirements and conditional rewards seemed not only discouraging but also a hindrance to the fundamental intent of any early intervention program to enhance a child's well-being. The premise behind these interventions was logical as they have a strong history

of effectiveness as well as a certain ease with which adults can tailor and design treatment to target individual skill deficits and unwanted behaviors. However, what must it be like for these young children to experience continual messages of needing to change and feeling as though they are not good enough to be accepted as they currently exist? What must these children feel when all of the adults in their lives give praise, attention, and acceptance contingent on their behavioral performance?

Throughout my professional experience as a nationally certified school psychologist with an Ed.S. as well as that of doctoral intern in a private outpatient clinic, I came in contact with several young children diagnosed with ASD. As part of my services, I also worked with the families of these children. Of the many with whom I worked, my experience with one young child in particular spurred my interest in research regarding the use of CCPT with young children diagnosed with ASD.

Following the recommendation of many independent specialty therapists and doctors who adhered to a strictly behavioral treatment protocol, the family and early intervention providers of this young child obediently followed the requirements of the recommended programs. Following implementation of these strategies, his family and providers began to see behavioral changes in him as he progressed toward the team's identified goals. However, his parents reported he began to display more tantrums, less emotional regulation, and lower frustration tolerance. While the concept of the extinction burst within the field of behavioral psychology is well known when modifying an individual's behavior, the increased negative behaviors displayed in this instance were different. There seemed to be a growing disconnect between the child and his providers. Furthermore, on various occasions, his parents commented on what they felt was a

growing disengagement in their child. These parents expressed such extreme apprehension at the idea of carrying through with the behavioral strategies in their home that they opted out of the early intervention services they had been receiving and expressed their desire to find an intervention that proved more conducive to everyday interactions with their son as well as improved their child's relational skills. This family indicated the behavioral strategies, while aiding in the change of their child's behaviors, felt artificial. These parents expressed great concern and dismay at the targeted behaviors being taught and felt their child was being subjected to a behavioral program that worked on skills most appropriate for a school setting--skills that allowed their son to fit neatly into the mold of a student yet left his relational difficulty and his unhappy demeanor untouched. They were dissatisfied with the idea of simply training their child to fit into the educational system. The main characteristic they identified as most important and wanting to change was that of an enhanced relationship. They wanted a deeper connection with their son and, as a result, began their search for alternatives to the behavioral interventions they had received.

Shortly after I met this family, I enrolled in my university's play therapy practicum. The content from this course seemed to fill the gaps I had recently discovered in my prior held professional beliefs. I soon found myself questioning my behaviorally-driven undergraduate education and identified more genuinely with a client-centered theory. On a personal level, I always valued my relationships with family and friends above all else. However, as I began to more fully explore the philosophy of the humanistic approach, I started to see the immense constructive power of these relationships. As I examined these values within my own life, I began to recognize how

it was the act of “being with” and my expression of my unconditional acceptance of my own toddler aged child, not the artificial positive and negative reinforcements pushed upon him, that enhanced the security of his attachment style and led to his increased self-regulation, confident exploration of the world, enhanced development, and ultimately his happiness.

My subsequent coursework in play therapy and later play therapy practicum revealed the therapeutic and self-healing benefit of relationships, trust, and safety. Furthermore, the therapist’s way of being within these relationships is so distinct from most other adults in children’s lives that they often react in awe that an adult can be so accepting. In a world filled with adult-posed questions, quizzes, structured play groups, and teaching moments, I can only imagine the experience of an adult who wants to learn about and understand the child’s world directly from the child is novel.

I found this experience not only encouraging but in a way empowering as I had finally found the type of intervention that fit with not only who I am as a person but with what I believe as a therapist. I found my previously held reverence for relationships within my personal life could effectively be endorsed within my professional work with children. I found play therapy, specifically nondirective play therapy with a reliance on unconditional positive regard and the relationship as the vehicle for children to reach their full potential, to be the perfect fit leading to an ultimate congruence between who I had become as a person and parent and what I believed as a professional.

I then began to wonder how this unconditional acceptance would be received by young children with ASD--children who spend most of their lives enduring the request to change (through behavioral modification and teaching/reinforcement) by most of the

adults within their immediate world. I found myself questioning how young children with ASD might respond to the experience of a setting in which they themselves could choose to play however they wanted--a setting in which their desires and needs to play a certain way would be respected versus corrected and a setting in which they were accepted without condition. This question sparked my interest in and eventual study of the use of CCPT with young children diagnosed with ASD. Through the previously described experiences, I found my perspective as a parent and a school psychologist to be child-centered. I believe the idea Bill Clinton declared as true for our nation is also true for each of us as individuals—"there is nothing so wrong with any of us that what is right within us cannot fix it." I believe human beings are innately inclined to move toward positive growth and healing and I believe that through a genuine relationship in which unconditional acceptance is conveyed, anyone, regardless of their disability or difficulty, can make lasting and meaningful progress toward positive growth.

Methodology

The methodology or guide for data collection used for this study was a qualitative, collective case study. Creswell (2007) described the case study research design in qualitative research as the examination of an object of study or a product of inquiry including the in-depth exploration and description of an issue through examination of one or more cases within a bounded system (Merriam, 1998). This qualitative approach utilizes the researcher as the investigator and explorer gathering and collecting detailed in-depth data. Merriam (1998) noted that "the single most defining characteristic of case study research lies in delimiting the object of study, the case" (p. 27). For the purpose of this study, the bounded system included three young children ages six to seven--one girl

and two boys who were all previously identified with ASD and participating in CCPT. A within and cross case analysis occurred as similar issues were explored through each of the three cases. The cross case analysis, which allows case studies a more in depth understanding and illustrative picture (Yin, 2014), described and compared the experience of these children through the course of their participation in CCPT.

Participant Selection

According to Merriam (1998), case studies differ from other types of qualitative research in that they are an in-depth description of a bounded system. This study was bound by families with a young child diagnosed with ASD. Participants for this case study were recruited through a purposive process. The power of purposeful samples lies in selecting information-rich cases from which one can learn a great deal about issues of central importance to the purpose of the research (Merriam, 1998; Yin, 2014). While there are several types of purposeful sampling, due to the extent of the selection criteria for the current study, a convenience sampling method was deemed the most appropriate (Merriam, 1998; Yin, 2014) and carried out. Multiple case sampling as reported by Miles, Huberman, and Saldana (2014) works to add confidence to study findings. As this was a collective case study, which allowed the examination and comparison of several cases within the study, a tentative sample size of three to five was sought; the total number of participants for this study ended up as three. This sample size allowed the comprehensive examination of different perspectives within this bounded system.

Participant Identification

Upon approval for this study from the University Institutional Review Board (IRB; see Appendix B) and approval from the administrator of the Educational Service

Unit #13 (ESU#13) in Scottsbluff, Nebraska, local special education directors and early childhood service coordinators were initially contacted via email with follow up in person meetings scheduled for those willing to allow recruitment within their school districts. Within the initial email, I summarized and described the nature of this study and requested permission to recruit families from their districts or schools. Recruitment efforts included two separate emails contacting special education directors and early childhood service coordinators of five districts within the Western Nebraska Panhandle. Basic study information was provided within these emails as well as participant criteria (i.e., age, diagnosis). Flyers were given to three school sites that approved recruitment of students/children (see Appendix C).

One area school district superintendent was willing to meet in person to learn about this study. Following this meeting, he subsequently allowed my recruitment efforts to occur in his school district. These efforts included contacting the special education director as well as special education teacher by email for identification of potential participants. This contact resulted in two potential participants. I obtained permission to contact the families of these potential study participants and briefly discussed the main components of the study with their parents. Both families agreed to meet in person to learn more about the study.

I met with the first family for our initial face-to-face consultation in June 2014. This family readily agreed to participation. Due to this family's immediate agreement, the explanation of the study specifics and signing of the consent were combined with the initial interview and child observation.

The second family recruited through the school district met for a face-to-face discussion of the study but chose to wait until August 2014 for the interview and therapy sessions to begin. This family subsequently allowed me to coordinate with their child's school to provide therapy sessions during the school day.

Following the recruitment of these two participants through the schools, there was a delay of several months because no additional families were identified from the surrounding school districts. Thus, I subsequently contacted the local pediatric clinic and met in person with their medical staff to discuss my study and obtain their permission to leave brochures in their office waiting room. This contact resulted in several referrals but no families were willing to commit to the full 16 sessions of therapy.

The third family for this study was referred from a local mental health therapist who had heard of my study via my play therapy supervisor. This family was initially approached about participation from their local treating therapist. The family was interested and contacted me about the possibility of participation. A face-to-face meeting was scheduled where the study was explained, consent was obtained, and an initial observation at the student's school was scheduled.

Five district superintendents and special education directors as well as two early childhood network coordinators were contacted through local school districts. In addition, one local pediatrician office was also contacted and resulted in several participant referrals. In all, four potential families were briefed about this study during face-to-face meetings; three families agreed to participate. All families were provided informed consent (see Appendix D) and all children were required to give verbal assent (see Appendix E).

Participant Criteria

Criteria for inclusion in this study were young children between the ages of three years to early elementary (approximately age seven) who had previously been diagnosed or educationally identified with ASD. These age brackets were chosen based on the idea early intervention services are essential for the prevention of new and remediation of current difficulties (Lord et al., 2012). It was essential that participants and their parents were willing to participate in bi-weekly CCPT sessions for the duration of 16 sessions across eight weeks.

Although it was not possible to rule out every potential disorder in an individual, every effort was made to identify participants who were currently diagnosed with ASD only. Participants were screened through the initial parent interview to determine if their child met study criteria and to ensure there were no self-injurious or harmful behaviors. These exclusionary criteria were carried out in an effort to reduce potentially dangerous situations for the participants. Furthermore, while participants were not required to be verbal, efforts were made to include children who had some form of functional communication (e.g., pointing, gesturing, signing, or used augmentative devices).

Throughout this study, all names and identification criteria were kept strictly confidential throughout all phases of this study. In all reported data, pseudonyms were utilized with no other identifying information revealed. Additionally, all research data including therapy and observation notes, video and audio tapes, as well as parent journals were kept in a locked room within the play therapy supervisor's clinic. All video and audio recordings will be destroyed three years following research publication in an effort

to further maintain participant confidentiality. Consent and assent forms (see Appendices D and E) will be kept by the research advisor per university IRB Procedures.

Participants

Two boys and one girl between the ages of six and seven years participated in this study. They were assigned the names Marley, Micah, and Joshua. Adult participants for this study included their parents, educators, the registered play therapy supervisor (RPTS), and me as a participant observer. As an incentive for continued participation, families who participated in the pre- and post-interviews and all 16 sessions of this study were provided a \$45 gift card following the completion of their final interview.

Marley

Marley, a young girl of six years, participated in the CCPT intervention beginning in the summer (June 2014) through the fall of her kindergarten year (September 2014). Marley is an only child who lives at home with her mother, an elementary school teacher, and her father, a Burlington Northern Railroad employee. Marley was reported to have been identified with ASD since the age of two following her parents' concern regarding her delayed speech and complex body movements. Marley's mother and father noticed Marley's developmental differences when Marley was five to six months old. These differences included delayed acquisition of major developmental milestones including non-discernable words until the age of three- to four-years-old, did not walk until she was 14 months old, and delayed toilet training until about age four.

However, Marley did not seem to have the extreme social difficulty many physicians in this area look for when diagnosing autism. Thus, Marley's family had to search a bit harder for a clear answer, meeting with several local physicians before

finally ending up in a specialty clinic in Colorado where Marley was evaluated and received the diagnosis of autism and attention deficit disorder. Following this diagnosis, Marley's parents started searching for appropriate treatment. While Marley has developed some speech since her initial referral, she entered this study with limited comprehensible language, although she often attempted to verbally share her ideas. Thus far, they have chosen the treatment options of equine therapy and speech therapy. Marley previously received equine therapy for a few weeks. She has received speech therapy since the age of three. For the duration of this study, Marley was receiving only speech therapy. This therapy occurred twice per week for 30 minutes each session for the first two weeks of the CCPT intervention and then was discontinued until school started during the last two weeks of the intervention. Marley's speech therapy was reported by her mother to focus on articulation and has been provided by the same therapist for the last 2.5 years.

Micah

Micah, a 7-year-old male, is the youngest of four siblings. He lives with his two sisters, brother, mother, and father. Micah's mother, the school librarian, and Micah's father, a high school teacher, reported that Micah, who is currently nonverbal, was identified as a child with autism at the age of two years following the lack of speech development. He has since received year round occupational and physical therapy one time per week and speech therapy services two times per week. These services have all been in place from the same providers since Micah was identified at 2-years-old and continued throughout Micah's participation in the current study. Micah started his

participation in CCPT sessions during the fall of his second grade year--September 2014 through December 2014.

Joshua

Joshua is a 6-year-old boy who was adopted by his current parents at the age of 11 months. Joshua was reported to have been verified by the school district's Early Intervention Network immediately after entering the preschool. Joshua was 4-years-old when he was initially verified as a student with a developmental delay. "We had him at a private preschool thinking that the smaller class would be beneficial for him. And then started noticing that he wasn't the same," Joshua's father revealed. Joshua was subsequently placed in the local public preschool where he was immediately identified as a student in need of extra support. "They (school teachers) noticed it right way," Joshua's father recounted. Therefore, the multidisciplinary team (MDT) quickly evaluated and verified Joshua as a student with a developmental delay. The most recent MDT in spring 2014 verified Joshua as a student with an autism spectrum disorder. Currently, Joshua receives special education services through the school in the form of weekly speech therapy (20 minutes one time per week), occupational therapy (30 minutes about once per week), and daily resource intervention (30 minutes per day). Furthermore, Joshua's mother, who is a student in an Applied Behavioral Analysis master's program, and his father, who is currently a dean at the local junior college, reported Joshua had been receiving outpatient therapy from a local mental health therapist (45 minutes every other week) for the last two years. For the duration of this study, the mental health professional provided only brief consultation for Joshua and his parents. Joshua's parents indicated no new strategies were recommended or employed by

the therapist or in the clinic or home setting. Additionally, Joshua previously engaged in equine therapy. Joshua maintained all therapies except that of equine therapy throughout his participation in this study, which spanned from November 2014 to January 2015.

As the therapist and as a participant observer, my role as a participant in this study must be considered (Lincoln & Guba, 1985; Merriam, 1998; Yin, 2014). Details of my participation included my direct involvement in the lives of families with young children diagnosed with ASD as well as the therapist providing CCPT to the young children participants. Due to this dual role, I found myself burdened with the continual challenge of balancing involvement and immersion into the lives of these children and their families while attempting to maintain professionalism (Creswell, 2007). The concept of researcher as participant is further explored in the data collection section.

Other adult participants within this study included the child participant's parents and educators as well as the RPTS. Mark Hald, Ph.D., licensed psychologist, licensed school psychologist, and registered play therapist served as the RPTS throughout this study. Dr. Hald has an extensive background working with children, adolescents, and families in a variety of settings over the last 24 years including residential treatment centers and psychiatric hospitals. While Dr. Hald prescribes to a trauma/attachment focused daily practice with specialized interests in interpersonal neurobiology, he also has extensive training in and frequently serves as a supervisor for other professionals in play therapy including child-centered play therapy. Dr. Hald's supervision throughout this study focused on the CCPT model as he provided feedback and guidance to facilitate my adherence to this model.

Procedures

Description of Therapy

Child-centered play therapy (CCPT) is a type of play therapy based on the belief that each child has within themselves and is an expert on what is needed to move toward healing and grow to his/her full potential (Landreth, 2012). Child-centered play therapy utilizes the therapeutic relationship and a playroom stocked with specifically selected toys. This allows the child to feel the safety and acceptance required and provides the setting needed to engage his/her most natural mode of communication--play.

As previously noted in Chapter II, creating an environment in which children feel fully accepted as they are and thus develop self-acceptance is vital to the success of CPPT. Within this accepting and understanding environment, the therapist helps the child move toward self-enhancement with specific techniques guided by Axline's (1974) eight basic principles. Table 3 provides examples of an ideal therapeutic contact with the child.

While the nature of CCPT is inherently nondirective and the essential vehicle for change is the therapeutic relationship with the child (Landreth, 2012), other essential components of CCPT include the therapist's use of specific therapeutic techniques. Ray (2011) described necessary techniques in the process of CCPT to include both nonverbal and verbal skills. The nonverbal skills convey unconditional acceptance and through the therapeutic relationship, allows children to see themselves as the experts capable of appropriately directing their own growth (Landreth, 2002). Verbal skills required of the CCPT therapist include tracking behavior, reflecting content, reflecting feeling, facilitating decision-making, returning responsibility, facilitating creativity, using

spontaneity, esteem building, encouraging, facilitating relationship, reflecting larger meaning, and limit setting (Ray, 2011). However, the power of CCPT lies in the fact that it does not require the use of verbal responses by the participant or the therapist. The previously mentioned skills could be affectively utilized in a nonverbal manner to create a sense of connectedness and acceptance.

The therapist is verbally and nonverbally engaged through continual reflections of the children's behaviors or reactions and through following them with eyes and body. The therapist seeks to match the children's tones and movements through into only verbal but also nonverbal reflections. (Ray, 2011, p.167)

Ray (2011) proposed that each of the constructs of child impairment is addressed respectively through all of the nine categories of responses utilized in CCPT. The specific techniques within CCPT as well as the nurturing environment provided by the therapist work together to improve overall functioning as well as specific areas of difficulty. The categories of CCPT responses and corresponding child impairment addressed are presented in Table 4.

Table 3

Eight Basic Principles

Principle	Example
1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.	Establishing rapport; establish a warm and friendly relationship; accepting tone of voice
2. The therapist accepts the child exactly as he is.	Accept the child completely; maintain a calm, steady and friendly relationship; do not show impatience; avoid praise or criticism; use action words; allow and accept the child's choices within the play room tone of voice, facial expression and gestures all exude acceptance
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely	Verbal expression of permissiveness in playroom "you may play with these toys in most any way you like"
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feeling back to him in such a manner that he gains insight into his behavior	Recognize and reflect feelings; "That made you angry"
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.	Maintaining respect for the child; the child makes the choices, the therapist remains friendly, relaxed, and interested
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.	The child leads the way; no criticism, no praise, if the child asks for help it is given, the child makes own choices; no prearranged selection of toys, suggestions offered, or prompting
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.	Therapy cannot be hurried; therapist must maintain patience; therapist must allow the child to take their time
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.	Value of limitations; limits few but very important; include limiting willful damage to room, self or therapist; time limit enforced in the room

Adapted from Axline, 1974.

Table 4

Therapist Responses Used in Child-Centered Play Therapy

Response Category	Target Factor	Description	Example
Tracking Behavior	Relationship alignment	Therapist verbally responds to behavior of the child by stating what is observed	"You're picking that up."
Reflecting Content	Empathy	Therapist paraphrases the verbal interaction of the child	"You went to see the pirate movie and there was a lot of action in it."
Reflecting feeling	Empathy	Therapist verbally responds to emotions expressed by child	"You're angry about being here and want to go home."
Returning responsibility	Emotional regulation	Therapist verbalizes statements to help child experience their own capability and take responsibility	"You decided you would be the boss and take charge." "That looks like something you can do."
Facilitating creativity	Emotional expression	Therapist verbalizes statements that help a child experience a sense of freedom and creativity	"In here, it can be whatever you want it to be."
Esteem building	Self-concept	Therapist verbalizes statements to help children experience a stronger and capable sense of self	"You did it. You tried hard and figured it out."
Facilitating relationship	Empathy	Therapist reflects statements that build the relationship between therapist and child	"You wanted to be close to me." "You wanted to do something to help me."
Reflecting deeper meaning	Empathy	Therapist notices and verbalizes patterns in the child's play	"When you come into the playroom, you want to be the one in charge."
Limit setting	Emotional regulation	Limits are set according to a three-step procedure of reflecting the child's intention of feeling, setting a definitive limit, and providing an appropriate alternative	"You are really angry with me but I'm not for throwing sand at. You can throw the sand in the sandbox."

Adapted from Ray, 2011.

Location of Therapy

The location for therapy was specific to the request of the child's parents as well as the time of year in which therapy occurred. Initially, therapy sessions were to take place in local educational institutions based on room availability and location of study participant's residences. For two participants, therapy was provided within the educational setting. However, one family chose to have the therapy occur in a private outpatient clinic because of the timing of the therapy (summer). Although the three participants took part in therapy in three separate locations, explicit effort was made to ensure therapeutic toys within each setting were similar so as to provide a degree of consistency. The same play therapy kit was provided in each of the two separate educational settings. However, the initial participant therapy sessions occurred in a private clinic therapy room established as a play therapy room. While there was consistency with regard to categories of toy selection within all settings, there were differences between physical layouts of the room as well as some differences between the toy items in the clinic and educational settings.

Selection of Toys/Playroom Characteristics

Play materials for use in the play therapy setting were indicated by Landreth (2002) to require careful consideration and selection; therapists are cautioned to make conscious decisions regarding the selection versus collection of these materials and toys (Landreth, 2002). Therefore, the selection of toys for this study followed those suggested by Landreth. Table 5 outlines the types of toys available to participants throughout all three settings through a mobile play therapy kit or previously stocked play therapy room --the only exclusion being a gun.

Table 5

Play Therapy Toys in the Mobile Play Therapy Kit

Category	Toys
Family/Nurturing Toys	Dollhouse (Fold and go travel doll house) Baby doll, cradle, blanket, bottle 2 doll families: Caucasian & Hispanic Complete Kitchen Set (Pots, pans, play food, play kitchen utensils)
Scary Toys	Creepy Crawler Set (Snake, Lizard, Spider, Scorpion) Farm Animal Set Plastic Monster Set Alligator puppet
Aggressive Toys	Army Set (army vehicles, toy soldiers) Action Role Play (Cape, Mask) Police Set (Handcuffs, Badge)
Expressive Toys	Art Supplies (paints, crayons, glue, Playdoh© scissors, paint brushes)
Pretend/Fantasizing Toys	Doctor kit Blocks Trucks (construction vehicle, emergency vehicle, police vehicle) Tool set

Due to the required location and room availability, a mobile play therapy kit was assembled and used for two participants' therapy sessions. Use of a mobile play therapy kit such as the one used for this study was reported as useful for all therapists with limited room availability, allowing therapists to provide therapy in most any setting (Landreth, 2002; Ray, 2011). The same five categories of toys appropriate for a stationary room were utilized for the portable play therapy room in this study.

Toys were selected according to the children's developmental level and based on Landreth's (2002) five main categories when utilizing a mobile play room include

ensuring consistency of setting and confidentiality provided by the space utilized (Ray, 2011). Correspondingly, with regard to this study, special consideration was taken when determining appropriate toys based on participants' developmental levels and sensory needs; this included the removal of specific toys or play kit items identified as negative sensory triggers for study participants. For example, Micah was observed in the initial session to have intense sensory needs including putting most items in his mouth. For his safety, sand was left out of the room and larger items were provided (e.g., rubber duck) to reduce choking hazards. Finally, play therapy toys were arranged in an identical manner from session to session in an effort to further promote consistency among each participant's therapy sessions. However, it should be noted that due to the structural room differences in the separate locations, placement of toys, while similar, was not identical.

Marley's Setting

Throughout the duration of Marley's CCPT intervention, which started during the summer months and finished during the fall semester of her kindergarten year, she attended intervention sessions located at a private outpatient psychology clinic in western Nebraska. This clinic was chosen at her parents' request due to their local school being closed for maintenance during the summer months. This clinic contained a previously created CCPT play therapy room already stocked with the same five categories of therapeutic toys contained within the traveling play therapy kit. However, this therapy room included the toy gun as well as multiple choices of toys within each category of therapeutic toys versus the more streamlined choices within the play therapy kit.

Throughout Marley's participation, no alternation to the room or the toys within the room was required.

Micah's Setting

Micah's mother and father both worked at Micah's school and reported it was not feasible to transport him to and from sessions during the day. Therefore, Micah's school setting was determined the most appropriate location to provide the CCPT intervention. Fortuitously, the superintendent at Micah's school had given his prior support when contacted about recruitment possibilities for this study. Thus, when approached regarding the provision of study intervention sessions in his district, he immediately agreed and graciously set aside one small unfurnished room that would be used almost exclusively for this intervention for the duration of the study.

All 16 sessions took place in this small room, which was adjacent to the special education room and Micah's individual "work room." This work room provided a quiet place for Micah; he and his one-on-one paraprofessional used it when they worked on academic and daily living skills. Most of Micah's specialized services through the school, e.g. speech therapy, occupational therapy, and physical therapy also occurred here. For Micah's intervention, I utilized the traveling play therapy kit assembled specifically for this study.

For each session, the traveling play therapy kit was transported to the school and efforts were taken to arrange the toys in a similar fashion prior to each of the 16 CCPT sessions. While all categories of toys within the play kit were placed within Micah's therapy setting, some alterations such as the addition of light filters, the removal of the sand tray, and the replacement of a large rubber duck for a small rubber duck were

required due to Micah's significant sensory needs. These individualized alterations to the playroom were noted by Ray et al. (2012) as appropriate if not essential to maintain a sense of safety within the therapeutic setting. In addition, Micah's communication device was brought into each session and the visual timer on it was used to help with the transition to and from therapy sessions.

Joshua's Setting

All 16 sessions of Joshua's CCPT occurred within his educational setting. Joshua's school counselor provided her therapy room for these sessions. This room--which was furnished with a table and chairs, several cupboards, and a standing sand table--was briefly cleared out (i.e., furniture moved to the side and residing toys placed out of sight) and the items of the play therapy kit arranged prior to each of Joshua's sessions. As with the other participants, efforts were made to arrange the toys in a similar fashion each session. No toys were excluded for any of Joshua's CCPT sessions. The only alteration to Joshua's setting was the standing sand table was used versus the sand tray.

Supervision Plan

Play therapy sessions were supervised by a registered play therapy supervisor (RPTS). Although it was originally proposed that 60-minute weekly supervision sessions would occur throughout the duration of this study, the actual amount of supervision time per week varied due to the schedule of the supervisor. Some weeks consisted of quick check-ins while other weeks consisted of two or more hours of supervision sessions to ensure adequate attention was given to maintaining the integrity of the CCPT. Supervision consisted of both live supervision as well as multiple reviews of recorded

sessions. These sessions served as an additional reliability check with regard to treatment integrity as well as identification and confirmation of emerging theme development among participants' play behaviors. The final supervision contract is included in Appendix F.

Data Collection

Multiple sources of information such as observations, interviews, audiovisuals, documents, and physical artifacts are vital to in-depth data collection necessary in a qualitative case study (Creswell, 2007; Yin, 2014). Data sources for this study aligned with the most common forms of data collection in qualitative case study research and included direct field observations, participant observations, audio recorded open-ended interviews, parent responses to weekly probes, and researcher field notes (Creswell, 2007; Merriam, 1998; Yin, 2014). Utilizing multiple sources of data collection not only increases the trustworthiness of the results through triangulation (Merriam, 1998) but also allowed me, as the researcher, to address a broader range of possible results (Yin, 2014). Furthermore, through the convergence of evidence, which was possible only by employing data triangulation, the construct validity of this study was strengthened (Yin, 2014). Data collection plan for this study (i.e., observations, interviews, and documents) allowed for this triangulation as well as multiple measures of similar phenomena, leading to the corroboration of study findings (see Figure 2), all of which ultimately results in the strengthening of the study results (Yin, 2014).

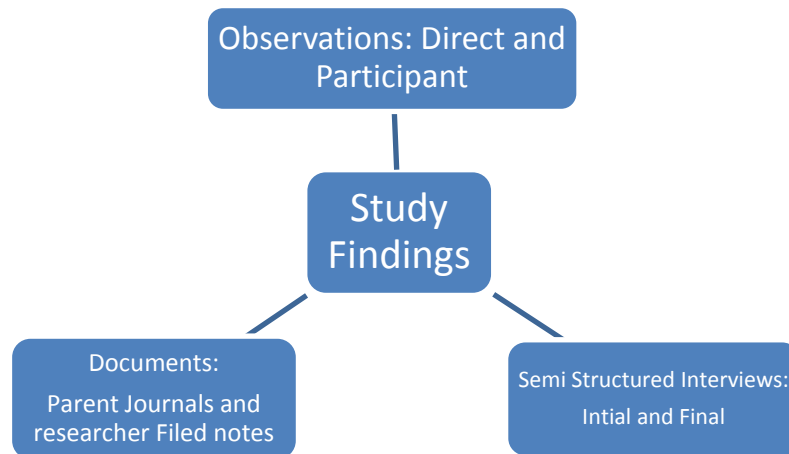


Figure 2. Convergence of evidence.

Data Collection Procedures

Prior to their participation in CCPT sessions, each child was observed in his/her home setting or another setting of the parents' choice. This observation was planned to be one hour in length and occurred in tandem with the initial parent interview or immediately after, depending on the parents' location preference. This initial individual contact was also the forum in which the researcher answered any additional questions and plans were finalized regarding the logistics (e.g., time, locations) for the CCPT sessions. Following the initial interview, typically within the next week or two, each child participant began receiving sixteen 45-minute CCPT sessions. Every effort was made to ensure these sessions occurred twice per week. As Josefi and Ryan (2004) indicated within their study, the most progress is made during the time frame in which sessions occurred twice per week. However, several extraneous circumstances did arise in which some sessions required cancellation (e.g., illness, weather, school cancellations) and some weeks did not allow for two sessions because of holidays or family vacations. In

these instances, the bi-weekly sessions were continued as soon as feasible in subsequent weeks and thereafter until the child had attended a total of 16 CCPT sessions. Table 6 presents a timeline for the CPPT sessions.

Table 6

Timeline of Child-Centered Play Therapy Sessions

Student	Timeline
Marley	Interview/Observation 6/25/14 Week 1 6/30/14 Week 2 7/3/14; 7/7/14 Week 3 7/9/14; 7/14/14 Week 4 7/24/14; Sick/rescheduled 2 nd session Week 5 7/30/14; Family vacation only one session Week 6 8/5/14; 8/8/14 Week 7 8/12/14; 8/15/14 Week 8 8/19/14; 8/21/14 Week 9 8/28/14; 8/29/14; *final make up session cancelled
Micah	Interview 8/6/14 Observation 10/10/14 Week 1 10/20/14 (second session not scheduled due to school break) Week 2 10/27/14; 10/29/14 Week 3 11/3/14; (Second session cancelled due to Micah's illness) Week 4 11/10/14; (Second session cancelled due to researcher absence) Week 5 11/17/14; 11/19/14 Week 6 11/24/14; 11/25/14 Week 7 12/1/14; 12/3/14 Week 8 12/8/14; 12/11/14 Week 9 12/17/14; 12/19/14 (catch up sessions)
Aidan	Interview: 10/27/14 Observation: 11/12/14 Week 1: 11/12/14; 11/14/14 Week 2: 11/17/14; 11/19/14 Week 3: 11/24/14; 11/25/14 Week 4: 12/1/14; second session cancelled due to Aidan's illness Week 5: 12/8/14; 12/10/14 Week 6: 12/15/14; 12/17/14 Week 7: 1/7/15; 1/8/15 Week 8: 1/12/14; 1/14/14 Week 9: (make up session) 1/20/15

Observations

Throughout this particular study, my role as therapist as well as participant observer created an intimate interaction with study participants within the therapeutic

setting. According to Merriam (1998), under this stance of “observer as participant,” my first obligation was to the observation but I also had the ability to interact enough to establish an insider’s identity with the child participant without being overly intrusive to effect the “core of the group membership” (p. 101). As such, when directly facilitating therapy sessions, I concentrated on my role as participant observer and focused primarily on providing quality therapeutic services while secondarily observing the therapy process. I then watched the video of each session to more specifically focus on observing the therapeutic process and participant behaviors.

Observational data collected included direct observations during each of the 16 CCPT sessions for each child participant as well as review of the audiovisual recording of each therapy session. Additionally, an observation occurred during an initial visit to the child’s natural setting or other setting of the parents’ choice prior to the initiation of CCPT and at the completion of the 16 CCPT sessions. An observational protocol was used to record notes during each observation. These observational protocols (see Appendices G and H) included items from a typical play therapy case such as those recommended by Ray (2011). The initial and final observation protocols were based on typical play therapy summary notes but were adjusted to include more general behavioral data. The protocol utilized for each of the CCPT sessions facilitated my observations related to the guiding question and sub questions of this study. Therefore, this observational form was tailored to include items that allowed for the tracking of the frequency and duration of objective behaviors/interactions of interest (e.g., eye contact, child initiation, joint attention, type of play). Participants’ significant verbalizations were also recorded as well as the frequency and type of limits required by the therapist.

Furthermore, participants' duration and frequency of play with specific toy categories was recorded as was a participant's duration and frequency of sensory and symbolic play. Subjective information was collected through the use of this protocol and included the recording of play themes, inclusion of therapist, and child affect. Finally, following each session, I chronicled my impressions including important moments and reactions pertaining to the CCPT session, participants' progress, and any significant information verbally relayed from participants' educators or parents within the researcher field notes section on this form.

Each CCPT session was video recorded (with parental permission); this allowed multiple viewings and more accurate observational opportunities. These recordings were reviewed by the researcher and RPTS as part of supervision and as part of the process for data analysis and theme development. Review of these tapes with the RPTS served as a form of reliability check that I was implementing CCPT with fidelity and that I had accurately identified emerging themes/play sequences.

Interviews

Interviews were used to yield a distinctive form of information prior to and following the completion of 16 CCPT sessions with study participants' parents (Merriam, 1998). These semi-structured, open-ended interviews were facilitated by a protocol in which the questions were guided toward the gathering of basic developmental information as well as information and insights related to the child's diagnosis of ASD and typical play behaviors. These questions followed a format consistent with a routines-based interview; the information gathered aligned with the premise of the guiding question and sub questions (see Appendix I). The interview guide served as a channel to

direct the dialogue and allowed for flexibility to accommodate parent input and direction. Follow up questions as well as prompts such as “Can you tell me more about that?” or “What do you mean by that?” were used when further explanation was warranted. According to Merriam (1998), “This format allows the researcher to respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic” (p. 74). This method of interview coincided with the theoretical framework of the study as they both aimed to explore the participant’s individual construction of reality.

The final interview was structured to begin with a review of the parents’ responses to the initial interview. Parents were often quite exuberant to discuss changes they noticed and thus allowed to more fully guide the format of the interview. Additionally, when possible and with parental permission, the study participant’s teachers were invited to share information regarding the child’s behavior within the educational setting; these insights were recorded within the researcher field notes. As suggested by Creswell (2007) and Merriam (1998), the initial and final interview sessions were audio recorded and transcribed to allow for preservation and analysis of all verbalized data.

Documentation

Ongoing documentation throughout this study included reflective researcher field notes and parent journals. As previously noted, researcher field notes including significant moments during CCPT sessions were recorded on the CCPT observation forms. This introspective record of the researchers experience was reported by Merriam (1998) to be a great source for the documentation of ideas, fears, thoughts, and reactions regarding the research, participants, and interpretation possibilities. In addition, as Park and Lahman (2003) suggested, a researcher’s use of journaling not only serves as a

channel to work through various dilemmas that might arise in the study process but might also serve to help the researcher see data through a new lens and focus on methodological matters. I found these field notes to be essential as I worked through reflective supervision as well as when I worked through theme development.

Parents of the study participants were requested to provide responses to weekly probes in a provided journal or through e-mail responses. The weekly probe (What, if anything, is different this week?) remained the same throughout the duration of the study and allowed the provision of information on the parents' perspective of their child's progress throughout the study. These responses, similar to other study documents, were kept in a locked file cabinet in the RPTS clinic when not in use. Email was sent to an email account through the CCPT supervisor's secure network, which was only accessible within that clinic. The data obtained from these documents were then combined with interview information to obtain a more complete picture of the parents' experience throughout the process of CCPT and this study.

Requests to respond to the weekly probe were provided following each week's CCPT sessions. Marley's mother requested to complete these probes within an individual journal. She was provided this journal at the start of Marley's CCPT session and responded to the weekly check-in/probe or recorded other significant moments from the week while she waited for Marley's session to conclude. However, since Joshua and Micah attended therapy sessions during school hours in their home school building, their parents were emailed the weekly probe at the end of each week.

In most instances, parents provided prompt responses to these email probes; however, there were some instances in which parents reported that nothing of

significance had happened or simply did not respond. In total, Marley's mother recorded 16 entries in her journal (two per week). Micah's mother completed eight weekly probes while Micah's paraprofessional contributed several photographs to document his progress as well as verbal information regarding his progress on all 16 days I was in the district for CCPT sessions. Joshua's parents completed six weekly probes and his teacher provided verbal information regarding his progress on three different occasions. All verbal information from educational staff was recorded within the researcher field notes.

Data Analysis

Ongoing data analysis occurred simultaneously with the data collection throughout the duration of this study. This concurrent process enabled a richer, more in-depth analysis (Creswell, 2007; Merriam 1998). Data analysis often begins with the consolidation, reduction, and interpretation of information gained through data collection (Merriam, 1998; Yin, 2014). Accordingly, I began the analysis for this study by engaging in rich descriptions of CCPT sessions with respect to each individual case in an effort to search for emerging patterns, novel insights, or promising concepts. These descriptions were presented to the RPTS during supervision and were continually adjusted as the study progressed. This type of "playing" with data was suggested by Yin (2014) as the best starting point for qualitative analysis. This initial excavation provided a holistic analysis to expose a comprehensive depiction of each case and evolving themes.

Video recordings of each CCPT session, which were initially viewed and themes discussed as part of the supervision process, were reviewed several times in a stop and go fashion while concurrently creating an in-depth written Word document of each session.

Various sections were flagged and reviewed again with the RPTS in an effort to more specifically record complex behaviors within the playroom on the play therapy session summary and in an effort to confirm the categories/themes of play, interaction, and child affect I previously had coded.

Creswell (2007) noted that when multiple cases are examined, the aforementioned within-case analysis is typically utilized prior to the cross-case analysis. This allows a thicker description and deeper understanding of the cases separately, allowing more seamless cross case analysis. Accordingly, the next step in the study was the investigation of identified themes through a cross-case analysis. Thus, the previously developed categories and themes were analyzed with data displays, which allowed for comparison within and between participants (Yin, 2014).

A graduate student trained in the provision of CCPT subsequently reviewed a sampling of these videos to validate initial findings. Furthermore, to foster the emergence of patterns, tabulations are often beneficial (Yin, 2014). Within this study, the duration and frequency of specific categories of objective behavior (e.g., sensory play versus symbolic play) and more subjective behaviors (e.g., therapist inclusion, intensity of play, play activity level, and child affect) were tabulated and compared between participants' sessions and between study participants.

Narrative data including transcriptions of the audio taped interviews, journals, and e-mails were analyzed for themes with regard to the supporting questions as well as any other unique findings that arose. The first cycle of descriptive coding was conducted with a focus on using different highlights to distinguish each broad category within all transcribed interviews and weekly probes as well as within the written description of each

CCPT session. Within the framework of this study's research questions, themes were allowed to emerge in an effort for parent perspectives to be heard and parent emphasis to develop into corresponding themes and categories. This allowed the development of categories not necessarily in line with prior study findings or theories (Miles et al., 2014). Interviews, journals, and emails were put into category matrices to facilitate the comparison and contrasting of each data source and allow for theme development (Yin, 2014). Next, the data were reanalyzed with second cycle pattern matching in which the main categories found within the descriptive coding process as well as the predetermined categories relating to the guiding question of the study were confirmed.

Following the initial identification of themes, categories, and concepts, a cross case synthesis was applied. This technique allowed for more robust aggregated findings (Yin, 2014). For the current study, Word documents with data on each individual case were created in an effort to compare findings across case studies. This information enabled me to draw cross-case suppositions about the guiding research question and more specific supporting questions (Yin, 2014). As with the observations, an individual trained in coding and qualitative design reviewed transcripts and emails to further verify the trustworthiness of the researcher's findings (Miles et al., 2014).

Trustworthiness

Dependability is a method of evaluating qualitative research to ensure the results are aligned with the data collected (Merriam, 1998). Trustworthiness is a method of evaluating qualitative research that deals with the questions of whether or not the information presented is congruent with what qualitative research defines as reality (or the reality constructed by observations, interviews, and participants' perceptions)

(Merriam, 1998). According to Merriam (1998), these two methods serve as a means of ensuring research studies are conducted in a manner in which the results are trustworthy. Four strategies--which were declared by Merriam (1998) as appropriate safeguards to ensure dependability and trustworthiness and enhance validity--were utilized within this study: triangulation, member checks, external auditor, and peer examination.

Stake (2006) identified one protocol for triangulation that included data sources, investigators, theories, and methods. Data triangulation was obtained for the current study through the acquisition of multiple sources of data throughout this investigation. Data sources for this study included observations (direct and participant), interviews (initial and final parent interviews), and documentation (researcher field notes, parent journals, and parent e-mails). Investigator triangulation, which allowed for increased trustworthiness in data interpretation, aided in combatting the potential effects of researcher bias. Reflexivity was employed through the identification and disclosure of my initial stance, which was continually readdressed as the study progressed through reflective supervision and the journaling/field notes process.

Additional components of investigator triangulation included peer examination and consultation and supervision with the RPTS as well as with my research advisor and committee members. Peer review occurred through the use of the RPTS as well as a graduate research volunteer who was trained in CCPT. Both individuals watched and recorded behaviors of a smaller sample of play sessions to verify the fidelity of the CCPT approach and the trustworthiness of the researcher's observations. A graduate student trained in qualitative study design was recruited to review interview transcripts and e-mail/journals for recurring themes to compare with and verify the trustworthiness of my

findings. According to Creswell (2007), these peer reviews served not only as “an individual who keeps the researcher honest; asks hard questions about methods, meaning and interpretations; and provides the researcher with the opportunity for catharsis by sympathetically listening to the researchers feelings” (p. 28) but also as a source for credibility checking. External auditors were also employed to further establish credibility for this study. This technique of having an outsider audit or examine the research process as well as the study results ensured interpretations and findings were concurrent with the data (Merriam, 1998). For the current study, the RPTS served as the external auditor to review the study results, theme development, and interpretations while the dissertation committee members served as auditors of the study process.

Member checks were created through the review of transcribed interview information with adult participants (i.e., parents and educators when appropriate) throughout the study to determine if the resulting information was consistent with their perspectives. This strategy was essential to ensure the information gathered was substantiated. Lincoln and Guba (1985) considered this as one of the most critical methods of ensuring trustworthiness. Participants’ parents were invited to provide feedback regarding how well the transcription captured their perspectives. In summary, the abundance of checks and balances within this study served to not only strengthen the trustworthiness of the findings but also proved a strength of the study design.

CHAPTER IV

FINDINGS

The goal of all case studies is to illuminate a contemporary phenomenon (i.e., the case) within its real world context (Yin, 2014). For the purpose of the current study, the bounded systems or cases included each of the child participants, their parents, the researcher, their educators when appropriate, and their experiences throughout 16 sessions of CCPT. When presenting this data, I viewed it as essential to describe the essences and common themes of what these individuals experienced. As such, I included verbatim quotes and written information from weekly probes (from which insignificant words such as ums and uhs were removed) to further illustrate the experiences of participants. The case study results presented within this chapter encompass a thick description of data collected in an effort to illuminate and depict a more holistic understanding of each case.

My intent for providing this in-depth description was not to conduct a thorough comparison between cases but to illustrate and enhance a more comprehensive understanding of these bounded systems. A constructivism epistemology and interpretivist theoretical perspective supported the idea that individuals' experiences are inexplicably intertwined with the contexts and system in which they live. To separate these was to negate the experience of those involved. Therefore, the current chapter

provides a comprehensive context from which to better understand the specifics of the three cases examined as the children participated in CCPT.

The context presented for these cases included (a) the child's relevant history and a description of the family's perception of the child before and after therapy derived from themes gained from the initial and final parent interviews; (b) an in-depth look at significant moments, thoughts, and behaviors observed by participants' parents throughout the course of the CCPT; (c) descriptive accounts of participant therapy sessions through the use of play codes and themes as gained through multiple session viewings; and (d) researcher experiences as a participant observer derived from researcher field notes taken throughout the case studies.

The current chapter serves to facilitate the understanding of these cases as it illustrates a descriptive account of the experiences of each participant. Furthermore, it provides multiple examples of participants' statements, behaviors, and those of their families to highlight themes presented in the findings of Chapter V. Although it did not prove feasible to fully depict the participants, family, and therapy context without beginning to merge into study development, I attempted to avoid blatant interpretations within this chapter. On the contrary, I tried to focus on the concentrated descriptions of participant experiences.

Participants

Three children between the ages of 6 and 7 took part in the current study. One female and two males (Marley, Micah, and Joshua, respectively) who had all been previously diagnosed or educationally verified with an autism spectrum disorder participated in the CCPT intervention. Children with ASD and their families often face

significant difficulty with the symptoms and co-occurring behavioral difficulty often associated with ASD. Thus, themes for this study were created in an effort to encompass some of these main symptoms and behavioral areas as they emerged within the data collected.

Meet Marley

Marley arrived at the initial interview and observation session sporting a colorful pink sundress with ruffles, a purple sweater, and purple flip flops. Not only did Marley's wardrobe evoke the impression of sweetness and innocence, so did the way in which she fluttered around the waiting room giving her mom big hugs and crooning sweet sounding comments. "Hello," I introduced myself to Marley and her mother, an action that resulted in Marley's quick retreat behind her mother's leg. As I started to visit about where we would be conducting the interview, Marley emerged, her dark eyes peering at me through her blunt cut brunette bangs. The striking contrast of her translucent skin and dark hair seemed pixie-like, a characteristic that was strengthened when she spoke. "Hi Marley, I'm Miss Katie," I introduced myself to which she replied "umm hmm" in a delicate, fairy like sing song. As the three of us migrated to another room and into the interview format, I found this singsong reply was a typical response for Marley. To try to facilitate conversation, Marley's mother asked, "How old are you?" to Marley who replied, "MmmHmm." "So will you be going to Kindergarten or are you going to preschool next year?" I Asked Marley. "MmmHmm," she again replied. Periodically, Marley would again release a string of mumbled words that sounded melodic but were not discernable. Marley's mother reported that Marley's language skills had increased

greatly as she was reportedly nonverbal until the age of three. However, it was still very difficult for others to understand her.

Initial themes from the interview/observation.

Communication differences. Marley's language skills, though wrapped in a sweet singsong voice, were clearly limited as was evident throughout this interview and observation. Marley's mother indicated Marley did not say her first intelligible word (Mom) until she was around 4-years-old and only after she had been in speech therapy for more than six months. Marley reportedly engaged in babble and jumbled speech but it could not be understood by others. "She would talk but it wasn't, you couldn't understand her. It was to the point that she would be bawling, we would be bawling because it was so frustrating but it seemed as soon as we switched [speech therapists] she just took off." Since switching therapists, Marley was reported to have progressed from knowing about five words to several thousand. There were still concerns about the clarity in which Marley spoke and her mother reported, "She's hard for other people to understand but I can understand most of it. But usually if she cannot tell us, she'll either act it out or she'll try drawing a picture of it, or she'll grab your hand and go show you." The difficulty in understanding Marley's language was observed throughout the interview and observation session. Other than her usual "MmmHmm," there were a few times when she would engage in unintelligible expressions. However, much to my surprise, when asked her favorite color, Marley answered with a crystal clear "purple."

Sensory differences/ repetitive behaviors. Colors appeared to be very important to Marley as her mother indicated she would at times refuse to wear anything but the

color purple. While the presence of a color preference in a young child is not atypical, Marley's level of aversion to the color orange was unusual. Marley's mother reported,

One time she would not go near anything orange. She would not touch orange and I don't know what it was with the color. She would scream if you mentioned it. Because John (Marley's father) works for BNSF and one of their colors is orange, he brought her this big foot [the company logo], she wouldn't go near it, touch it, or anything for a year and a half.

Marley was also reported to display intense repetitive behaviors in some situations. She reportedly engaged in humming and flapping when she was excited and happy. She also rocks and paces with large arm movements of flapping when she was anxious or nervous. Marley's display of unusual sensory behaviors occurred at a very early age as her mother reported,

Even when she was a baby. The reason I thought something...not was wrong with her, was different, was when she was six months old we were headed to Denver to get my sister-in-law and she would flap and hum in the car. And I have never seen a baby do that before. And she'd like bring up her head and try rocking.

Marley continues to display intense flapping, rocking, and humming in the car--whether the family was driving a short distance to school or a longer distance for a family vacation. Although sometimes Marley can be distracted by movies in the car, her mother described one trip where these behaviors were so intense "all she did was scream. We got to North Platte and we about turned around and came back". While the intensity of her humming was not as disturbing as her screams, it was one behavior that created significant difficulty for the family. Marley's mother shared a video of Marley's typical response to being in the car. In the video, Marley engaged in the described intense whole body movement--large arm flapping movements and loud humming or screeching. Interestingly, no sensory behaviors were observed throughout the initial observation.

Social deficits. Socially, Marley's mother reported fewer concerns but she did indicate that Marley did not seem to have stranger awareness. In contrast, there were times when Marley is very shy around her own family members and she often prefers to be on her own. "She does actually prefer playing by herself even when she is with others," Marley's mother reported. "Every once in a while her cousins will stay over and 10, 11 o'clock at night she will come and ask us to take them home. She's had enough." In other social situations, Marley's mother indicated Marley gets very nervous and "she'll run and hide a lot of times. When we're with family members, she will go off by herself and just do something on her own to get away."

Marley's mother described instances of Marley's tendency to avoid social situations very early in life. For example, she noted,

We would have to hide her under a blanket to bring her into a restaurant. She didn't want anyone to see her; she didn't want to see anyone. And as soon as she got in there, she would like cuddle up in the corner if we got a booth. And she always stayed there and sat under the blanket until her food came.

This shyness was confirmed by my own observations during this initial observation.

Marley displayed a timid demeanor within the waiting room and appeared very reserved throughout the observation period. Marley would sometimes respond to the questions I asked of her, though she most often did so while looking downward. Marley's mother indicated this was typical of Marley until she felt comfortable.

Play behavior/intense interest. Throughout this interview and observation period, Marley played with a variety of toys she had chosen from the playroom. She sat on the floor looking through the toys as her mother engaged in the interview. At no point during this one hour interview did she attempt to gain her mother's attention by showing her toys or asking her questions. Marley was observed to sort through the toys and

engage in simple exploration of the items she had chosen. This type of organizing play was similar to the play her mother described occurred at home. Although occasionally Marley seemed to engage in brief pretend play with her Barbie dolls, she was described as more often playing by organizing. Marley was described to have an intense interest in her Barbie dolls and her mother noted, “We’ll go into a store and that’s all she wanted to look at. At one time, she had over 50 Barbie dolls and she would have them all out!”--depicting a scene in which Marley unpacked her Barbie dolls, lined them up, sorting and organizing the dolls and their accessories.

It was also noted that Marley sometimes hoarded various toys. “She collects everything and knows exactly if something’s missing,” Marley’s mother reported. Currently, Marley has a large bucket she carts around and has to have with her at all times while at home: “She just puts random stuff in there. Like right now there are toy horses in there, there’s Legos, there’s a crown in there, and she sleeps with the bucket.” Marley was also described as often lining up her toys in a certain order or specific pattern--a behavior she started at a very early age:

She was probably about two when she did this. She had little multicolored elephants and there was probably three or four of each color and she would put them in patterns on the wall. Or she’d be like two pink, two blue, two purple, two pink, two blue, two purple. We just used to think it was something fun she did. But she never grew out of it. Yeah, she’s very precise about stuff like that. She’s into grouping.

When asked about the other types of things Marley liked to group, her mother noted that pretty much any item would be put into a pattern if Marley was allowed to do so:

If she can group it some way, she’ll group it. The other day, we were in Sally’s Beauty Supply and they had the nail polishes in like a pattern on there and she took and had to line them all up correctly. She’s one though that if you...she listens really well. If I tell her to stop something she may get like, give you a really bad face. But she’ll stop it. She listens very well and that’s one

compliment we have gotten from teachers and Holly (speech pathologist) and all of them.

This compliance was observed and noted throughout this first interaction with Marley.

Progression of therapy. Following the initial interview and observation, Marley began attending bi-weekly CCPT sessions. For the purpose of this study, Marley participated in 15 child-centered play therapy sessions; the final session (a makeup session due to two previously postponed sessions) was cancelled due to the death of a family member. While every effort was made to conduct two sessions per week, there were three instances in which only one session was held as Marley was sick, out of town, or unavailable due to a family vacation. All sessions took place in a private outpatient clinic playroom and were videorecorded. Throughout her participation in CCPT therapy sessions, Marley's parents completed a weekly open-ended probe to describe their experiences with Marley as she participated in the therapy. Following completion of therapy sessions, Marley's mother and father took part in a post-intervention interview. However, due to the tragic and unforeseen circumstances of a death in the family, this interview was delayed several weeks.

Marley's play therapy progression. Marley eagerly accompanied me to the first and all subsequent play therapy sessions. Her compliant personality, as described by her mother during the initial interview, was evident throughout this process. During the first few sessions, Marley's affect was somewhat restricted as she showed very little facial expression and maintained a very slight "Mona Lisa" smile throughout. Due to her limited facial expression, I focused my efforts on commenting and making reflections about even her micro expressions, an approach that was endorsed within my supervision sessions with the RPTS. Marley's interpersonal connection with me also felt limited.

She often played a few feet away from me or beside with her back slightly turned toward me. When reviewing the video of these sessions, very few social overtures were noted. Marley had very few moments of joint attention, almost no meaningful verbal or nonverbal reciprocity, and no imitation was noted.

For the majority of first three sessions (weeks 1 and 2), Marley engaged in exploration of the room and the various toys. She often picked up one toy and asked a question about it seemingly in an effort to understand the “rules” of the therapy room. Each time Marley questioned a toy, I confirmed she could choose how to use the toy by noting, “In here you get to decide.” Following exploration of various toys, Marley appeared to categorize or label the toys within these initial sessions. At one point, Marley was looking through the family figurines and proceeded to label each one (e.g., mom, dad, baby) as she lined them up similar to the type of organizing play her mother had described at home. Marley’s exploration of toys often included her examination of the working parts; she repeatedly moved these parts until she seemed satisfied with either her understanding or her ability to make them operate. Many of Marley’s verbalizations throughout these first few sessions were simply an extension of those seen within the initial observation. “MmmHmm” and “Uh huh” or “Oh” were most often utilized. There were sporadic instances of more expanded verbal use, although these were again very difficult to decipher. Reports from Marley’s mother during the first few sessions were similar, responding to my weekly probe of “what if anything stood out this week” that very little happened outside of session the first week.

Outside of session during week 2, Marley’s mother began to notice some subtle changes. Most notably, Marley was reported to have decreased the amount of

sensory and body movements during car rides. Her mother noted within the weekly journal that “Marley didn’t flap her arms as often in the pickup! But still hummed and rocked.” This same week, Marley’s activity within the CCPT sessions was again dominated by simple exploration and occasional labeling of objects. She began to use various items in mimicry of function specific ways (i.e., she used the wood working tools to work on the barn) and briefly engaged in nurturing and fixing play. In addition, she began initiating questions about most every item she encountered. “What that?” she would repeatedly ask as she held up various items. “In here, you get to decide,” I would comment. Marley would most often put the toys back or respond with a “yeah” while moving to another item.

However, during session 5 (week 3), autonomy began to emerge in session as Marley stopped asking as many questions about how to use various toys and spent the duration of the session in exploratory and thematic play (with themes of rescue, fixing, and nurturing). During this same week (3) outside of session, Marley’s parents observed continued reduction of Marley’s sensory needs: “This week she isn’t rocking as much but still is flapping (more it seems) and humming. I have noticed her humming is quieter.” The most significant improvement described during week three was an increase in Marley’s autonomy outside of therapy sessions. Marley was reported to have cleared an impressive hurdle of independence--sleeping in her own bed. Marley’s parents indicated they had been trying for quite some time to encourage Marley to sleep in her own room and during week three of intervention, Marley mastered this change: “Marley started sleeping in her own room after we painted it purple. She settled in great first two nights, third night she struggled and came to (parents) our room two times, but settled back in.”

This was not the only improvement noted--Marley had suffered night terrors for several months leading up to the intervention, but did not have any during this third week of CCPT. "She isn't complaining of nightmares like she used to," Marley's mother reported, drawing a large smiley face after this journal entry.

There were also minor changes noted within Marley's vocalizations. During the fourth week of therapy, Marley started a new vocalization that was described by her mother to occur when Marley was eager about an upcoming event:

I have noticed she makes a weird noise whenever she's excited to go somewhere. On Monday we told her we were going camping and she made a weird shrieking noise. I've noticed this each time we've told her we're going places this week (On rides while camping, seeing people- aunts, cousins, uncles, Katie). She shrieks and it's just different than before.

Sessions 6 and 7 (weeks 4 and 5) marked the emergence of a brief period of aggressive play within the CCPT sessions. Her parents' journals during week 5 made reference to changes in her behaviors outside of the play room as well: "I noticed this week Marley is humming and flapping in public again, though this behavior was reported to be an indication of Marley's increased happiness. She hasn't done this in probably six to nine months." Marley was also reported to be more helpful and was using more verbal commenting: "She is getting easier and easier to understand." The excitement of her increased verbal use as well as the increased intelligibility of her words was shared by more than just her parents as her mother noted, "Marley's Nana even said she understands Marley better" and then drew a big smiley face: "It's good to see others finally being able to understand her speech," drawing another large smiley face.

Specific play themes within Marley's play through weeks 4 and 5 (sessions 6 and 7) included a reoccurring interaction among a family. Marley used the family figures and

labeled them as “mom,” “dad,” “baby,” and “Honey” (daughter). The play scenario generally began with nurturing interactions between the mother figure and children. Sometimes, the initial nurturing behavior of the family briefly turned into aggression with loud angry sounding interactions between the father and daughter figurines, though these quickly returned to nurturing with a loving interaction between the mother and daughter. “Mommy,” squealed Marley as she made the daughter and mother figures hug. These types of interactions continued as the family fluctuated between moments of laughter, happiness, and aggression. There were several short scenes in which the baby and the mother were separated and the mother was searching for the baby. “Baby, baby,” Marley would call out as though searching for it. Throughout weeks 3 and 4, this separation did not end in reunion. While it should be noted the themes that emerged from this symbolic play are often considered typical for children Marley’s age, the uniqueness to these actions was found in the parallel shift of her play within the playroom and her progress outside of the playroom.

Halfway through this intervention (session 8, week 6) marked a shift to more sustained symbolic play. The changes observed within this session transpired with Marley’s initial questioning of a sand toy to which I reiterated, “You can decide.” Marley did not noticeably respond and instead continued her play in the sand for almost 12 minutes. At this time, Marley launched into more intense symbolic play laden with themes of aggression, rescuing, separation, and reunions while interspersed with moments of nurturing. She had never shown this intensity of play within session and it appeared to mark a crucial shift as she continued the intensity of this play for several weeks. Marley also began to enter the room with apparent intention and autonomy. “She

entered the room and went straight for the pulley” or “She immediately walked to the farm set” I recorded in my field journal. Marley no longer asked for permission to engage in play and requested no more suggestions of how to use the various toys. While watching the videos of Marley walking immediately and with certainty toward specific toys, it seemed as though she had a premeditated plan of what she wanted to do each time she arrived to session--as though she had been thinking about what she needed to do in session before hand.

Interestingly, the eighth session started with Marley’s use of a pulley and a box she had filled with jewels. She worked briefly but in a deliberate manner with these two items before picking up the magnifying glass and purposefully examining me. I commented on her behavior, “You’re looking at me through there; you looked right at me.” She continued to do so until she seemed satisfied, then put the magnifying glass down with a smile, and started to engage in a very short reciprocal conversation. While some of the language she used throughout this conversation was difficult to understand, she looked to me expectantly each time she responded, seemingly searching for the back and forth volley present in any typical social conversation. I often reflected her emotions and her expression to which she would smile and reply “Yeah” before continuing with another statement.

Marley subsequently began a very deliberate search for specific figures and toys, putting them all on the table in front of me as she collected them. Once she was satisfied with what she had gathered, she began a slightly less intense replay of her separation-reuniting-rescue play with a clear component of good versus bad. The fixing play transpired at the end of the session following an especially aggressive scenario of good

versus bad in which one character held a sword to the young girl's throat. Following the rescue of this girl who had been stolen by the bad guy, Marley made specific effort to bring not only the ambulance but also the helicopter to provide medical care.

"Whoohohoho," the helicopter flew over to the table. "Help, help," called the girl as Marley drove the ambulance over stating, "I help you." The doctor figure then got out of the ambulance with tools and used them on the girl. "That's better?" the doctor asks. "Thanks, Doctor," the girl replies. "Welcome, your boo boo better," the doctor states and then leaves. A very similar scene is replayed by Marley a few more times with the doctor figure fixing the other figures before this session ended.

A similar scenario in which the same figures were placed in the same quandaries with a parallel story line was played out in session 9 (week 6). However, there was a divergent ending with the doctors needing help themselves when their ambulance fell off the table. "Yuck," Marley said and then got supplies from the kitchen to wash off the ambulance before proceeding to fix the doctors and the ambulance herself. The ambulance got "stuck" and needed her assistance one more time before she announced "All better" and the session time was up. Similarly, session 10 (week 7) also opened with Marley's search for the same characters and she proceeded to play out another parallel story line. This session included the characters going to school, something that started out seeming quite happy. "School, school, school," Marley made them sing. However, the play then turned to something scary: "No not me," one of the figures cried as a larger figure stood over her. "Help! Help!" the figure cried right before the session ended.

During the two weeks in which these intense and aggressive scenarios dominated Marley's play, her mother noted changes outside of session that were similarly stressful.

“Marley has been struggling with being around strangers in big groups,” she reported. “She was fine with this before but I’ve noticed she goes through phases where she doesn’t like this or something sets her off.” More frustration and a bit of defiance, perhaps in an effort for Marley to assert her autonomy, was noted as Marley was reported to have difficulty tolerating frustration: “We went to a horse show and she always seems to have a hard time with understanding certain things. Why she can’t do this or why she has to do that.” Additionally, changes to her routine at home spurred more difficulty as Marley’s mother started the school year; “I went back to work, which Marley found hard to cope with.”

Marley seemed to be expressing more negative affect at home throughout the duration of week 7; similarly, her affect and overall presence within session was also notably altered. During these sessions, Marley displayed not only animated verbal use but also expressive and congruent facial representations of the feelings she was conveying. This was the first time I explicitly commented in session on her facial and verbal animation as well as the congruence between the two. Interestingly, during this session, Marley brought all toys over to where I was sitting before engaging in her play scenarios. This act seemed deliberate and slightly different than earlier sessions when she would play with the figurines on the floor or beside me, not always seeming to care which. Furthermore, while I made note that her inclusion of me in her play had not changed from previous session, her interaction with me was different. Marley began to make periodic and deliberate eye contact during the rescue play. She did not respond when I commented on this change. I had started to track and reflect on her behaviors, matching the inflection in her voice--a suggestion that transpired during supervision with

the RPTS. Marley seemed pleased and looked directly at me with a smile, giving a sense of nonverbal reciprocal interaction.

Session 11 marked another shift in Marley's choice of play. She came into this session and began working in the sand, a sensory activity similar to her initial sessions. She seemed quite content while sifting the sand through her fingers and filling and then purposefully spilling bucket after bucket of sand. "You have a smile," I reflected. "Uhhuh cause school," she replied. (The school year had just started.) "I guess so," she then responded after a few of my attempts to reflect deeper meaning. Marley's presentation seemed different from the previous sessions as I indicated in my field notes significant sensory play, less interaction, less eye contact, and less verbal. Marley spent about 20 minutes engaged in sensory play before transferring to symbolic play. Her play reflected themes of mastery, nurturing, broken play followed by fixing, and ending with sleeping play as Marley put the baby doll to bed saying, "Please go, shh." It was notable that no aggressive play occurred throughout this session.

Session 12 (week 8) was marked by clear, positive nurturing and failed nurturance as one of the baby doll's needs was met and one was clearly neglected and given poor care. The failed nurturance was followed by fixing play and then aggressive play as she got out the monsters and tried to scare the baby doll. Similar scenarios were again played out in session 13 (week 8). However within this session, Marley initiated the use of several aggressive toys she had not yet handled including the gun, handcuffs (which she put on the baby), and the sword as she acted out a scene of protecting play. Furthermore, it seemed as though Marley was using the sand as a way to prepare for the intense symbolic play and then returned to the sensory play as a way to help soothe or regulate.

Marley increasingly verbalized the characters' thoughts and created in-depth narration of the scenes she enacted including exceptionally animated voices for each character used complete with inflection and expression changes. There was also an increase in the aggression between characters within these sessions as well as the introduction of fixing play in which Marley used the doctor kit to fix various characters when they were hurt.

Marley's mother reported in her journal that during weeks 7 and 8 (sessions 10-13), Marley was adjusting well to all the changes that had occurred to her routine (e.g., returning to school, her mother being back at work). "She's adapted well to school schedules and has done (well) for the most part," her mother went on to note. "The teacher said her flapping and humming are not as frequent, she engaged in activities, listens and follows directions well." Marley was reported to be happier as well: "This is Marley's first full week. She enjoys school; she has been flapping and humming some." Furthermore, "She was super excited to check out her first book."

Marley's interactions with me as we worked within the playroom for sessions 10-13 also felt different, although definitely not as positive as what her mother reported outside of session as Marley had again increased the amount of verbal expression and it became difficult for me to interject. I talked to my supervisor and he noted that sometimes as children's play becomes more intense, it is best to reduce the amount of verbal reflections so as not to disrupt their work. I tried this approach and Marley seemed to respond by appearing fully immersed in her play. I made specific reference to this in my own field notes as I found her animation continuing to grow with this absorption into her play. Furthermore, it was interesting to note that even though she was more immersed in her play, she actually engaged in more reciprocal interactions with me.

During session 13, I noted another multi-exchange conversation. This reciprocal conversation revolved around Marley's initiation of asking for help and then proceeding to direct my help to fit her needs. This conversation was surprisingly clear and Marley was able to relate several discernable verbal exchanges. Nonetheless, Marley's joint attention and imitation remained quite limited, making no significant alterations despite the increased initiation and reciprocity of verbal and nonverbal exchanges.

Throughout the final two sessions, Marley again engaged in play that included themes of aggression, fixing, nurturing, and separation with reunion. However, in the 14th session, Marley began to play out a role of power--a scenario that continued for about 12 minutes. During the final session, Marley again incorporated themes of aggression, nurturing, separation, and reunion interspersed among sensory play in the sand table. Marley displayed increased inclusion of me within this session as she repeatedly asked for help and directed her comments during her play toward me. During our final session together in the playroom, Marley drew various faces on the board. She drew happy and sad faces and was teaching me about them. "Which do you feel?" I asked her. Marley drew a sad face and then a happy face. "Happy and cry," Marley replied. "Happy?" I asked. "No I cry," Marley countered and then she whimpered as though she was crying. She talked more about all of the faces on the board and then circled them all. "That a me" as she drew another happy face and said, "Happy" and put a box above the smiley face. She then looked toward me, checked the box, put the cap on the marker, and the session was finished.

Tragically, due to the death of her cousin with whom Marley was very close, the 16th session of CCPT was cancelled and Marley's mother did not complete the entry for

her final weekly probe. Furthermore, the final interview session was rescheduled and occurred several weeks later. Table 7 presents Marley's progression through therapy.

Table 7

Marley's Therapy Progression

Session	Dominant Theme(s)	Play Stage(s)	Confidence/ Security	Happiness	Weekly Parent Probe
Week 1: 6/30/14	EXP	Constructive play	5	5	Helped Mom in garden; participated in speech testing; had difficulty understanding why house was being worked on
Week 2: 7/7/14	EXP, CON, BND, Sensory	Sensormotor, Constructive	3	5	Reduced flapping in car; speech therapist thinks her language has improved
7/14/14	EXP, CON, BND, Sensory	Sensorimotor, Constructive, Autorepresentational	2	5	
Week 3: 7/16/14	EXP, CON, BND, NUR+, FX	Autorepresentational, Allorepresentational	5	5	Started sleeping in own room upon request; isn't complaining of nightmares; rocking and flapping in car reported as less intense
7/17/14	EXP, CON, FX, MAS, SEP-R	Allorepresentational	5	5	
Week 4: 7/24/14	SEP-R, EXP, MAS, AGG	Allorepresentational	5	3	Makes new sound when excited
Week 5: 7/30/14	NUR+, AGG, Sensory	Sensorimotor, Allorepresentational	6	3	Humming and flapping in public again (reported to occur in public when happy); mother and grandmother reported speech easier to understand; excited for school

Note. Play Codes: G>B = Good guy vs. Bad guy; AGG = Aggression; SEP-R = Separation play-reunion; NUR+= Nurturing play; NUR- = Failed Nurturance; SLE = Sleeping; BR = Broken play; FX = Fixing play; CLN = Cleaning play; EXP = Exploration; MAS = Mastery play; BND = Boundary setting; ANG = Anger; ROLE = Role mix. CONFIDENCE/SECURITY scale of 0-10, with 10 being the highest. HAPPINESS rated on a scale of 0-10, with 10 being the happiest.

Table 7 (continued)

Session	Dominant Theme(s)	Play Stage(s)	Confidence Security	Happiness	Weekly Parent Probe
Week 6: 8/5/14	AGG, G>B, POW, NUR, EXP	Symbolic, Allorepresentational	6	6	Struggling being around strangers and in groups; difficulty understanding certain rules
8/8/14	AGG, POW, ROLE, CON, SEP, FX	Symbolic	5	8	
Week 7: 8/12/14	G>B, AGG, POW, SEP-R, NUR+, NUR-, EXP	Symbolic, Allorepresentational	9	9	School started; has 3 friends; some flapping in classroom; difficulty coping with mother's return to work
8/15/14	NUR+, SLE, BR, FX, Sensory	Symbolic	7	5	
Week 8: 8/19/14	AGG, NUR+, SLE, BURY, FX, CLN, EXP, Sensory	Sensorimotor, Constructive, Symbolic	9	9	Enjoys school; super-excited to check out first book; adapted really well to new school routine
8/21/14	AGG, SEP-R, NUR+, NUR-, SLE, Sensory	Sensorimotor, Constructive, Symbolic	6	6	
Week 9: 8/28/14	AGG, POW, SEPR, NUR+, FX, BND, Sensory	Sensorimotor, Symbolic	8	8	Flapping and humming not as frequent in classroom; engages in academic activities and listens to directions well in school; adjusted really well
8/28/14	AGG, CON, SEP-R, NUR+, BR, BND, Sensory	Sensorimotor, Symbolic	8	6	

Note. Play Codes: G>B = Good guy vs. Bad guy; AGG = Aggression; SEP-R = Separation play-reunion; NUR+= Nurturing play; NUR- = Failed Nurturance; SLE = Sleeping; BR = Broken play; FX = Fixing play; CLN = Cleaning play; EXP = Exploration; MAS = Mastery play; BND = Boundary setting; ANG = Anger; ROLE = Role mix. CONFIDENCE/SECURITY scale of 0-10, with 10 being the highest. HAPPINESS rated on a scale of 0-10, with 10 being the happiest.

Post-treatment observations.

Social engagement. Throughout all sessions, Marley's inclusion of me within her play was limited. However, her interaction with me did shift throughout the sequence of this intervention. Initially, Marley responded to my tracking and reflecting with brief responses such as "yeah" and "uhhuh." She then moved to less verbal responses but increased her verbal use during her play, eventually narrating the scenes and creating voices for each character. Midway through these sessions, Marley increased the intensity of play and her interactions with me were notably fewer. However, Marley began to display an increased attention to my presence in the room as she started to enact her scenarios in front of or beside me. Marley's engagement in social reciprocity increased slightly toward the last few sessions; there were several instances in which Marley would look directly at me and ask a question or make a statement. Furthermore, Marley was beginning to engage in longer verbal exchanges as recorded in the last two sessions.

While I found myself feeling more connected to Marley due to some of these changes, this connection did not transform to my inclusion in Marley's play. I remained an observer throughout all sessions. Outside of session, Marley began to greet me with a smile and a hug, saying my name, "Katie!" She would then chatter to me all the way to the playroom, telling me about her day and what she had done. Once in the playroom, her focus shifted to her play as if she knew this was her special time. Once the session was over, Marley would happily accompany me back to the waiting room where she would talk with me about whatever was on her mind. Starting our third week of sessions, Marley began to consistently give me a big hug every time before leaving the office, a simple but sweet habit that allowed me to see that our connection was indeed growing.

With regard to her interaction with her parents, when starting this intervention process, Marley was described by her mother as loving and caring toward her parents and family members. This characteristic apparently remained unchanged throughout the intervention process.

Marley's increase in social interaction with others and use of language to effectively communicate was noted by Marley's mother within the parent journal and by her parents during the final interview. "She's come a long ways; she's talking a lot more," Marley's father revealed. Marley's mother agreed and confirmed, "There's only been one day where she got to talking in class I guess." Marley apparently was so involved in talking with her peers the teacher had to ask her to stop. Marley's use of enhanced language was further supported by her speech pathologist. In the parent journal, Marley's mother noted Marley's speech pathologist told her "she has really improved."

Play. Marley's play, though initially reserved, was overall symbolic and representative of an individual at the sixth and final play stage (Sheridan et al., 1995). However, Marley's play did have components of nearly all of Sheridan et al.'s play stages. Marley initially engaged in play that would fall within the autorepresentational stage, which consisted of labeling and deferred imitation of objects (i.e., labeling the family figures and then using the phone to call others) within the first few intervention sessions. She then briefly displayed behaviors that would be considered within the allorepresentational stage (i.e., feeding the baby with the bottle) before she began her intense sociodramatic play, which was representative of the symbolic play stage. However, as noted by Sheridan et al., often children fluctuate between stages as was the

case with Marley. Interestingly, Marley often returned to the sensorimotor stage in between her more intense play at the symbolic stage. This sensory play, though most often occurring among infants, appeared to calm Marley and might have allowed better regulation of her emotions.

Reports from Marley's mother and father during the final interview supported the progression of Marley's play to a more symbolic stage outside of sessions as well. "She actually like uses her imagination verbally now," Marley's mother reported when asked about Marley's play at home. "And before she didn't, she would just sit there and play. You'd hear a few things now and then but she does verbalize a lot more now that I think about it." This difference in her verbal expressions during play seemed to stand out for Marley's mother as she reported again at the end of the interview, "At home she will talk and chatter, like if you sit down on the floor and play Barbies with her, they interact and she talks and she actually has different voices for different ones. And they all have different personalities." Throughout this final observation, Marley did not engage in this more intense symbolic play; instead she looked through the various toys she had taken from the play room. Her play seemed in a way to have returned to the beginning stages of exploration, though it should be noted that it had been several weeks since her last session. Thus, Marley was likely testing to see if things were as she had remembered.

Emotional state. Marley's emotional state was one area reported as much different during the final interview. Throughout the last few intervention sessions, Marley was noted to appear happier in the waiting room and at the end of session. During her last intervention session, she directly discussed and drew about emotions and her own feeling of happiness (a checked box above the happy face). This happy

demeanor was confirmed outside of session as well as Marley's mother made remarks in her journal indicating Marley's happiness and excitement for recent events in her life: "She's getting more and more excited for school; she enjoys school; she was super excited to check out a book". During the follow-up interview, Marley's mother indicated the excited flapping and humming that Marley sometimes exhibited when she felt happy had diminished. "That's the thing" Marley's mother noted. "She does it a lot when she's happy," alluding to the fact Marley has not recently been as happy. However, it should be noted that since the conclusion of the intervention sessions, Marley experienced the loss of a close family member. During this final observation, however, Marley had a smile on her face throughout and eagerly held toys up for her parents to comment, smiling each time they noticed her.

Sensory/repetitive behavior. One area that stood out as changed for Marley's parents was Marley's repetitive complex body movements. "I don't think her arm flapping (sensory behavior that occurs in tandem with intense rocking while in the car) is as bad or her humming. She'll do it sometimes on the way to school but it's not as bad, I mean she doesn't do it like she used to" Marley's father confirmed. "Her teacher said she'll do it every once in a while at school, but it's not as much as it was the first couple weeks of school." These sensory behaviors of intense rocking paired with flapping were previously indicated to occur continuously when in the car with humming occurring occasionally when anxious.

Autonomy. "She can get dressed on her own but as you can see it can end up....." Marley's mother trailed off as she glanced toward Marley who was wearing a floral skirt, button up western shirt, brightly colored leggings, and cowboy boots. "She

has been a lot better about wanting to do it herself and she wants to start doing everything on her own it seems like,” Marley’s father interjected. Marley was described as having grown more independent and more willing to assert this independence. This autonomy was reflected in her daily routine where Marley was reported to get up, brush her teeth, and pick out her clothes and shoes for the day. She was described as getting her own snacks and drinks and “yesterday she got her own cereal.” Marley has become more independent in helpful ways. “She knows what night it is and if it is bath night and if she wants a bath another night she just tells us and then, and then she goes,” Marley’s mother started. “Does it on her own!” Marley father exclaimed.

This growth of autonomy was also reflected in therapy sessions as Marley shifted from a standpoint of asking if and how she could engage with the various objects within our sessions to directing her own play, coming to an apex in our final session when she took the role as the teacher and taught me a song about feelings and then finally taught me about her own feelings. Correspondingly, throughout this observation, Marley asserted her independence as she walked into the play room and retrieved the toys she wanted, bringing them back to the interview room. Marley did not ask for permission throughout this process; however, on several occasions, she emphasized a toy she had found until her mother responded to it, seeming to exude pride as she was able to make various toys operate without help (i.e., the lock box, crane, etc.). This autonomy was further observed as the interview ended. Marley approached her mother, took her hand, proceeded to lead her into the play room, and showed her around the play space before they left the clinic. Marley and her parents then headed to their car; as she reached the

front exit, Marley turned slightly, looked at me from the corner of her eye, and smiled.

“Bye Katie,” she sang out before she and her parents walked out the door.

Meet Micah

Micah’s blue eyes sparkle if you can get him to look toward you and his sandy brown hair is always smoothed across his forehead in a typical little boy haircut when he is still. However, Micah is rarely still and is rarely willing to look right at you; his intense sensory needs and repetitive behaviors most often envelope his entire being as he frequently rocks or paces while engaging in finger flicking. He is so immersed in his sensory world that there seems to be little room for social connection. Micah’s sensory behaviors were so concentrated that Micah’s parents chose not to bring him to our initial interview; instead, they requested the observation be conducted in his educational setting. Thus, I met with Micah’s parents separately and I subsequently completed the initial observation of Micah in his educational setting.

While Micah’s parents beamed with pride during this initial interview as they described tiny bits of progress he has made over the last few months, describing how he had attended a day camp over the summer for children with special needs, their concern for Micah and his challenges was apparent. Micah’s communication difficulty and potty training were reported to be two of their main concerns. While they reported some distress regarding the intensity of Micah’s sensory needs, they indicated their acceptance that these intense sensory behaviors were static and they were trying to adapt accordingly.

Initial themes from the interview/observation.

Sensory differences. “He does a lot of sensory things, mostly involving biting things and tapping things.” This is the first thing Micah’s mother mentioned within our initial interview setting. “Biting and tapping and rubbing,” Micah’s father added, indicating these sensory behaviors were not exclusive to any one setting or time frame but instead occurred on a continual basis and apparently in an incessant repetitive fashion. Similarly, when walking into his wing of the school building for the initial observation, I immediately thought to myself, “That must be Micah” as I could hear his low groan and subsequent high pitched screeching from down the hall. As I entered the classroom, I saw Micah sitting in his rocking chair, throwing his body back and forth in an effort to make it lurch forward and backward in large, abrupt movements. As I slowly walked toward him, Micah did not look up but instead continued lurching forward, backward, forward, backward while holding tightly with both hands to a small purple object. Maneuvering around the table, I got closer to Micah and could see this purple object was a very worn elephant, which had visible teeth marks on its large plastic ears. The one-on-one paraprofessional who works with Micah motioned for me to join them and I pulled up a chair beside Micah. I sat down and Micah turned his head toward me, his pale blue eyes darting across my face though not landing on my face but my hand and the notebook I had carried in with me. He then seemed to grimace as his face folded into wrinkles. Micah clenched his teeth and he squeezed his eyes shut tight as he pulled his arms and hands still holding the purple elephant. He seemed to be hugging it firmly into his chest, trying to ensure no one would take it away from him. Micah’s rocking did not subside as he did this, though he slowed and then stopped when his paraprofessional

placed her hand on his knee. “Micah, look who’s here,” his paraprofessional invited him to open his eyes. Micah opened his eyes, still squinting so only his large black pupils were visible and then raised his eyebrows causing his porcelain smooth forehead to crinkle as he again glanced in my direction. Micah leaned forward, pressing his body and head into his paraprofessional’s body and opened his mouth to let what sounded like a deep laugh escape. Micah’s paraprofessional reciprocated this motion with a tight squeeze and a quick back rub before repositioning him in his chair and putting his communication device on his lap.

Communication differences. Micah was reported by his father to have no discernable words. He was thought to have at one point used the words “Hi” and “Bye,” though not in a consistent manner. Micah uses assistive technology for his communication needs and currently utilizes the iPad with a communication app. However, Micah’s parents reported disappointment in Micah’s current use of this device: “You know there for a while, at least with meal times and stuff, you know (pressing) I want more, or please help.” However, Micah was described by his father to now “just want to fly through it.” Similarly, throughout the initial interview, Micah tended to flip through the various pictures on the iPad communication app although he was observed to make a meaningful phrase when heavily prompted by his paraprofessional. This occasional appropriate use of the communication device was noted to occur at home as well:

He’s just hitting the pages, scrolling the next one and hitting whatever is on the bottom corner when he scrolls. So once in a while he will stop. Like if he’s eaten, then he’ll come back to the page about cereal. If he’ll find it (and) if he wants more cereal then he’ll hit it. If you are doing something else and you’re not listening because it was duck, horse, orange, purple, oval, circle. Then you’ll hear cereal, cereal, cereal. He can use it but he mostly just messes with it.

While Micah was perceived to be disinterested in consistently using his communication device, it was noted that he displayed frustration when unable to efficiently find and use the appropriate phrase as his mother indicated,

I think sometimes he gets frustrated looking for something. I think sometimes he'll be scrolling through it looking for cereal or for more, he knows where the "please help me" button is, I mean it's on the same page as "I want more," and "I'm finished" and sometimes he just hits that over and over again. I think he knows what it means. He's like just do this for me!

Social deficits. While Micah was reported to at times become frustrated with his communication device, he is notably a very even-tempered young boy, so easy going in fact that he was described by his mother to go along with pretty much anything :“Most of the time whatever you say, he'll do it whether or not he really wants to”. This amiable nature was also observed throughout the initial observation as Micah would often take the outstretched hand of a peer. Although there was no meaningful social interaction nor would he consistently or directly look at his peers, he would let them lead him by the hand down the hall to the next activity in the daily schedule. It is important to note that while allowing others to lead him in this manner, Micah was often observed to seem quite unaware of his surroundings. Often he would gaze at the floor or toward the wall as he walked. He never seemed to focus on any one thing and, furthermore, was never observed to have engaged in protodeclarative or communicative pointing.

Micah simply seemed to respond to the physical prompting of others. This type of social interaction, consisting of others initiating the interaction and Micah simply complying, was observed throughout this observation. This type of one-sided interaction was also reported as quite typical by Micah's paraprofessional. Micah's parents indicated a slightly more assertive type of interaction in the home setting, indicating that

often Micah would interact with them by grabbing their hand and using it as a tool to get a rub or a tickle. He was indicated by his father to at times “grab your hand and put it on his shoulder” and then stand passively to receive the massage. Other times, Micah was reported to take his parent’s hand to lead them to something he needs: “Sometimes he just comes and gets you and takes you somewhere. You go where he wants to.”

However, Micah’s parents were excited to report that Micah had just recently engaged in a more reciprocal interaction with his grandmother: “She’ll tickle and he’ll tease and stuff,” indicating that Micah would lean toward her as she tickled him: “you know he hasn’t really done a whole lot of [this].”

Micah sometimes allow his sisters to read to him, sitting beside them for a book but only “as long as it’s not too many words on the page. Like they have a Bernstein Bears book, which sometimes some of those have too many words. They’ll have a big paragraph on one page, he’s not interested.” Micah’s paraprofessional confirmed that Micah also sometimes tolerates his peers reading to him at school. However, she indicated he appears to simply endure this period of time with others near him rather than drawing enjoyment from the interaction. During these times, he was described as often holding his ears, rocking and looking around, shifting his gaze quickly around the room, and not ever really looking at the book or his peers as they are reading.

At times, Micah will interact with his older brother, the sibling closest to his age. However, Micah’s mother and father both reported the two boys tend to play so differently that it becomes difficult. Micah prefers jumping on the trampoline for hours or watching the cars slide down his spiral car ramp. As might be expected, his brother has little patience for these repetitive activities. Micah’s parents indicated a desire to find

ways in which Micah and his brother would have more in common and more opportunities to interact.

Play behaviors/intense interests/repetitive behaviors. As previously indicated, Micah's play behaviors bear more resemblance to sensory or repetitive behaviors than natural play. Micah often seems to simply tolerate being next to others as they play and was most often indicated to be a passive onlooker or merely in the presence of those playing. Micah was reported by his parents and paraprofessional to have never engaged in natural play, instead spending his free time engaged in repetitive sensory behaviors. This was further supported throughout the observation in which it was apparent Micah's preference for sensory behaviors consistently overrode his desire to play.

Micah's described tolerance to the presence of others as they played was further supported and described by his educators and was observed first hand during the initial observation in the school setting. Micah was observed at recess where he chose to repetitively pace back and forth on the playground as peers played nearby. His paraprofessional indicated that at times other children approached Micah and Micah would allow them to lead him to another location on the playground but no independent reciprocal interaction had ever occurred. Occasionally, various adults would engage in physical prompting of Micah, direct his play in an effort to encourage reciprocal interactions with his peers, but he was noted to have never engaged in these behaviors independently.

It became evident throughout this initial interview that Micah also never engaged in play behaviors beyond that of sensorimotor exploration of toys. When asked about Micah's favorite toys, Micah's parents reported that at home, Micah loves his rubber

duck and his Monsters Inc. toy, Big Mike. When asked to describe his play with these toys, Micah's mother described sensory behaviors. "He chews on it. Holds it," she stated. "Yells at it," his father added. Micah's parents also noted that Micah would at times look at a toy car ramp he has in his room: "He'll just kind of put them (cars) on there sideways and it won't slide, but he'll try to put other stuff on there." However, most of Micah's time was reported to be spent in more active, sensory type activities. "He likes to be outside jumping on the trampoline. Or if the neighbors are running their sprinklers, he likes to go get in that and (he likes to) go swimming," Micah's father fondly described on instance of Micah's intense enjoyment of the sprinklers.

One night, I came home, he's over there standing in our driveway, their sprinklers are the pop up sprayers and he/s standing in the drive way with his hands in their yard and bent over and its spraying right in the forehead. Just completely drenched. He really likes it [water].

Micah was also indicated by his paraprofessional to love water; she takes him to a swimming class twice per week during the school year, indicating that he seems much happier and more alert when in the water.

Micah's play therapy progression. Following the initial interview and observation, Micah began to participate in bi-weekly CCPT sessions. Micah completed 16 CCPT sessions, all of which took place in his school setting. While every effort was made to conduct two sessions per week, there were a few instances in which Micah was sick or school was cancelled. In those cases, the sessions were rescheduled as soon as possible. Following the completion of 16 sessions, the final observation occurred in the educational setting. The final interview was delayed due to Micah's parents' work and extracurricular activity schedule.

When arriving for the initial CCPT session, Micah appeared indifferent, looking away from me; however, he automatically took my outstretched hand and allowed me to lead him to the therapy room. This would become our typical routine for the next several sessions as Micah grew accustomed to walking hand in hand with me to therapy room. Once inside the room for the initial session, Micah immediately began to pace. He walked very quickly from one side of the room to the other while emitting a near constant groaning with periodic screeching sound. This pacing was paired with intense and repetitive finger flicking in front of his eyes. For the duration of this initial session, I attempted to verbally track and reflect his movements and the apparent dysregulation he was experiencing. However, my attempts at these verbal techniques appeared to further dysregulate Micah as his screeching grew louder and his pacing was more intense. Additionally, throughout this initial session, Micah continually squinted his eyes and had a pained grimace showing on his face, leading me to wonder about the fluorescent lights in this setting. Immediately following this session, I met with Micah's paraprofessional. Micah's mother's previous reports of Micah's heightened sensitivity to light along with his reaction to this therapy room led to our belief that the lights were causing Micah's intense reaction. Micah's paraprofessional indicated the same type of light dimmers in her room could be placed over the fluorescent lights in the therapy room. These dimmers were put in place prior to the second session, though his pacing and moaning continued.

Micah's participation within the CCPT sessions was continually dominated by varying degrees of sensory behavior. The first four sessions (weeks 1-3) were observed to include intense sensory behaviors of pacing and screeching that at times lasted the entire 45 minutes. In session 2, Micah initially sat down on the floor facing me; however,

following my verbal reflection of this, he popped up and began pacing, leading me to wonder if my verbal techniques were indeed serving to somehow produce further discomfort within him. Micah's pacing back and forth from one side of the room to the other throughout this session was interspersed with occasional moments in which he laid face down on his stomach with arms tucked underneath his chest and rapidly rocked from side to side. I began to engage in a quieter verbal tack. "Oh you need to move today," I would respond or "You seem to really need to rock." However, Micah's sensory movements did not change and continued in a repetitive fashion for the duration of session 2.

Sessions 3 and 4 were identical--Micah entered the room, pacing and rocking, and continued these sensory-based behaviors for the duration of each session. I began to attempt various types of verbal tracking, concentrating on a quieter tone with fewer words. However, Micah did not respond differently. While in session, Micah's intense sensory needs were unchanged. Micah's mother and his paraprofessional both made comments on his increasing responsiveness. "He was wearing a new shirt and I commented on it several times, every time he looked down at his shirt!" his paraprofessional relayed to me, going on to explain that he then gave a fleeting smile as he looked back up toward her. This description of joint attention was reportedly a new skill his paraprofessional had not noticed in Micah within the past two years she had worked with him. Similarly, Micah's mother indicated an additional instance of Micah's increased awareness and direction. Micah, who was described as being somewhat aversive to even holding crayons in the past, started using them to color during the beginning of this school year. Micah's mother excitedly reported:

It's mostly scribbling, but on 10/27 they had a packet in music to color which had an instrument and a cat on each page. (His paraprofessional) said she was just letting him color however he wanted, but when they got to the last page, she asked him if he could color the kitty and he did just that!!

Throughout sessions 5 and 6 (week 4), Micah again engaged in sensory behavior throughout the duration of both CCPT sessions by choosing to pace, stomp, rock and chew on the rubber duck for the duration of each session. I continued to vary my tone, voice, and the amount of language I used, all strategies I had developed with my RPTS supervisor while reviewing Micah's sessions in supervision. While Micah was observed to make some fleeting eye contact during my tone and voice changes in these sessions, his reluctance to focus on my face resulted in these instances not being considered sustained eye contact or signs of typical of social interaction.

Micah began our time together in both sessions 5 and 6 with significantly intense sensory behaviors--pacing and stomping while chewing constantly on a rubber duck and displaying periodic facial grimacing. Micah's vocalizations during these initial moments were very loud and altered between a high pitched screech and a low groan. While in session 5 the intensity of his vocalizations started out very loud and then subsided about midway through this session, Micah began to look toward me more frequently. While his eye contact was again fleeting, his glances in my direction appeared more deliberate as they started to occur after my verbal tracking. I made a note in my field journal that while Micah again engaged in mostly sensory play, "he seemed a bit more aware of me toward the end."

Session 6 (week 4) was again dominated by sensory behaviors. However, Micah picked up and examined the baby doll for the first time. While this toy was utilized for sensory play (i.e., chewing), it seemed notable that he briefly explored this toy (turning it

around and looking at its hands and feet) before chewing. I moved closer to him as he engaged in this new behavior and began to verbally track his movements. As he would tap the baby doll's head, I commented, "you're exploring that" and pointed to the doll. However, Micah did not respond to me and soon stood to resume his pacing. There was a continued disconnect within the session and I made note of my discomfort regarding not only this disconnection but also the intensity of Micah's pacing and screeching. "It's hard to be regulated myself when he does loud vocalizations," I recorded in my notes. Notably, at the end of this session, I gave the typical warning "Okay, time is up for today" and Micah stopped, got up off the floor, handed the doll to me, and headed to the door. Following this session, I met with the RPTS for supervision where it was suggested I begin to incorporate more nonverbal reflections of Micah's behavior.

Session 7 (week 5), Micah was again consumed by sensory activity within the play room. I began to engage in small attempts to nonverbally reflect what Micah was portraying as well as significantly reducing the amount of verbalizations. As Micah engaged in finger flicking, I too would mimic this action and when Micah tapped the floor, I too tapped the floor. This mimicry of Micah's behavior continued interspersed with minimal verbal tracking throughout the session. However, while Micah would at times look briefly in my direction, these attempts proved futile and the intensity of his sensory behavior did not change. I again noted within my field journal "lots of sensory, intense feeling to his sensory needs today!"

Although Micah was engaged in significant amounts of sensory activity within session, his mother reported an increase within his social interaction outside of session: "Micah is having another great week, just so engaged and happy. Micah and (his sister)

spent most of the night snuggling and tickling and giggling together!! He usually interacts with his sister but not usually for such long periods of time!” Micah also seemed to become more aware of his surroundings and his peers. “His (physical therapist) told me that he just noticed the basketball hoop in the gym where she had him, so they practice throwing a small ball towards the basket and he really liked it!” This is the same gym Micah has worked in for the last three years of his therapy. Furthermore, Micah’s mother reported excitement about his increased social interactions as well: “Two days this week he used his AAC to say ‘hello’ in the morning to one of the girls. One morning, he kept pressing it until they responded!” The excitement from Micah’s mother was further supported by Micah’s paraprofessional. She reported he had tried three new things just that afternoon including drying his hands without help, remaining calm and quiet during a lockdown drill, and stopping in the hall to admire the third grade bulletin board. Micah’s increased regulation, awareness, and autonomy were reportedly emerging within several settings.

The end of week 5 (session 8) stood out as different within the CCPT sessions. In supervision following session 7, the RPTS pointed out that while Micah was observed to make fleeting eye contact, he did not seem connected or even very aware of my presence. We discussed the possibility that Micah’s language deficit, paired with his lack of neurotypical play behaviors, might be interfering with his ability to respond to the CCPT therapeutic strategies of verbal tracking and reflecting. The RPTS discussed various alternative nonverbal ways in which I could still reflect and track Micah’s behavior with instances of nonverbal tracking and occasionally reflecting/mimicking Micah’s utterances versus using my own language-laden tracking and reflecting techniques. The RPTS and I

determined that including more nonverbal techniques for tracking and reflecting in session would not only allow me to demonstrate my presence in the moment with Micah but would likely enhance his experience of me “being with” him in session by entering into his world and fully accepting him and his intense sensory needs. In other words, I attempted to connect with him in “his language.” As previously discussed, I had made small attempts at this type of interaction that included quiet mimicry of his verbal utterances and a few instances of me tapping items in the way he tapped them. However, prior to session 8, I had not engaged in grand gestures of nonverbal connection but remained tied to the more verbal techniques of CCPT. My efforts were met by Micah with an occasional glance, though more often not acknowledged. Thus, in session 8 (week 5), I employed nonverbal reflecting and tracking by following Micah with my eyes and body and matching his tones and movements.

This shift in my techniques proved immediately effective as the changes in Micah’s behavior during session 8 were in stark contrast to previous sessions. Session 8 started out in the typical sensory-based movement with Micah pacing back and forth within the room. He ran side to side, periodically stomping his foot in a loud, deliberate manner; his loud, deep groaning resonated within the room in a way that made it nearly impossible to incorporate any verbal tracking. However, after a few minutes of this intense pacing, Micah laid down on his stomach and began to rapidly rock side to side. At this point, I moved toward Micah, tracking my own movements and said, “I going to move closer,” and laid down right beside him, placing my face next to his so he could see me. Micah looked toward me, still rocking side to side, and hit the ground beside his face with his flat palm. I mimicked this same action and slapped the floor in front of me with

my palm. Micah watched me do this and then he suddenly stopped and laid completely still as he stared directly at my face for almost a full minute. He then wiggled, placing his face closer to mine. As he moved closer, I propped myself up with my elbows. Micah watched me do this and again inched himself closer, eventually putting his head down right next to me. He was so close at this point that his head rested against my arm. I began to quietly track his minute movements and soon he pushed himself up to his own elbows and turned his face upward so he could look right into my eyes. Micah held my gaze for several seconds, a seemingly small but truly substantial moment that would serve as a catalyst for further moments of connection as this intervention progressed. In these few moments of interaction, Micah seemed more connected than ever. It is notable that there were no sensory behaviors during this time period; the sensory needs seemed to fall away just enough for the reciprocal interaction and connection to emerge. From this point on throughout the remainder of session 8, Micah engaged in less intense sensory behaviors and increased interaction as he would look to me each time I would nonverbally track his actions. This session marked a transformation in Micah's behavior during our time together. Micah continued to engage in sensory behavior but it no longer dominated his presence within the intervention sessions. Micah instead began to engage in increasingly longer and more connected moments of reciprocal eye contact and periodic joint attention.

The changes observed in Micah's connection and awareness of his environment within the intervention session were not immediately reported outside of CCPT sessions as Micah's mother reported there was "not much new this week." However, she went on to report that Micah had not been feeling well due to some digestion difficulty, indicating

however that “when he’s not feeling bad he’s been really sweet and snuggly and liking to tease.” Micah was further reported to be making slight progress with autonomy as his mother described, “He’s been working on getting undressed and dressed a little more independently and doing a good job.”

Following the shift in connection that occurred during session 8, Micah continued to display an increased awareness of my presence in the therapy room. However, Micah also continued to engage in sensory behavior. In fact, in the session immediately following Thanksgiving break (session 9, week 6), he was back to pacing the room with what seemed agitation and increased intensity (it should be noted that his paraprofessional and his mother both commented he was getting a new tooth and it seemed to be very uncomfortable for him). In my own notes, I commented on how difficult it was to be regulated within this this particular session when Micah engaged in such loud screeching. The duration of this intense display of sensory needs was slightly different than prior sessions as the time he spent engaged in these intense sensory behaviors was interspersed between more connected interactions.

Micah was observed in video reviews to have spent the initial five minutes of session 9 engaged in pacing (resembling that of running and lurching) before settling to slightly less intense sensory play while sitting next to me in the corner of the room. Subsequently, Micah laid on his stomach on the floor and began rocking. I again matched this behavior and Micah appeared to calm for a minute and then moved his face close to mine and looked right at me before hopping back up and beginning the sensory behaviors of pacing and screeching with the same intensity. Periodically throughout this session, he would lay on his stomach and rock. I attempted to match this behavior every

time and each time I did so, Micah would cease the sensory and look to my face momentarily before returning. At one point, Micah sat down with legs crisscrossed and faced me. I mirrored him, to which he responded with fleeting eye contact and a smile. He subsequently leaned forward and laid his head in my lap, staying in this position for almost a minute before sitting up and grabbing the baby doll to chew on. These patterns of brief connected interactions continued interspersed throughout the periodic pacing for the remainder of this session as well as throughout session 10 (week 6). However, the pacing was less intense and much briefer, seeming to serve as self-soothing in between moments of nonverbal engagement.

Micah's affect and demeanor continued to evolve and in week 7 (sessions 11 and 12) were quite different than any of his previous sessions. During session 11, he seemed genuinely happy--an observation that felt notable as I recorded it within my field notes. "Happy, laughing more than usual, seemed to have some moments of teasing and joking," I noted within my researcher journal. Micah was also observed to make significant and sustained eye contact throughout this session and initiated a hug that was followed by giggling and smiles. I continued to engage in nonverbal reflecting and tracking throughout these sessions but also continued to engage in quiet verbal tracking as well. "You seem happy today," I remarked, or "You want to be closer to me," as he would move toward me. Micah appeared to tolerate and at times respond to this verbal tracking as he looked toward me as I spoke in session.

Micah's increase in connection shown within the intervention sessions was also reported by his parents who noticed an increase in Micah's social engagement within the community as well. Micah displayed flexibility to changes in his routine that he had not

previously tolerated and engaged in peer interactions at a basketball game. Micah's parents noted that despite a disrupted routine prior to leaving, he readily went with his mother to a basketball game:

When we got there his friend Paige, who is in his class, came down to sit by him. He got so excited, smiling and giggling and gave her a big hug! For most of the rest of the time we were there, those two giggled and she talked to him and scratched and rubbed on him (his back) and he gave her several hugs. It was so awesome to see him just interacting in such a positive way!

Micah's mother went on to indicate that while Micah did get tired toward the end of the game, it was overall an exceedingly delightful and new experience to see Micah so engaged with a peer.

Micah's paraprofessional also observed positive changes in Micah's social interactions outside of therapy sessions. She was in fact so excited about a peer interaction she observed at recess during week 7, she sent a picture of the interaction to Micah's mother and then with permission to me. This interaction was described to occur during recess, a time when Micah usually engages in repetitive running back and forth between fence lines. However, on this day, Micah independently accepted an invitation from a peer and began kicking a ball back and forth with this classmate with no adult prompting needed. Micah's paraprofessional was beaming with pride as she recounted the details of this interaction and then went on to describe how Micah was continuing to become more and more aware of his surroundings--noticing long standing murals on the hallway walls for the first time and beginning to display an awareness of his classroom environment as well. Furthermore, Micah was reported to have become more autonomous. "Micah walked with me but not holding my hand for most of the day," his

paraprofessional recounted--a behavior quite different from the previous school year in which Micah would reportedly run away through the halls without physical direction.

Weeks 8 and 9 (sessions 14-16) were marked by the addition of Micah's anticipation of my arrival prior to our scheduled session. Micah was reported by his paraprofessional to have periodically walked into our therapy room and just sat down, a behavior he had not previously displayed. During sessions 14-16, Micah seemed calmer; he continued to engage in periodic sensory behaviors but his pacing was not as intense and the vocalizations he performed were more regulated and had taken the form of a softer humming. Overall, Micah's conduct within the therapy session carried with it a difference that felt more communicative as he looked to me more often, sometimes with minute facial expression such as a slight smile or other times with a loud laugh. Furthermore, Micah's vocalizations contained traces of inflection and at times were followed by a quick glance in my direction that proved more reciprocal and purposeful than before. Additionally, while nearly all of Micah's time in our sessions had at least some sensory component, Micah began to spend increasingly more time engaged in simple reciprocal moments.

Session 16 began with Micah immediately sitting down upon entering versus his typical pacing. Once seated, he seemed acutely aware of my presence in the room and watched me as I moved to set the visual timer and then moved his gaze toward my boot as I brushed off a piece of snow before sitting beside him. Micah then shifted his gaze between my face and my hand as I attempted to match his hand movements of rubbing the carpet. I quietly reflected his behavior and continued the nonverbal tracking, to which Micah responded with occasional glances and periodic smiles. Notably Micah

remained calm and engaged throughout the duration of this session. This type of reciprocal interaction continued throughout this 16th and final session. Micah was in the lead and I followed, matching and reflecting his movements throughout. This session accordingly seemed more connected; he allowed and watched while I matched him movement by movement. He allowed this mirroring, seemingly enchanted by it as he watched me intently and at times looking to my face with a smile. I could not interpret what he was thinking, although the fleeting smiles he portrayed felt as though he was having pleasant thoughts.

Micah's mother reported joyfulness and engagement outside of sessions during weeks 8 and 9; Micah was reported during week 8 to have not been feeling well. Nonetheless, Micah was reported to have, for the first time ever, started to spontaneously dance to Christmas music at his house without any prompting. "He was so happy!" his mother reported in her journal. This increase in positive affect was sustained for the remainder of the intervention as during week 9, Micah was again described by his parents to be happy. Micah was reported to have again started dancing without any adult prompting or persuading to "*Rockin around the Christmas Tree* when it came on and he just started dancing and had the happiest, most joyful look on his face!" his mother recounted. This type of spontaneous behavior was something that until this point had never occurred.

Micah's connection to me and others seemed to grow quickly as we neared the end of our work together. My RPTS noted as he watched our recorded sessions the blossoming social engagement seemingly prompted by the authority within Micah to know what he needed and the power of our relationship within the CCPT session.

Outside of session, he also seemed to become increasingly connected to his peers at school. Micah's paraprofessional shared two pictures of Micah and a peer as they read a book together in class. These pictures showed Micah looking at the book with a big smile while his peer held the book and read to Micah. While the pictures depicted one instance, it was reported to be illustrative of how Micah's current peer interactions typically transpired after 16 sessions of CCPT. Table 8 presents a summary of Micah's play therapy progression.

Table 8

Micah's Therapy Progression

Session	Dominant Theme(s)	Play Stage(s)	Confidence/ Security	Happiness	Weekly Parent Probe
Week 1: 10/20/14	Sensory	Sensorimotor	2	3	Nothing new noted
Week 2: 10/27/14 10/29/14	Sensory Sensory; CON	Sensormotor Sensorimotor	2 3	5 4	Calmer than usual during lock-down drill; stopped to admire bulletin board he walked past every day without noticing
Week 3: 11/3/14	Sensory; CON	Sensorimotor	2	5	Will now hold and use crayons to color; started coloring pictures when requested (usually just scribbled on page)
Week 4: 11/10/14 11/12/14	Sensory; CON Sensory; CON	Sensorimotor Sensorimotor	5 8	7 8	(None returned)
Week 5: 11/17/14 11/19/14	Sensory; CON Sensory; CON	Sensorimotor Sensorimotor	5 4	7 4	"Great week!" Engaged and SO happy; unusually long and reciprocal social interaction between Micah and sister; increased awareness of environment, noticing new things; used AAC to say "hello" in morning (kept pressing it until peer responded)

Note. Play Codes: CON=Constancy; Sensory. CONFIDENCE/SECURITY scale of 0-10, with 10 being the highest. HAPPINESS rated on a scale of 0-10, with 10 being the happiest.

Table 8 (continued)

Session	Dominant Theme(s)	Play Stage(s)	Confidence/ Security	Happiness	Weekly Parent Probe
Week 6: 11/24/14 11/25/14	Sensory; CON Sensory; CON	Sensorimotor Sensorimotor	3 5	3 9	Digestion difficulty, still sweet and snuggly; started to become independent in dressing and undressing
Week 7: 12/1/14 12/3/14	Sensory; CON Sensory; CON	Sensorimotor Sensorimotor	1 8	1 9	Significant reciprocal social interaction between Micah and peer in community setting; enhanced tolerance for changes in routine, easy transition typically resulting in tantrum; independently engaged in reciprocal social game during recess, first time without adult prompting
Week 8: 12/8/14 12/11/14	Sensory; CON Sensory; CON	Sensorimotor Sensorimotor	8 9	7 9	Not feeling well at beginning of week, still engaged in lots of social engagement at home toward end of week (initiated hugging and kissing parents and siblings); accepted and ate new food items presented periodically for several years; spontaneous initiation of dancing to Christmas music (new behavior never seen before); "He was so happy!"
Week 9: 12/14/14 12/19/14	Sensory; CON Sensory; CON	Sensorimotor Sensorimotor	9 9	10 10	Micah so Happy and loving Christmas lights

Note. Play Codes: CON=Constancy; Sensory. CONFIDENCE/SECURITY scale of 0-10, with 10 being the highest. HAPPINESS rated on a scale of 0-10, with 10 being the happiest.

Post-treatment observations.

Social engagement. Micah's mother beamed and could not contain her pride as she described the progress she had seen and the happiness and connectedness Micah now exudes. This same enthusiasm was apparent in Micah's educational setting. Micah's paraprofessional eagerly showed me all the progress Micah had made over the course of this intervention that she purposefully set aside time to have Micah demonstrate all of the academic tasks he had mastered. In addition, she also arranged to have me watch social interactions within the general education classroom and even prepared lunch early for Micah so I could see how much he had grown with regard to his autonomy and independence within the lunch room.

Micah's parents and paraprofessional started noting Micah's increased social engagement in home, school, and community settings starting around week 5. Micah's parents further supported not only the increase in social engagement but the sustained change regarding Micah's social interaction throughout the final interview. "It's just like he's so in love with everybody. You know? He's so affectionate. He's more interested in being around people," Micah mother reported. Micah's increased social engagement was reported to occur with individuals outside of his immediate family as well:

(Micah's uncle), he always goes and talk to them and stuff. When we have like a party or something he (Micah) comes out a little bit, but he mostly likes to be in his room. But (Micah's uncle) had gone in there to talk to him and stuff and then he came out here and Micah came out here an grabbed his hand to pull him in there.

"A couple of times," Micah's father interjected. "Like come on, were going to go play."

Micah's mother went on to describe how this was new: "He's never done than with anybody but people in our family, just his dad or the girls or I." Micah's mother and

father continued to describe Micah's increased interest in being with others: "I think he's, I don't know, wanting to interact with people and letting you know that he does."

Despite the delight everyone exuded regarding Micah and his progress, Micah's language use was not observed nor reported to change. He continued to remain nonverbal throughout the duration of this intervention. Furthermore, Micah was not reported by his parents to have made any improvement in the use of his iPad communication device. However, Micah's nonverbal communication and engagement was noted to have undergone significant transformation.

Play/sensory behaviors. Throughout this intervention, none of Micah's play behaviors fell within the thematic codes of Helen Benedict's (2012) play theme codes. His activity within the play room, as depicted by Table 8, was consistently considered to be under the dominant theme of sensory and within the sensorimotor stage described by Sheridan et al. (1995).

Interestingly, while the type of behaviors Micah displayed within session remained static, the intensity of these sensory behaviors was observed to decrease as the intervention sessions progressed. Table 8 again depicts the progressive confidence and security Micah showed within CCPT sessions. As Micah's security within session increased, the intensity of his sensory behaviors appeared to subside and his social engagement increased. Initially, Micah spent nearly all of his time engaged in intense sensory behaviors, leaving no room for social engagement. These sensory behaviors were reported to be similarly intense outside of session within the educational and home settings. Toward the last few weeks of intervention, Micah was observed to engage in significantly less intense sensory behaviors (a notable shift at about the half way point of

session 9) and, as shown in Table 8, concurrently he displayed greater security and positive affect in session. However, throughout the final interview, Micah's mother reported she had not noticed a significant difference in Micah's sensory behaviors in the home setting: "I have not noticed it get worse, but it really hasn't gotten better." She did report his increased happiness and social connection.

Emotional state. Throughout the final interview, Micah was described to have transformed with regard to his emotional state within the home and school setting. This shift in his demeanor was also depicted in session through the increase in his security and confidence as well as his positive affect within CCPT sessions (see Table 8). Initially within CCPT sessions, Micah was observed to display predominantly agitated behaviors as he engaged in intense sensory/repetitive behaviors. As sessions progressed, Micah began to portray more security and confidence within sessions and the emergence of positive affect such as smiling and giggling; his shared enjoyment began to emerge during the last two weeks of sessions.

The increase in positive emotions was also noted outside of intervention sessions; Micah was observed during the final observation to smile as a peer read a book to him in the general education classroom and when working with his paraprofessional, he leaned toward her, putting his face close to hers with a large smile and giggled. Micah's mother further confirmed an increase in positive emotions as she reported, "He's just so happy" several times within her weekly probes. This stable increase in positive affect was again addressed within the final interview session as his mother described Micah to be giggly and happy as they get ready for bed: "Everything is funny (to him) and he'll come over giggling." His mother reported, "

The other night he wouldn't stay in bed so I finally just let him get up, (his brother and father) were out here and he came out here and he was giggling around and (his brother) got up and was kind of "oh do you want me to get you?" and then (his brother) would stand in the middle of the room and he would run and come over here and run towards (his brother) at the last minute he'd go around him.

Micah's mother smiled as she recounted this interaction and the happiness and positive affect Micah displayed. Micah's father confirmed Micah's overall shift to a more positive mood as he exclaimed, "He's a happy guy!"

Autonomy. Micah further described within the final interview that Micah had displayed increased autonomy and initiation within the home and school setting. While Micah displayed only a slight increase in his autonomy within the CCPT session, he did begin to engage in visual exploration of the toys and the room as well as some initiative with regard to choosing a few new toys in session.

In the home setting, Micah was reported by his mother in week 4 to have started to more independently get dressed and undressed. Micah's mother reported additional instances of autonomy. She described during the final interview how he often would get his own snacks and drinks "instead of just kind of waiting for somebody to notice that he (is) hungry he'll get one for himself and open them." Micah's mother further indicated that previously Micah would get something and just put it on the table, standing there until help came. Now he would initiate help by getting others attention: "Today, he got one (granola bar) out of there and I was standing and my back was to him, I felt him kind of come up behind me and he kind of grabbed my arm to like turn me around, like .HEY (help)." Micah's father reported instances of increased flexibility and awareness of his surroundings as well. "He's become a ton more flexible" was the first thing Micah's father reported when asked about Micah's daily routine:

Little things used to really, I mean set him off! And he's pretty adaptable to lots of stuff. I mean like if we used to go someplace and he'd fall asleep on the way, he'd wake up and he'd be ANGRY! And now, I mean the other day you guys (mom and Micah) were going to the basketball game and he fell asleep for a few minutes on the way over...Happy as can be when we got there!

This flexibility to his routine was also observed during the final observation as Micah's schedule was rearranged so his paraprofessional was able to show me all of the progress he had made in various areas. These changes did not seem to bother Micah at all; he went to his general education classroom instead of his one-on-one resource time and he ate lunch an hour early. Micah remained calm, compliant, and regulated throughout all of these changes.

Micah's paraprofessional reported Micah to be able to sit alone at the lunch table and continue eating without wandering off (he previously was noted to require his paraprofessional to sit beside him with her leg behind him to block his escape). This report was confirmed during the final observation as Micah sat quietly while his paraprofessional got up to refill his water. Micah watched his paraprofessional walk away and then continued to eat independently until she returned, at which point he looked directly at her as she sat next to him. Furthermore, Micah's paraprofessional also described instances of Micah independently completing academic tasks such as identifying letters of the alphabet, spelling out his name with letter cards, completing various tasks on the iPad with no assistance, and sustaining brief periods of reciprocal interaction with peers (such as when reading books, giving high fives, etc.).

Meet Joshua

Monday morning at 8:05, I looked at my watch as I entered the kindergarten classroom. I walked to the edge of the room and introduced myself to the class teacher.

She pointed out the best place for me to observe for the next hour; as I took my seat on the south side of the room, I began to scan for Joshua. “Is he sick again today?” I asked the teacher as this observation had been rescheduled due to Joshua’s recent illness. “No,” she replied as she walked across the room. “He is in the coat closet”. I must have had a strange expression on my face for as she glanced at me. She quickly explained.

Evidently, Joshua chose to spend large amounts of time in the coat closet working on tasks or examining various objects he brought from home. Today he was apparently interested in writing utensils. As Joshua emerged from the coat closet following the teacher, his two tiny hands were wrapped around a fist full of pens. “Magic pens,” Joshua’s teacher mouthed to me, motioning to Joshua’s hands. Joshua approached his desk and his body barely touched his seat before he sprang up and started darting around the room. He seemed to be anxiously looking for something. Joshua’s teacher intercepted him and herded him back to his desk where he again sat momentarily as his dark eyes moved around the room. Soon his jet black hair was just a blur as he again zipped about the room. This scenario was re-enacted for the remainder of my observation and was confirmed by the teacher as typical behavior within the classroom. Joshua’s parents had mentioned this difficulty staying on task during the initial parent interview, warning me about the difficulty of holding his attention.

Initial themes from the interview/observation.

Cognitive skills/inattention. “You can tell he is a really smart kid but it’s just getting him on task with it that is the hardest part,” Joshua’s father indicated at the initial interview. Joshua displayed difficulty staying on task throughout the initial observation as he wandered the room regardless of the amount of redirection provided by his teacher.

Joshua was also noted to have the ability to intently focus on items of interest as his father indicated, “If you introduce something new you’ll know instantly if he thinks it’s cool. He’ll stay with it for a while.” During my initial observation, Joshua remained fixated on his magic pens to the point it consumed his behavior. It was this observable difference in Joshua’s behavior that initially concerned his preschool teacher.

Emotional state. When asked how the day starts, Joshua’s mother reported, “Just screaming.” “He’s crabby in the morning,” Joshua’s father described. “Horrible in the morning,” his mother stated as she shook her head. “He will hit. He will yell and then he cries if we walk away and then he doesn’t want to eat.” Joshua was reported to have very difficult behavior in the morning for every step of the routine. “So he wakes up incredibly cranky. Then we have the breakfast issue. We have the going pee issue. We have the brushing teeth issue. He doesn’t want to do any of them. He doesn’t want to go to school. It’s just a struggle,” Joshua’s mother recounted. Once he is ready, the struggle apparently continues as Joshua has to have various, random items in his back pack before leaving the house. “I mean there’s one day he needed three golf balls, a snorkel, a bunch of weird stuff,” Joshua’s father reported. “If he knows it’s in there, he’s okay and he’ll get in the truck,” Joshua’s mother confirmed. “And then usually I stay by my phone because I never know if I’m going to get a call or an email.” Joshua’s mother described how she had to remain on call in case Joshua had a bad day at school. Joshua was described as frequently engaging in perseveration at school, which often resulted in significant disruption to his daily school routine. Joshua’s parents reported that often they were able to give suggestions to the teacher during the day that would help Joshua move on, often knowing what to say or do to help him stop his fixation. His family and

teachers were continually challenged to decipher what Joshua needed in these difficult moments. If they are unable to anticipate his need, Joshua was reported to often become aggressive.

“When things get overwhelming for him, he gets violent.” Joshua’s mother described the aggressive behaviors as mostly spitting and scratching. Furthermore, once he is overwhelmed, Joshua has significant difficulty regulating himself. However, Joshua’s parents indicated if they are able to intervene before he became overwhelmed, then they could often prevent the aggressive behavior. Joshua’s parents described antecedent based interventions put in place at home to aid in the prevention of Joshua’s escalating frustration. Joshua’s parents have identified some of his triggers and have worked toward removing these. For instance, Joshua had specific routines that help him regulate his emotions when he gets home and these seem to aid his transition. Joshua also has calm-down strategies such as reading books that his parents help him carry out before he becomes overwhelmed. Other types of interventions used included “We do a lot of redirecting, car rides, I end up showing him lots of stuff, pictures are good, [and] we talk him down more now than (we have) been able in the past.” However, Joshua’s tendency to be very concrete could make this difficult, i.e., when Joshua’s mother told him to use his mouth and not his hands or feet when his is angry, he started spitting.

While Joshua’s aggression was not apparent throughout the initial observation, he was reported to at times become quite angry at school as well: “He’s punched the teacher where she said it actually felt like her stomach, it knocked the wind out of her,” Joshua’s mother recounted. Joshua’s parents discussed how they had worked with the school staff to better read Joshua’s emotions as well as respond to him in a more effective way:

They ask, “How do you know he’s getting overwhelmed?” His eyes go black and his face turns red. And I just feel his hair, he’s probably sweating. Don’t expect him to respond, give him some juice. Get him cooled off, give him five minutes and then he’ll respond just fine.

It became apparent throughout this interview that Joshua’s parents worked very hard throughout their daily routine to ensure they anticipated Joshua’s needs so as to prevent the escalation of his anger, utilizing antecedent based interventions, visual aids, behavioral interventions, as well as sensory interventions.

Sensory differences. “He’s extremely sensory,” Joshua’s mother stated. “He will actually take blankets and self soothe,” she indicated as she motioned the way in which Joshua would rub the blanket on his skin. “We started brushing. Unfortunately they don’t do it in Kindergarten. It really does have a calming effect; immediately after, he will almost become paralyzed.” Joshua’s parents continued to describe the sensory component of Joshua’s behavior, describing him to have intense sensitivity to lights and sounds as well. “When he was younger, sounds were horrible, then he got over it. Now it’s back,” Joshua’s mother described. “He doesn’t like music, he used to like music. Now he doesn’t like music and will tell us to be quiet if we try to dance.” Joshua’s new brother, whom the family recently adopted, loves music and dance. Joshua was reported to plead with his mother to tell his brother to be quiet. “The weird thing is,” Joshua’s father reported, “now he’s singing, that’s so weird to me because we couldn’t get him to sing and now he sings.” Apparently Joshua does not like the sound from others but engages in singing himself. “Yeah every morning when I drive him in the truck I (have) to find “Fun House” on my iPad and then he’s happy,” Joshua’s father described their morning routine. “It’s on his terms, its acceptable, otherwise he tells us to stop,” Joshua’s mother confirmed. Further, Joshua has extreme sensitivity to clothing. He can

tolerate them during the day but once he is home, “he totally changes his clothes, he gets out of everything,” Joshua’s father reported. “He’s got to get completely all of his stuff off. Pants are horrible when it gets cold out,” Joshua’s mother started. “He hates long sleeves and long pants,” his father chimed in. “He doesn’t like socks, he doesn’t like shoes, he hates pants, he hates long sleeves, he wants shorts,” his mother concurred.

Intense interests/repetitive behaviors/play. Joshua’s tendency to become fixated on various objects (e.g., the magic pens) as well as his impulsivity and distractibility were apparent throughout the initial observation. Joshua’s parents reported Joshua to have a tendency to frequently engage in these repetitive types of behaviors: “Most of the time, he’s pretty good but if he gets fixated on something its tunnel vision.” His father confirmed Joshua’s preoccupation with a variety of topics that continuously shifted with respect to the movie he had most recently watched. Furthermore, Joshua was reported to engage in these repetitive preoccupations in his free time; his parents described his play at home to include either imitations of various movie or television scenarios or recreations of various items he noticed in these shows.

Joshua’s play therapy progression. Joshua and his mother accompanied me to the initial CCPT session. With his mother’s assistance, Joshua gave verbal assent and she accompanied us to the therapy room as I described what would happen as part of this intervention. When asked if he wanted to continue, Joshua nodded his head “yes.” After watching his mother sign her name, he insisted on signing his name as well. Joshua’s mother left and we immediately started our first session. All 16 of Joshua’s CCPT sessions were held at his school in the school counselor’s office.

Throughout this first session, Joshua displayed restricted facial expressions and seemed to intentionally sit with his back turned to me. However, several times throughout this session, he asked, “You my friend?” in what appeared to be an attempt at determining the safety of the setting. Joshua’s questioning continued until I replied, “You’re wondering if I am a friend.” Joshua finally seemed satisfied and discontinued his questioning. Throughout this first session, Joshua initially engaged in exploratory play as he looked through the toys, briefly moved to fixing play, and ended the session with mastery play, making the statement “me got it” when he finally achieved his goal following several minutes of hard work. When time was up for this session, Joshua easily left the room, though he ran away from me as we walked back to his classroom, a habit that continued throughout this study. However, this initial session, Joshua ran away in the opposite direction from his classroom. Thus, pre-teaching was implemented in subsequent sessions to ensure Joshua’s safe return to his classroom.

Throughout session 2 (week 1), Joshua engaged in predominantly repetitive mastery play within the sand table. He repeatedly buried and unburied various objects as he displayed a clear but microscopic expression of pride (i.e., puffing his chest and looking at his work with a pleased expression) after successfully retrieving these items. Joshua did not respond to my reflection of this pride, though he did begin to over-emphasize his effort in these tasks immediately following my reflection of how hard he was working, thus allowing me to see he was able to understand and respond to the verbal tracking and reflecting.

Interestingly outside of session, Joshua’s parent noted a change in his behavior after the first week of intervention. “He had a good week,” Joshua’s mother reported.

He received a blue both days you saw him. They use a color system for daily rating of behaviors for all kindergartners. Everyone starts off on green for ready to learn. This is generally the color Joshua has gotten thus far. There are I believe 5 colors total (2 below green and 2 above green). Blue demonstrates going above expectations. He has only achieved a blue on other time. This was encouraging to us.

Joshua's mother went on to explain changes she started to see in the home as well, which occurred over the weekend after the first week of CCPT: "He shared the Kindle with his brother. He usually is very possessive of items and does not let his brother use his things. I am hopeful for generalization."

Sessions 3 and 4 (week 2) of this intervention started out in a similar fashion to the first two sessions; Joshua spent over half of his time in the sand table engaged in repetitive burying themes. Joshua would deliberately place an object in the sand and then cover it up, subsequently pushing the sand back and forth with great intent and force apparently in an attempt to cover up the item and smooth the surface. Joshua was expending such energy on this task that he began to breath heavily. I commented on the effort he was using, "You are working really hard," to which he did not respond.

Joshua engaged in this repetitive play-smoothing the sand until it was completely flat and blemish free before grabbing a chunk of it, holding it close to his face, and letting it sift through his fingers. He watched intently as the grains of sand slid from his hand to the table. He engaged in this activity of watching handfuls of sand fall to the table for several minutes before digging up the object and starting the whole process over again. Throughout the time Joshua worked in the sand, I sat next to Joshua reflecting and tracking his behavior, commenting when possible on the micro expressions he portrayed. Joshua continued in his play without acknowledging my presence despite my proximity.

Halfway through session 3 (week 2), Joshua abruptly stopped, started to engage in transitory fixing play as he briefly opened the doctor's kit and used the stethoscope on himself, before entering into intense messing play. Joshua continued this messing play as he began to dump all the toy containers upside down, threw toys around the room, dumped the blocks on my head, subsequently dumped the blocks on his own head, and again started to throw toys and stand around the room. During this time, limits were set to maintain room, child, and therapist safety as Joshua engaged in numerous behaviors to test play room rules. When given limits, Joshua would reluctantly discontinue that behavior but would quickly move on to another behavior that broke play room rules and another limit would be set. This testing of rules continued for the remainder of the session. At the session's end as we started back toward his classroom, Joshua again attempted to run away but changed his mind when I proposed a racing game to see who could reach his classroom door first without running.

A similar scenario and parallel themes were played out in session 4 though Joshua needed much fewer limits and displayed increased autonomy within the play room. Joshua continued sand play, his interaction with me still limited to occasional requests for help throughout this session. Joshua again spent the majority of his play in the repetitive burying of objects, meticulous smoothing, letting handfuls of sand fall in front of his face, and then digging up the items and repeating this sequence.

Interestingly, Joshua's mother stopped by in the middle of session 4 (week 2) to relay the message, "Your cupcakes are in your classroom." Joshua was again so immersed in his sensory play in the sand table (i.e., the smoothing actions) during this session that when his mother arrived, he barely acknowledged her; he only looked to her

when she moved closer to him and called his name. However, upon her departure, Joshua proceeded to place the doll house in the sand table. He then threw sand at various parts of the house for the remainder of the session, again with great effort and focus as he started to breathe heavily as though he was working as hard as he could to carry out this play action. I stayed beside him at the sand table during this time and reflected his effort and actions, commenting on how important it seemed to him to complete these actions. Joshua again did not respond or acknowledge my tracking or reflecting.

While Joshua seemed to master the tasks he initiated in week 2 (sessions 3 and 4), he continued to display restricted affect and as previously indicated, made no visible acknowledgement of my reflections. Joshua did, however, display changes with regard to his play in session. He engaged in testing the play room rules and limits as well as slightly increased his autonomy and independent initiation of activities within the play room. Outside of session, Joshua's mother reported great improvement in the educational setting. "For this past week, the special education teacher reported he was calm in the classroom," Joshua's mother recorded in her journal. "This (is) a new occurrence."

Joshua's contained affect and repetitive plays scenarios consisting of burying and sensory play within the sand (including the meticulous smoothing of the sand and subsequently holding it close to his face while it crumbled) continued through sessions 5 and 6 (week 3). Joshua spent all of his time for both sessions 5 and 6 engaged in these play scenes. Throughout this time, he made very little eye contact and continued to have limited verbal use in the intervention sessions. Throughout these sessions, I remained attentive to his actions despite their repetitive nature. I worked to stay connected to Joshua and his play through the use of verbal tracking and reflecting, working to find the

differences in his activities despite their similar appearance. I attempted to reflect microexpressions he displayed and found that while he did not verbally respond, he did begin to move slightly to the side of the sand table to allow a space for me. I accepted this as an invitation to move even closer. I moved right next to him at the sand table and we remained side by side--Joshua working through his repetitive burying routine and me reflecting and tracking his movements. While no weekly probe was returned for week 3, Joshua's teacher indicated that Joshua was starting to appear calmer and he was able to sit with the class for longer periods of time (i.e., circle time, reading time, etc.).

Session 7 (week 4) marked a distinct shift in Joshua's play behavior within CCPT sessions. Throughout session 7, Joshua engaged in exploratory play, asking more questions than ever. "What is this?" he would say as he quickly looked through play items he had not before acknowledged. Joshua spent this session moving quickly between various toys within the therapy room, momentarily exploring each one as though he had gained enough confidence now to really look at what was available in the therapy room. At one point, Joshua found a small globe and gently turned it as he started to teach me about where things were on this globe, a very assertive behavior that carried with it an interactive component I had not before seen in session. I moved to sit right beside him as he engaged in this lesson and listened intently to him commenting on how he was now teaching me things. Later in this same session, Joshua made another attempt at social engagement with me as he initiated a puppet show wherein he used the puppet to engage in a very short, reciprocal conversation with me.

Joshua's repetitive sand play was again reduced within session 8, though this session was marked by frequent testing of limits for the duration of our time. Although

Joshua had previously engaged in behaviors that required limit setting (e.g., throwing sand and toys around the room), this session was different as Joshua seemed to purposefully engage in certain behaviors and then would turn to look at me for my reaction. Ultimately, a final limit was required and sand table use was terminated for the remainder of this session. Joshua's increased language use noted by his parents in the home setting was matched by increased verbalization within this CPPT session as he engaged in short reciprocal verbal exchanges and teaching during our time together.

While there remained a component of sensory play throughout week 4 (sessions 7 and 8), Joshua appeared to use the sensory play as a means to ease or prepare himself for the transition between exploratory and mastery play. It appeared as though the sensory play was a tool to help Joshua regulate his own emotions and perhaps build the courage to transition between play themes. While Joshua's play was notably altered throughout week 4, so was his inclusion of me within sessions. Joshua's mother reported a similar increase in Joshua's social overtures outside of session as well, indicating an increase in his language use: "We did notice he is using his words more to communicate."

Throughout week 5 (sessions 9 and 10), Joshua returned to the sand table and the majority of his time for each of these two sessions was spent engaged in themes of mastery and sensory play in this medium. Session 9 began with Joshua immediately entering the room and beginning to work again in the sand table. At one point, he stopped to blow his nose and did so very deliberately, looking directly at me while he did this. I reflected, "You wanted to make sure I say you do that." He seemed satisfied and then moved back to the sand table where play themes included the alteration between sensory play and aggressive play. Aggressive play was directed at me for this session as

he would throw various small figures he used in the sand toward me. Several limits were set during this time to which Joshua quickly responded and adjusted his play accordingly; instead, he continued his aggressive themed play within the sand. Toward the end of this session, I gave the customary time warning, "Joshua we have 10 minutes left for today." Joshua abruptly stopped his play in the sand table and moved to the handcuffs. He placed me in handcuffs and then declared, "NEVER, NEVER!" after I delivered a second time limit for the end of the session. I reflected Joshua's desire for more time in session: "You don't want to leave today." Joshua looked toward me but did not respond immediately. After a few minutes, he moved closer and sat directly in front of me, holding his nose close to my nose for a few seconds. He then moved to examine the handcuffs he had placed on my wrists. When I gave the final warning, "We are out of time for today," he looked right at my face and then leaned his body into mine, nearly sitting in my lap as he, without complaint, took the handcuffs off me. Joshua then got up and walked out of the room with me, allowing me to guide him toward his classroom instead of running off ahead of me.

Session 10 (week 5) was also notably different as Joshua began to engage in more verbal communication. Upon entering the play room, Joshua displayed an assertiveness not before seen as he deliberately walked straight toward the soldiers, looked at them for a few minutes, and then picked up the handcuffs. "Can you help?" he looked toward me as he held up the handcuffs. I moved closer to Joshua and reflected, "You need help, how can I help you?" He began to search for the keys and motioned to me to do the same. "You're looking for something," I commented. Joshua slightly nodded his head but did not look up. "There in the cash register!" he happily declared as he found the

keys and proceeded to put the handcuffs on me, spending several minutes in deep concentration locking and unlocking the handcuffs. Joshua stopped this activity only to get up and grab a Kleenex. “I need a Kleenex,” he announced. “I got green bugs in there.” Next, Joshua moved to the sand table where he worked in the sand for the remainder of session 10. However, his play was different as he began to fill tubs of different sizes and then worked with different tools in the sand as he smoothed it. On several occasions during his sand play, Joshua verbally commented to me on his own actions, seeming to narrate his own play for me. Throughout week 10 (session 9 and 10), Joshua’s actions within the therapy room were much more interactive and assertive. However, Joshua’s parents indicated in their weekly probe that outside of session there was “nothing noticeably different from last week.”

Session 11 (week 6) started with Joshua’s sensory play within the sand where he again engaged in much more authentic (versus his typical stereotypic language use) verbal exchanges. He expanded the narration of his own play throughout parts of this session. At one point, Joshua looked at me and stated, “Look at this ball; it is gigantic,” a type of interactive and authentic statement that was new to our sessions. Another instance included his declaration of “Gross, disgusting” as he held up a pipe cleaner for me to see and then threw it in a very dramatic motion to the floor. Several other short verbalizations directly tied to his play were used rather than his more typical echolalia. Additionally, Joshua began to initiate instances of cooperation as he would ask, “Can you help” and then we would work together to complete a task. Toward the end of session 11, I set the 10 minute time warning. Joshua responded by saying, “Ok,” then moving toward the corner of the room. Joshua then initiated a reciprocal game of hide and seek.

Joshua would very purposefully place the pillow over himself and then giggle loudly. I played into this game by reflecting, “You want to play,” and then proceeded to look around the room calling out, “Where are you?” Joshua responded with bouts of giggles, moved around, and then would take the pillow off his head and reach for me “here” and he would laugh and start over. The social engagement within this session was more intense than before and was continually initiated by Joshua. These authentic verbal and social exchanges started during this session (11) and continued throughout the remainder of our CCPT sessions.

Session 12 (week 6) was also much more interactive as Joshua began to include me in his play. Joshua steadily increased his social engagement in this session as he began to initiate reciprocal games that included pivotal skills such as joint attention and mutual play. Additionally, Joshua seemed to expand his play as he began to engage in nurturing and fixing play. At one point, Joshua picked up the baby doll, rocked it, and began to diaper and dress it, displaying a type of positive nurturing never before presented in session. During session 12, Joshua also spent significant time with the doctor’s kit, using it to first check and fix himself before using it on me, spending several minutes checking my heart and putting band aids on me, etc. This fixing play was very deliberate and had not before presented within session or in the home setting. Furthermore, Joshua began to seek out my attention, making various funny sounds and looking at me and laughing, attempting these novel social exchanges throughout the duration of the session.

Outside of session during week 6, Joshua’s teacher began to seek me out more regularly upon arrival to discuss the progress she was seeing within the classroom.

Joshua was reported to have again increased his ability to stay on task as well as increased his class participation. “He’s like a different kid,” Joshua’s teacher remarked as I picked Joshua up for session. Joshua’s parents expressed similar significant changes in Joshua’s behavior at home as well. Over Christmas week, which fell between weeks 5 and 6, Joshua’s parents reported significant excitement regarding several instances of progress. Joshua’s mother described this progress in her weekly probe:

We had family over quite a bit over the break, some of which Joshua does not see often. Typically when he have people for dinner Joshua will not eat. He will instead pace, attention-seek, or self-stimulate. We had 4 occasions where family came for dinner. During all of the occurrences Joshua sat for at least 5 minutes or more and also ate. This is the first time he has been able to eat and sit when there are other people present other than mom, dad and brother. Family who do not see him often commented on how mature he is becoming. This was good to hear!

Joshua continued to display themes of cooperation and increasing inclusion of me within his play in sessions 13 and 14 (week 7). The reciprocal interactive game played between the Joshua and I during session 12 was now played out by Joshua and a rubber duck in session 13. Joshua initiated this activity by grabbing the rubber duck, squeezing it, and then declaring, “This duck so loud,” and then look toward me and giggle. He then placed the duck under a pillow and began to re-enact my role in the previous session of calling out for the duck, “Where are you,” and then lifting the pillow and laughing with the duck. This seemed a deliberate act of deferred imitation that had not yet occurred in session. Additionally throughout session, 13 Joshua expanded his play to include themes of aggression, constancy, burying, cooperation, messing and cleaning play, and boundary. These play themes were all briefly presented and interspersed with sensory play within session 13.

Session 14 was marked by an expression of delight on Joshua's face when I walked in his classroom to pick him up. "KATIE!" he exclaimed as he rushed over to me, took my hand, and led me out of the room and up the stairs to our therapy room. He seemed eager to start his work in our room on this day and walked straight to the sand, moving to one end of the table and looking in the empty spot beside him as if to invite me to sit beside him as he played. This session was once again dominated by intense sensory play in the sand table with themes of burying, mastery, exploration, and cooperation. After spending the majority of his time in the sand table burying and smoothing the sand, he searched for and found the rubber duck and again engaged in deferred imitation as he played a game of peek-a-boo with the rubber duck. Joshua also began to display glimpses of symbolic play as he pretended to use various objects in new ways in the sand table. At one point, he created a ball of sand and began to reenact a treasure hunt that revolved around a boulder and then pretended a treasure was buried in the sand next to it. While Joshua's play began to expand and continued to become more interactive during week 7 (sessions 13 and 14), it is interesting that during this session I prepared him for termination the following week. He responded by immediately turning his back to me and then pushing and pounding the sand with significant force and intensity. This apparent angry behavior continued for the duration of session 14.

Week 8 (sessions 15 and 16) began with Joshua again running to greet me at his classroom door, taking my hand, and leading me to our therapy room for session 15. Joshua entered the therapy room, quickly began to work in the sand before briefly engaging in nurturing play with the baby doll, and then briefly engaged in symbolic play

with the doll figurines. Next, Joshua momentarily moved to sensory play before proceeding to his initiation of an interactive social game between the two of us. Joshua spent the remainder of this session engaged in a reciprocal social game he initiated. This game included joint attention and mutual delight with Joshua engaging in laughter and giggling throughout its duration. Session 16 had parallel themes as Joshua again engaged in brief exploratory play followed by sensory play before initiating the same type of interactive game that again included joint attention and mutual delight. The increased social interactions of week 8 were matched outside of session as Joshua's mother indicated good reports were coming home from school: "We received good reports from the teachers for his participation and work completion." Joshua was reported to have made behavioral improvement with regard to attention and appropriate interactions within the home and school settings. "All good things!" his mother concluded. Table 9 presents Joshua's therapy progression.

Table 9

Joshua's Therapy Progression

Session	Dominant Theme(s)	Play Stage(s)	Confidence/ Security	Happiness	Weekly Parent Probe
Week 1:					
11/19/14	EXP, MAS, SOR, FX, BND	Constructive	5	5	Nothing new noted
11/20/14	EXP, MAS, COOP	Constructive	4	4	
Week 2:					
11/24/14	BURY, MESS, Sensory	Sensormotor, Constructive	5	4	“Good week!” Sharing with brother (usually does not let brother use his things); earned a “blue” at school which means he is going above expectations (happened only one other time)
11/25/14	BURY, Sensory	Sensorimotor	5	5	
Week 3:					
12/2/14	BURY, FX, Sensory	Sensorimotor, Constructive	5	5	Teacher reported “calmer,” this is new
12/3/14	BURY, FX, Sensory	Sensorimotor, Autorepresentational	5	5	
Week 4:					
12/8/14	EXP, MAS, BND, Sensory	Sensorimotor, Allorepresentational	5	5	Using his words more to communicate!
12/10/14	AGG, POW, BND, CON, Sensory	Sensorimotor, Allorepresentational	5	1	
Week 5:					
12/17/14	CON, BND, Sensory	Sensorimotor, Allorepresentational	7	7	Nothing new to report this week
12/18/14	CON, BURY, EXP, IM, BND, Sensory	Sensorimotor, Allorepresentational	7	6	

Note. Play Codes: AGG = Aggression; NUR+= Nurturing play; NUR- = Failed Nurturance; BURY = Burying or drowning; FX = Fixing play; MESS = Messing play; CLN = Cleaning play; SOR = Sorting; COOP = Cooperation; ART = Art and drawing; EXP = Exploration; MAS = Mastery play; BND = Boundary setting; CON = Constancy. CONFIDENCE/SECURITY scale of 0-10, with 10 being the highest. HAPPINESS rated on a scale of 0-10, with 10 being the happiest.

Table 9 (continued)

Session	Dominant Theme(s)	Play Stage(s)	Confidence/ Security	Happiness	Weekly Parent Probe
Week 6: 1/5/15	NUR+, BURY, COOP,	Sensorimotor, Autorepresentational, Allorepresentational	9	9	Sat at table and ate with family members he does not know well (this is first time he has been able to eat with people present other than immediate family!); extended family members commented on how mature he's becoming
1/8/15	Sensory CON, NUR+, NUR-, ART, COOP, FX, Sensory	Sensorimotor, Autorepresentational, Allorepresentational	9	9	
Week 7: 1/13/15	AGG, CON, BURY, MESS, CLN, EXP, COOP, BND, Sensory	Symbolic, Constructive, Allorepresentational	8	8	Nothing new noted
1/14/15	BURY, EXP, MAS, COOP, Sensory	Sensorimotor, Symbolic	8	5	
Week 8: 1/22/15	AGG, CON, BURY, EXP, COOP, BND, NUR+	Sensorimotor, Constructive, Symbolic	7	5	Great reports from teachers for participation and work completion; "All good things!"
1/23/15	Sensory, BURY, NUR+, Sensory	Sensorimotor, Constructive, Symbolic	6	6	

Note. Play Codes: AGG = Aggression; NUR+= Nurturing play; NUR- = Failed Nurturance; BURY = Burying or drowning; FX = Fixing play; MESS = Messing play; CLN = Cleaning play; SOR = Sorting; COOP = Cooperation; ART = Art and drawing; EXP = Exploration; MAS = Mastery play; BND = Boundary setting; CON = Constancy. CONFIDENCE/SECURITY scale of 0-10, with 10 being the highest. HAPPINESS rated on a scale of 0-10, with 10 being the happiest.

Post-treatment observations.

Social engagement. Joshua's inclusion of me within the play sessions steadily increased throughout our CCPT sessions. He went from little acknowledgement of me (often with his back turned to me) in the early session to initiating reciprocal play with

joint attention and mutual delight in the last four sessions. Outside the play room, a similar increase was noted in the final interview with Joshua's parents as they reported increased connection with Joshua in his communication and overall demeanor. Joshua's father initially described a moment that stood out around Christmas time as Joshua was reported to have initiated several reciprocal conversations about Santa: "I guess I'm just not used to having like normal kid conversations with him. Like if I have a conversation it's like in *Sponge Bob*...this was just a normal kid that was excited for presents around Christmas time. So it was definitely different!" Joshua's father went on to emphasize the difference he noticed in Joshua's interaction style: "He talks more fluid now and he'll like engage in it more than just conversation, he'll actually ask 'how you doing daddy?' 'Having fun dad?' so he is actually engaging and not just talking." Joshua's father continued to describe the reciprocal nature of these interactions several times throughout the interview by continuing to emphasize the interactive component of the newfound typical volley within Joshua's conversation patterns: "It's not a lot of back and forth but it's noticeably different. It might only be two or three back and forth but that's quite a bit." Joshua's father continued to emphasize throughout the interview Joshua's social connection during these instances as well: "He's not just talking but he's actually engaged when he talks." Joshua's mother also reported several moments that stood out with regard to how much more engaged Joshua seemed to be when interacting with her. She reported the school commented on Joshua's social language as well: "The school is saying he's using his words more." This increase in social interaction within the school setting was further supported throughout the final observation in the educational setting. Throughout this observation, I made continual notes regarding the increased attempts

Joshua displayed as he initiated one social interaction after another. Some of these initiations were in the form of teasing and some were with direct verbal comments to a peer. However, all appeared a stark contrast to the initial observation. Joshua's teacher confirmed this change as she mentioned that Joshua was more social within the classroom and was often initiating various interactions with his peers. Joshua's teacher also commented that his social interactions started to increase around the time the CCPT intervention was in place and the interactions had continued since the intervention completion.

Emotional state. Joshua's emotional state was noticed to shift slightly within CCPT sessions, moving from a flat affect to more positive affect including expressive smiles and giggles in the last two weeks of session. This affect change was addressed within the final parent interview as well. Joshua's parents made several comments regarding an increase in Joshua's patience level as well as an overall sense of calm in Joshua's demeanor. Joshua was in fact noted to have sat at the table during a family dinner. "He actually sat at the table for the first time and ate for about ten minutes with us," Joshua's mother happily reported. Although he was noted to have become calmer and more patient, Joshua's parents made only one reference to Joshua's display of increased positive affect: "He actually drew a picture of people too, which is really strange. Like faces and happy faces and stuff like that. He would never do that (before)." However, while there was minimal discussion of an increase in positive affect, Joshua's increase in emotional regulation was presented as a significant improvement as was his decrease in aggressive behavior.

Joshua's mother described this change in Joshua's behavior:

One thing I notice is prior to starting this, almost every single night he would ask for something at the store. "I need it...I need to go to the store...just one toy....I need (a) five dollar (toy)." Every single day. That stopped. It stopped completely when all of this started.

Joshua's mother and father agreed this behavior had disappeared during the course of CCPT intervention; however, it was reported to have started to re-emerge over the weekend following the last CCPT session. "It's coming back a little bit," Joshua's father indicated as he noted that just over the weekend Joshua had mentioned he needed to go to the store. "I had told (his dad) that, I said he hasn't asked for the store in a really long time. Like he hadn't needed....I don't know why. Yeah that stopped the whole time," Joshua's father again confirmed. Joshua's mother described how prior to the intervention, Joshua asked to go to the store every night: "It drove us crazy, it was like every single night." She reported, "He would have a tantrum when we said no, we're not going to the store every day." "Yeah," Joshua's father reflected again. "He didn't do that for a long time."

Disruptive aggressive/behaviors. Joshua was reported throughout the intervention to have significantly reduced the aggressive and disruptive behaviors that previously dominated the daily routine. "Little less of an issue getting him up in the mornings. It's been easier in the morning too," Joshua's father indicated, although Joshua was reported to have more difficulty as the week progressed. Joshua's father also indicated Joshua's aggressiveness had been reduced over the past several weeks but was reported to have spiked over the last weekend. Joshua was noted to still have difficulty with impulsiveness within the home setting, a concern that at times became a safety issue. However, during the final observation, Joshua was reported by his teacher to have had an

increase in his attention in the classroom, indicating his participation in class discussion increased around the time CCPT started but noted that since intervention stopped, Joshua's inattentive behaviors had started to reappear.

Play. Within the CCPT session, Joshua's play was observed to move through several of Sheridan et al.'s (1995) developmental stages. Joshua's play shifted from exploration to a sensorimotor stage of soothing and then seemed to shift between the sensorimotor and constructive play stages before briefly dipping in to the autorepresentational stage during moments within the last two weeks of CCPT. During the final interview, Joshua's parents reported changes with regard to his play in the home setting as well seeming to describe Joshua's play shifting from a most often constructive play stage to a more autorepresentational stage wherein he mimicked behaviors he had observed in others. Joshua's mother described the changes she had noticed in Joshua's play:

It's gotten (deeper) I think, in thought. He will grab stuff and he's got to live out what's in his head. Like if he wants to create a pulley system. He's really into balancing a scale so he'll create some sort of pulley system where he puts stuff (on it) and calls it play and science. Prior to that he would just throw balls!

"Yeah," Joshua's father confirmed. "There's a guy (on TV) who is an engineer who makes this elaborate pulley system, so we had to do that in his closet. He sees something and want us to recreate it for himself." Joshua was further described to often want to take toys apart instead of playing with them. Interestingly, Joshua was observed to engage in emerging moments of more symbolic play toward the final weeks of CCPT; however, this type of play was not observed outside of session.

Sensory/repetitive behaviors. While Joshua was described to have many sensory differences, the main sensory behavior that occurred within CCPT sessions was that of

sensory play in the sand table. As previously noted, this type of play decreased as the sessions progressed. Outside of session, it seemed there was no change with regard to Joshua's sensory needs. He was reported to continue to need his clothes just right, the seam on his socks just right, and the noise level at home just right: "He'll self soothe all night and he'll smell his blanket...he'll rub his arm or his finger." Thus overall, very little change was indicated with regard to Joshua's sensory needs.

While little change was indicated in Joshua's sensory needs, significant strides were reported with regard to his perseverative thinking and intense interests.

His perseveration has gone down a little bit where he would have to have something whatever it was....a little tiny yellow fuzzy ball or something he had to sleep with or whatever for that comfort piece and I don't know if that's exactly sensory but he had to seek out...."

Joshua's mother trailed off when Joshua's father jumped in, "Yeah." Joshua's father continued,

He stopped playing the computer too...now he's back to it (in the week since CCPT ended). It's one thing I noticed, like at the beginning of the year. Every day he would NEED the computer to decompress and by the time I got home he was still on the computer and then for a while that stopped.

Joshua was described as having reduced several of his compulsive behaviors: "He's not running laps like he used to." His mother continued, "He used to run and run in the living room." However, Joshua was noted to have started to engage in a new repetitive behavior, spinning, which was noted to have started within the last few days since CCPT ended.

Autonomy. When discussing Joshua's routine and his participation in the daily routine, Joshua's parents reported an overall substantial change. Some of this change appeared to be related to an increase in Joshua's autonomous behaviors as well as his

increased initiative. “I’d say right around the beginning of the school year, when he wanted something he wouldn’t be verbal at all. He would come up and grab your hand and take you where he wanted and set you there.” Joshua’s mother continued, “Over the school year that’s changed to where he’s more verbal. He’ll go ‘Hey!’ Or ‘Mom!’ Or whatever instead of coming and grabbing you.” “Definitely more verbal,” Joshua’s father confirmed as he described Joshua’s increased ability to verbalize what he needed and wanted and was thinking. Joshua’s mother continued to discuss how previously Joshua would engage in aggressive behavior when he was frustrated or overwhelmed, noting specific difficulty at church: “We’ll tell him, if you need to walk around that okay, just tell us.” But Joshua was reported to most often act out when overwhelmed: “He’ll start scratching and pinching and getting frustrated that there’s so many people and so much noise. However, recently this changed: last Sunday, he said ‘mom I need to walk around’. And so we just go and he paces for a little bit and then (came) back!”

Furthermore, Joshua was reported to have displayed an increase in his independence with regard to daily skills such as getting dressed, tying his shoes, and putting on his coat, as well as increasingly trying new tasks at school (such as writing, reading, and participating in circle time).

Cognitive. Additionally, Joshua was described as having a better ability to not only be more assertive of skills within his daily routines but also becoming more aware within his environment. Joshua’s mother pointed out,

That’s something that I think has changed. He used to need steps. Like we always did things in threes. Like first we eat, then Joshua in bed, and then you get to go to the pool and then he would say that over and over. Now he watches when the sun goes down. He’s kind of more observant.

“He’s more aware,” Joshua’s father agreed, indicating in a sense that Joshua seemed to have started seeing himself as separate from the world around him. He was becoming more observant and more aware of this world versus immersed in his own. “He seems more alert and engaged than normal,” Joshua’s father continued. “Like usually he’s off in his own world and that really, probably right before Christmas and I would say (changed).” Interestingly, this was around week 7 when in session, Joshua was beginning to display increased interaction and cooperation within the playroom as well as when Joshua’s teacher had stated she had noticed vast improvements.

Joshua’s parents discussed some of the improvements Joshua’s teacher had shared with them: “I guess how (his teacher) put it in one of his report cards was that he can actually decode. So it’s not that he’s reading the word from memory (anymore).” Joshua’s parents described improvements with regard to Joshua’s cognitive skills and academic performance that had occurred during this intervention: “He’s been wanting to grab a pen and write things down or draw or attempt to draw a picture. He did not want to hold a pen prior”. “Yeah, he would never do that, now he will write,” his father chimed in. Joshua’s mother went on to describe her appreciation for this change. “He’ll go ‘mom I need paper okay’. I’ll go find it and I’ll help him write out his thoughts and stuff so that’s amazing. We were even doing homework,” Joshua’s mother exclaimed. “They sent homework with him every night, I don’t know what you did to him but...” Joshua’s mother laughed. “It just seems like his IQ has changed a little bit,” she declared.

Collective Themes Cross Case Analysis

Following the examination of each child and their experiences throughout their participation in CCPT, comparison across cases revealed both similarities and differences with regard to overall themes of change. In general, it was clear that CCPT did not serve to create a spontaneous change of the children to overall more functional and neurotypical behaviors although many specific areas of improvement were detected. Child-centered play therapy appeared to serve as a catalyst allowing the children who participated in this study to not only become more aware of but also more able to participate in their typical home and school environments in a variety of ways. The main areas of improvement as depicted in Table 10 were not identical across participants but included varying degrees of improvement among participants in the areas of increased social engagement, enhanced natural play, increased positive affect, decreased sensory/repetitive stereotyped behaviors, increased academic performance, and increased autonomy.

Table 10

Post-Intervention Cross Case Themes

Theme	Marley	Micah	Joshua
Increased Social Engagement	Increased verbal communication and interaction with cousins, peers at school	Increased social engagement with peers Increased initiating of interaction with family	More authentic verbal exchanges, increased social engagement with peers
Increased Autonomy	Independence of daily living skills, sleeping on own	Independence of some daily living skills	Independence of daily living skills and use of language to get needs met
Emotional State	Increased happiness “I happy”	Increased happiness “Joyful”	Increased emotional regulation, reduction of tantrums and anger
Decreased Sensory	Decreased flapping and in car	Decreased intensity of sensory in sessions	Decreased frequency of sensory in session
Play	Increased symbolic play in session and home	Increased awareness of surroundings and visual exploration	Increased symbolic play in session progressed developmental play at home

Social Engagement

As I recorded within my researcher notes and again observed through review of the tapes, various moments of engagement were interspersed throughout the CCPT sessions with each participant. Each participant was noted to have become progressively more connected and engaged in increasingly interactive activities within the intervention sessions. However, as shown in Figure 3, for each participant, the bulk of these moments tended to occur toward the end of the 16 sessions. The progressive enhancement of study

participants' social interaction was observed to occur within their interactions with me in CCPT sessions, although it was also reported within their interactions in their school and home settings.

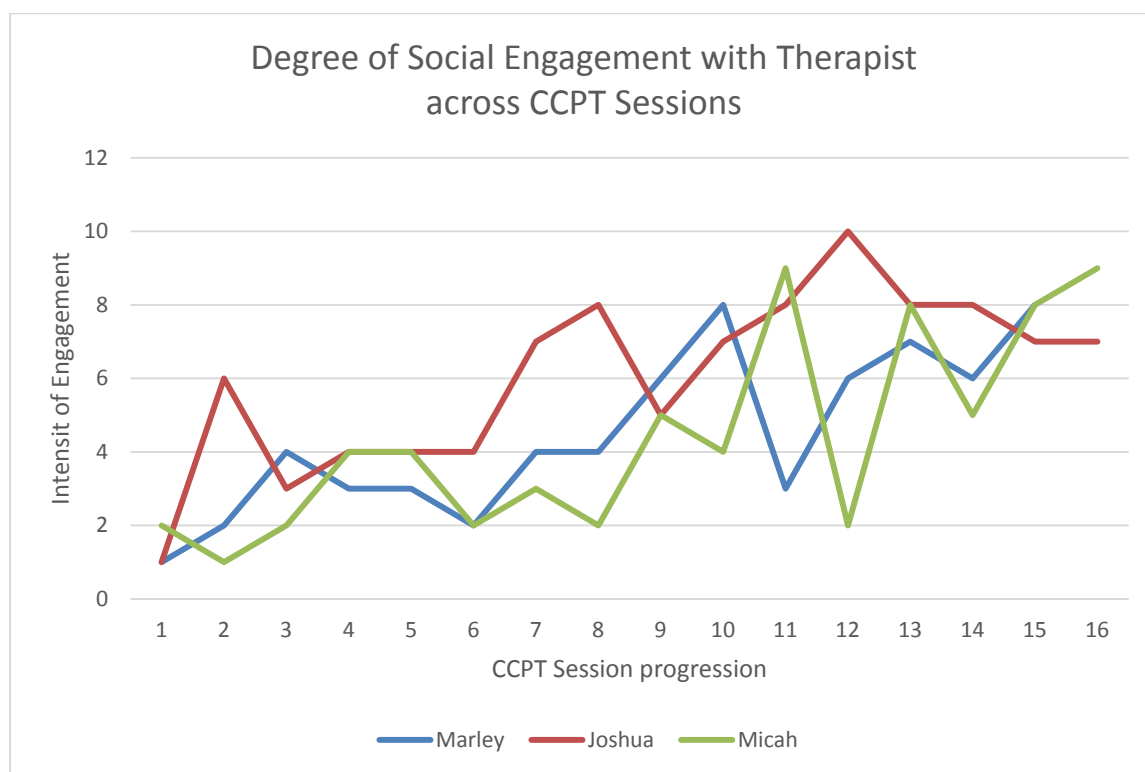


Figure 3. Social engagement with therapist.

Micah was reported by his parents to have made progressively enhanced and notable changes with regard to his social interaction outside of intervention sessions, having started to initiate cuddling with his father and reciprocally interactive social games with his brother during the second half of the intervention. Micah's mother also reported Micah had begun initiating social interactions with his uncle as well as peers within the community setting, a drastic change from his previously reported contentment

to be left alone. Micah's paraprofessional reported auxiliary examples of social engagement within the educational setting. These instances of reported engagement were indicated to have never before occurred prior to the time frame of CCPT implementation.

Joshua was reported to have also made significant advances with regard to his social engagement within CCPT sessions (see Figure 3), the home, and school settings. However, Joshua's transformation was illustrated to include not only enhanced social interactions but also enriched verbal communication within his social relationships. Joshua's parents repeatedly indicated throughout the final interview that Joshua seemed much more engaged, asked real questions, and initiated authentic interactions versus his previously frequent use of stereotyped language and echolalia. Joshua was also indicated to have developed an enhanced reciprocal interaction pattern with the development of a socially appropriate back and forth volley within his conversations. Likewise, Joshua was also noted by his teacher to have made considerable changes with regard to his social participation in the educational setting. Joshua was described by his teacher at the conclusion of the final observation to have started initiating reciprocal social conversations and games with his peers on a daily basis. This was specified as a distinct difference from his initial social behavior at school and was demonstrated during the final observation.

Like Micah and Joshua, Marley displayed increased inclusion of me as CCPT progressed (see Figure 3) but was noted to have completed a lesser degree of progression with regard to enhanced interactions with her parents. This was likely due to Marley's previously reported strong attachment to her parents, which was in place before the current intervention. However, the relationship between Marley and her cousins was

notably enhanced throughout the intervention period due to what Marley's mother described as Marley's ability to utilize increasingly intelligible language. Furthermore, Marley was reported by her mother to have become more social engaged and participated in more reciprocal verbal exchanges with her peers. Marley's teacher noted the increase in Marley's social interactions on occasion to the point Marley at times had to be reminded to not talk to her peers in class.

Emotional State

Micah displayed a significant reduction in the intensity of his sensory behaviors when in the playroom as CCPT sessions progressed. While he continued to display an element of sensory behavior throughout nearly all of his time in the playroom with the reduction of intensity of sensory behaviors, Micah's positive affect (i.e., he smiled and moved close or would giggle and turn away in a teasing fashion) was observed to emerge. This positive affect evolved most significantly throughout the last few weeks of this intervention and was a topic of continual excitement within the weekly probes as well as the final interview with Micah's parents. In addition, Micah's paraprofessional also commented on how Micah's demeanor was shifting to not only being compliant (as he was described prior to the interventions) but to be happy, smiling, and giggling more than ever within the educational setting.

Joshua too developed a more positive affect within the playroom; in the last four sessions, he began to initiate a reciprocal social game within the therapy room that resulted in his explosion of laughter and mutual delight between the two of us. While Joshua's parents did not specifically mention a notable change with regard to Joshua's

increase in positive emotional state in the home setting, they were excited to describe Joshua's reduction of disruptive behavior and his increase in self-regulation.

Marley, while entering this study with what were reported as mainly positive emotions, ended her final CCPT session with her initiation of an interactive lesson she taught regarding emotions--her final explanation to me was "I happy" as she put a check mark above the smiley face she had drawn on the board and then looked to me with a smile. Additionally, Marley's positive emotions were reported by her parents to have steadily increased in the home setting during the CCPT intervention as evidenced by her increase in her excited humming and flapping. However, during the final interview, these same indicators of happiness were reported to have dissipated, likely due in part to her cousin's death.

Play

Within CCPT sessions, all three children were observed to display a decrease in their sensory behaviors in tandem with an increase of their thematic play behaviors. Dominant play themes that emerged for Marley throughout intervention session included sensory, mastery, constancy, aggression, separation and reunion, fixing play, nurturing play, and cooperative play. As Marley began to engage in more symbolic play, she began to display common themes typical for many children her age more regularly within her play. Similarly, Joshua displayed play themes that included sensory, mastery, constancy, cooperation, aggression, burying, and fixing play. Within the last three weeks of sessions, Joshua also began to display thematic play resembling that of children his age and seemed to engage in more variety of play themes during this time. Micah engaged in

sensory and constancy play for the duration of all 16 of his sessions, showing no change with regard to his thematic play.

Interestingly, as participants engaged in more variety of play themes within each session, they also began to display progressively enhanced developmental play behaviors with regard to Sheridan et al.'s (1995) play hierarchy. Marley appeared to have the most progressively developed play as she appeared to have evolved through the sensorimotor stage (where she periodically spent time in self-soothing play), the constructive stage (as she explored and labeled items), and briefly passed through autorepresentational and allorepresentation before her final few sessions in which she displayed mainly symbolic play. Joshua displayed play that fell mostly within the sensorimotor (i.e., self-soothing behaviors in the sand table) and constructive play stages. However within the last three weeks of intervention, Joshua began to engage in play that fell within the atutorepresentational and then in the last two weeks had periods of play that fell within the allorepresentational stage. While Micah's play was mostly static at the sensorimotor stage, he began to increasingly engage in visual exploration of the toys, a shift that occurred as his sensory behaviors were reduced.

Regardless of the varied advancement made with regard to each participant's progression through developmental play stages, there was a distinct shift with regard to all participants' sensory play versus symbolic play. Interestingly, sensory play was dominant for all three participants during the initial therapy sessions; however, as sensory play subsided, more symbolic or natural play emerged (i.e., symbolic play for Joshua and Marley, sensorimotor play for Micah).

Academic Engagement

The connection between a child's play development and his/her development of various cognitive, social, and linguistic skills is undeniable (Frost et al., 2012). Interestingly, this connection was supported throughout the current study as all three participants were reported to have experienced various cognitive and linguistic skills enhancement as they became increasingly engaged in more natural play within CCPT sessions. Marley was reported to use more intelligible language with her family and peers and was indicated by her parents to have adjusted to the routine and academic demands within kindergarten more easily than they had ever expected. Joshua was reported to have become increasingly engaged in his academic setting; he was noted by his teacher to participate in circle time and instructional time without wandering off, staying on task, as well as displaying an increase in his reading skills during the time frame of this study. Joshua's parents noted the surprising changes with Joshua's sudden ability to engage in these academic tasks and insisted that his IQ had somehow been enhanced. Micah was also reported by his educators and observed during the final observation to have experienced an increase in his ability to complete a variety of academic tasks including his significantly increased alertness and awareness of his surroundings and his active participation in the academic lesson versus his previously described passive tolerance of being present while the educator was presenting the lesson. Micah not only increased his actual academic participation but also experienced a significant increase in his academic performance throughout the time frame of CCPT. This included the emergence of academic skills such as independent puzzle completion, letter identification, name identification, shape sorting, and picture sequencing.

Sensory/Repetitive Behaviors

Sensory/repetitive behaviors occurred for large portions of each child's time within the CCPT sessions. For Marley and Joshua, these behaviors began to dissipate as the sessions progressed. Micah's sensory behaviors remained present throughout all 16 sessions although the intensity and duration of these behaviors decreased in the last half of CCPT sessions. While in all three cases the sensory behaviors did not fully dissolve, they did appear to transform within session and were equally reported to diminish outside of session.

Micah, who displayed the most significant and intense sensory behaviors both in and outside of session, was observed within session to significantly reduce the duration and intensity of sensory behaviors throughout the second half of CCPT sessions. Joshua appeared to utilize the sand as a means of meeting his sensory needs within session, an activity that was observed to decrease following session 7. Marley was also observed to spend less time in sensory play following the halfway mark.

For all participants, their reduction in sensory behaviors was countered with an increase in social interaction with me during these sessions. While this interaction looked quite different for each of the three participants, the common feature included their initiation of interaction. It seemed as though once sensory needs diminished, their capability to engage in social interaction as well as other more developmentally appropriate behaviors was freed. While this could be thought of as a product of competing behavioral pathways (Attwood 2003), it is intriguing that with the reduction of sensory/repetitive behaviors, each participant began to engage in newly developed skills, seemingly having found access to new behaviors that were previously unavailable

when the sensory/repetitive needs were in play. While it is difficult to discern if these skills and behaviors were newly learned as each individual was more capable of participating within their environment or if they were simply unmasked by the reduction of sensory needs, it was apparent the reduction of sensory behaviors resulted in the emergence of improved and advanced behaviors and skills.

Autonomy

Marley and Joshua's level of autonomy was reflected within session in their need for help, their management of playroom rules and limits, and the development of their assertiveness and curiosity. At the start of CCPT sessions, Marley entered the room and appeared to need my approval for the various ways in which the toys could be used. She often asked questions about toys, seeming to need an explanation for how she could use them. As she became accustomed to the idea she could choose how to use these items, she began to enter the room with assertiveness and purpose, often heading straight for certain items without the previously mentioned hesitation and engaging them in purposeful and intense types of play.

Similarly, Joshua's initial work in the playroom consisted of his asking for lots of assistance on tasks he was often capable of completing independently. However, as sessions progressed, he appeared to ask for assistance much less and on several occasions began to initiate interactions in which he would teach me. As Joshua became less dependent, he appeared to grow more inquisitive and his exploration of the toys increased. Micah's autonomy within the playroom was observed to increase as he grew more inquisitive of his surroundings and upon the eventual reduction of his sensory/repetitive behaviors appeared to be visually exploring the toys within the room.

Likewise, parents and educators for all three children reported increased curiosity in new items, an enhanced willingness to try new activities, and an increased tolerance of changes within their routines. All three were described as having the confidence of children willing to explore new things or adapt to changes. Joshua was described by his parents to have much less difficulty with the transitions throughout the day and seemed better able to accept when new activities and tasks were placed within his routine including homework and writing (two things previously described as impossible to persuade him to complete). Micah was reported to have easily adapted to changes to his daily routine even when he was tired (which previously would have resulted in extreme disruption) and Marley was indicated to have easily transitioned to her new room, new routine for school, and her mother's return to work with absolute ease (transitions her parents had worried about).

Moreover, parent reports for all three participants indicated increased independent participation in their daily routines although again to varying degrees. This enhanced autonomy outside of session was reported to include Marley and Micah's attempts to dress themselves and all three children's attempts to engage in increasingly age appropriate independence of meeting their own basic needs within the daily routine.

Balancing the Role of Therapist/Researcher

The precise definition of participant observation is "the mode of data collection whereby a case study researcher becomes involved in the activities of the case being studied" (Yin, 2014, p. 240). As a participant observer, I not only assumed the role of observer but also that of therapist. This dual role carried clear advantages as I was able to gain an insiders' perspective of what it was like to engage and interact with participants

on an extended basis and the opportunity to perceive reality as it was viewed from “inside” the case. Furthermore, my role as a participant observer allowed me to collect evidence of case members’ experiences within this intervention that would not otherwise be possible (Yin, 2014). However, I found the seemingly straightforward balance of participant and observer more difficult than anticipated. My tendency to become a supporter of the children I worked with as well as the extensive amount of time it took to complete the interventions and subsequently take notes proved difficult and a possible disadvantage to the quality of this study (Yin, 2014). While I focused on my role as a therapist when in session with the participants. I found it quite difficult to switch gears to then take on the role of researcher between session and during data collection. The difficulty I experienced with these switchbacks was perhaps exacerbated by the fact that I met with participants bi-weekly as well as my RPTS to discuss therapeutic integrity. These frequently scheduled therapy focused roles resulted in less time for role transition into that of researcher.

The supervision I received from the RPTS proved essential to help sort out these dual roles. Reflective supervision allowed me to gain awareness and insight regarding the topic of dual role confusion. Throughout supervision, I was able to delineate more defined boundaries of therapist versus researcher and then more easily apply these within the therapy session. The supervision process was structured to help me first focus on therapy techniques with participants and then subsequently move to the role of researcher as we reviewed and discussed theme development for each participant. The support for each was essential to the success of the intervention and study findings.

CHAPTER V

DISCUSSION

This research study was designed to explore the experience of young children with autism spectrum disorder (ASD) who participated in child-centered play therapy (CCPT). The expectation for this study was that young children with ASD would have a positive experience and that this therapeutic approach would serve as a catalyst for personal growth of participants both inside and outside of the therapy sessions. The overall guiding question that served as the framework for this study was whether children with ASD would experience changes in their interpersonal and social interactions after engaging in 16 CCPT sessions. Specific interest was directed toward the impact of CCPT on the transformation of the autonomy/initiation displayed by these children, the interaction of these children with their parents and the therapist, and how the children's play behaviors transformed.

Findings

Participants appeared to experience important changes over the course of this therapy intervention. Largely, the CCPT experience for children with ASD was observed to be positive. While the degree or exact type of changes were not heterogeneous, over the course of the intervention, all participants became progressively more socially engaged, were involved in more autonomous actions, presented with more positive affect, and displayed increased academic participation. Upon review of the data and depicted

within the cross case analysis, it became increasingly clear that individual participants portrayed improvement in each of these areas but to varying degrees. Interestingly, the behaviors observed within and outside of intervention session throughout this process looked quite diverse between participants. However, improvements noted could be consistently categorized into similar groupings related to the research questions: social engagement, play, autonomy, and other areas of consistent presence--emotional state, academic participation, and sensory/complex body movements.

Social Engagement

All three participants demonstrated not only an increasing ability but also an increasing drive to engage in social relationships as the therapy sessions progressed. These behaviors were most notable within the second half of CCPT sessions. During the same time frame in which an increase in social engagement was observed, all three participants also displayed less sensory or self-soothing behaviors. The decreased need for self-soothing was likely a result of their increased feelings of regulation including a sense of safety and security with the therapist and within the CCPT setting. In this context, the theory advanced by Porges (2007), associating one's limited social engagement skills to one's autonomic fear response, was supported. Porges indicated this fear response removed the individual from direct social contact by supporting the adaptive defensive strategies of mobilization (i.e., fight-or-flight behaviors) or immobilization (i.e., shutdown) responses with the corresponding deactivation of neural regulation. Accordingly, the Polyvagal theory (Porges, 2007) promotes the idea that if individuals with autism could move from the activation and use of their sympathetic nervous system to that of their ventral vagal, the brain circuitry of social engagement

would naturally emerge. The movement from the sympathetic to ventral vagal circuitry, thought to be facilitated through the use of safe, accepting relationships, had relevance to this study as it was observed that participants became progressively more aware of my presence and made increasingly greater attempts at connection as they displayed increased security and decreased sensory/repetitive behaviors.

As participants offered increasing attempts at initiating engagement, I worked to remain engaged but unthreatening, further allowing each child to determine the nature and pace of the social connections. With this allowance, each child seemed to emerge with more authentic and reciprocal volleys of a verbal and nonverbal nature, supporting Badenoch and Bodgen (2012) as well as Ray et al.'s (2012) suggestions that with the provision of a safe, accepting relationship/environment, individuals with ASD would experience a chance to become more fully integrated and able to connect.

The enhanced social engagement findings for this study were also consistent with those of Josefi and Ryan (2004) in their study of a young child with ASD. Furthermore, the extension of enhanced social engagement outside of CCPT session for the three participants were equivalent with Ray et al.'s (2012) hypothesis, indicating that through the therapeutic relationships of CCPT, their self-enhancing behaviors would be more likely to generalize to additional external relationships.

Autonomy/Initiation

To address this study's inquiry of how CCPT would impact the autonomy or initiation of the children participants, their need for help, management of play room rules and boundaries, development of curiosity and exploration, as well as their initiation of interactions and behaviors of independence were reviewed. In session, all three

participants were observed to make some advancement with regard to their display of autonomous behaviors. Marley was noted to initially require reassurance and validation of what the toys were and how to use them, although she quickly grew into a more assertive, more autonomous state. Joshua too initially requested assurance of what toys were and how to use them and gradually became more willing to explore and direct his own play in session; however, this autonomy did not consistently occur until the last three weeks of the intervention. Micah's behavior in CCPT sessions shifted slightly to include more visual exploration toward the second half of the intervention.

Furthermore, all three participants began testing limits within the playroom on at least one occasion throughout this intervention. This testing of limits seemed to resemble that of young children working to develop their own sense of self and was followed by an increased sense of freedom in their actions and play within sessions. Interestingly, this development of autonomy observed within sessions appeared to mirror that of a young toddler. The pleasure evoked from the engagement and enjoyable moments within the playroom perhaps served to form the cores around which these individuals' inner representations could be organized. As individuals' inner representations were strengthened including the sense of self as separate from others, this marked the beginning of object and self-constancy and the beginning of their wrestling with autonomy and individuality (Sheridan et al., 1995). As this transformation occurred within session, all three participants began to expand their autonomy outside of session as they made progress toward independent completing of various daily needs as reported by their parents and educators.

Play Changes

This multiple case study also informed the question of how CCPT would impact the play behaviors of young children with ASD. Changes in participants' play behaviors as CCPT sessions progressed were examined in general to define how CCPT might influence the progression of predominantly non-play behaviors into more natural play, specifically to determine if play could progress with regard to Sheridan et al.'s (1995) developmental play stages.

Marley and Joshua both experienced observable growth with regard to the progression of their play development. Initially, they both started CCPT sessions with a mix of sensory and exploratory behaviors that fell within Sheridan et al.'s (1995) sensorimotor and functional-combinatory stages. They both fluctuated between the constructive autorepresentational and allorepresentational before briefly moving into symbolic play stages in the second half of CCPT sessions. This overlapping of stages is reported typical for children as they undergo natural maturation. Thus, it was important to consider the changes noted in session with regard to play stages might be a product of typical child maturation versus a direct result of CCPT. However, parents and educators reported the changes observed outside of session seemed to follow the exact timelines of the intervention.

While Micah's play was static at the sensorimotor stage, minute changes were noted as his choice of toys expanded as sessions progressed. This expanded toy use notably linked to Micah's increasing awareness and visual exploration of his environment, which, as previously mentioned, expanded during the second half of CCPT sessions when his sensory behaviors became less intense and when I had begun to

incorporate more nonverbal reflecting and tracking, a technique thought to make CCPT particularly effectiveness for children with ASD (Ray, et al., 2012).. While the addition of this technique did not result in Micah seeking out genuine play, he did begin to increasingly seek activities that offered more direct social engagement (i.e., reaching for my hand, leaning close and giggling, etc.). These activities were deemed developmentally necessary for Micah as they resembled infantile reciprocal social games that often occur as children engage in playful experimentation while working toward the concept of object constancy (Sheridan et al., 1995). Concurrently, as Micah engaged in these consistent playful experiences in session, his awareness and autonomy began to blossom outside of session. Micah's nontraditional play within CCPT sessions appeared to create growth and changes outside of intervention. Providing support for the idea that all play when self-directed is beneficial regardless of its appearance or quality (Landreth, 2012) can help children at all play stages grow and work toward increasing their potential.

Overall, results from this study supported the idea that despite the differences in the type of play behaviors displayed within each participant's therapy session, benefit from CCPT was experienced and was in agreement with Josefi and Ryan's (2004) findings that nondirective play could enable a child with ASD play more symbolically and experience increased autonomy, social engagement, residual benefits of increased positive affect, academic participation, and overall awareness. Through the therapeutic CCPT lens, it seemed to confirm Ray et al.'s (2012) theory that when a child with ASD is provided an environment in which they feel safe and understood, they engage in

internally driven play behaviors that serve to support internal individual growth experience and an increase in their motivation to interact with their external world.

Emotional State/Disruptive Behaviors

Results from this study supported Landreth's (2002) declaration that despite the differences in the type of play behaviors displayed within each participant's therapy session, benefit from CCPT is experienced. Through the therapeutic CCPT lens, it seemed the overarching child-centered philosophy that internally driven play behaviors accordingly serve to support internal growth was depicted in general throughout this interventions progression and more specifically with regard to participants' emotional state. Each child's play, regardless of its quality, stage, or appearance, seemed to serve a specific purpose and resulted in an increase in all three participants' positive affect. This improvement was noticed outside of session as well; parents and teachers both commented on participants' increased happiness and significant reduction of disruptive behaviors or anger. These results served to not only support Ray et al.'s (2012) proposition that CCPT is effective in ameliorating disruptive behaviors (i.e., tantrums, yelling, screaming, and extreme emotionality) but also the finding of increased happiness among study participants (Baggerly, 2004; Ray et al., 2007; Reyes & Asbrand, 2005; Tyndall-Lind et al., 2001).

Academic Participation

While it was not a topic of concentrated focus for this study, all three participants were reported to have experienced a notable gain with regard to their academic participation. All three children were reported to have increased their ability to sustain effort and were indicated to have mastered various academic skills throughout the CCPT

intervention. Marley and Joshua were both reported to have improved with regard to their speech/language skills, each reported to participate in more reciprocal conversations with speech that could be more easily understood. Joshua was reported to have not only become more attentive, focused, and more willing to complete academic work but also significantly more advanced in his reading skills. Marley kept up with her peers academically despite her language and prior developmental delays. Micah was reported to have finally mastered many basic academic skills he had previously struggled with including sorting shapes, letter, number, and name identification.

These results while not specifically identified as questions within this study were in line with previous CCPT studies in which similar academic improvements were noted (Blanco, 2010; Danger & Landreth, 2005; Ray et al., 2007). The prospect of CCPT helping children with ASD to gain more from their education and treatment protocols seems encouraging as most young children with ASD experience intense treatments regimes throughout their day in an effort to effectively enhance skills. Landreth (2002) suggests that the very purpose of providing CCPT within an educational setting is to allow children to gain more benefit from their educational experience. Thus, the possibility that CCPT could help to not only facilitate a more complete treatment plan but also support children in their ability to profit from the learning experiences with resulting enhanced skill acquisition necessitates further examination.

Sensory/Repetitive Behaviors

While not addressing a direct research question, participants' changes with regard to their sensory and repetitive behaviors continually occurred within the parent interview and probes as well as throughout CCPT session observations. Interestingly, as each

participant engaged in fewer sensory or repetitive behaviors within session, more natural play began to emerge as though the barrier to natural play was somehow crushed. While the specific source of this barrier is not fully understood, several theorists have expressed the unarguable component of fear and anxiety, resulting in sensory needs that override an individual's innate capacity to participate in any other activity and even biologically programmed processes (Porges, 2007), which in this study included play. The apparent connection between the increase in sense of security, corresponding reduction of sensory behaviors and the emergence of natural, more neurotypical play within this multiple case study further supported Badenoch and Bogdan's (2012) proposition that relational interventions such as CCPT could serve as a catalyst to remove obstacles within children who have ASD (i.e., sensory driven repetitive behaviors), subsequently allowing the increase of relational skills and interpersonal connection as well as the emergence of more developmentally appropriate play behaviors. Participants within this study were observed to have increased play, social engagement, and exploration upon the reduction of their sensory needs, suggesting support for Badenoch and Bogdan. However, it must also be considered that within this study, play might have simply been a competing behavior to sensory behaviors.

Limitations

Several limitations of this study have been discussed in previous sections including that of researcher bias. Attempts to reduce bias were taken into consideration and the study was designed to reduce this possibility. These measures were further delineated within Chapter III and included peer review, member checks, multiple data

sources, and the implementation of an external auditor. However, the possibility of bias as well as study limitations within any research design must still be considered.

An additional potential limitation to this study was the variability between participants. While the differences between participants and their developmental levels allowed the examination of CCPT on varied states of ASD severity, having a larger sample size would have allowed for greater transferability. Furthermore, the possibility of natural developmental maturation among participants must be considered when interpreting the study results and the progress observed. Likewise, each child was receiving additional therapy throughout this intervention so the progress illustrated within each case study could not be solely attributed to CCPT. However, it is notable that each child spent only eight to nine weeks engaged in the intervention; thus, the timeframe of change was such that significant maturational changes were less likely. Furthermore, each participant had been receiving their respective therapeutic interventions for at least one year prior to the implementation of CCPT; thus, it serves to point out that the timing of changes within participants was interestingly connected to the very time CCPT was administered.

The discomfort of being an outsider in a scenario in which research was conducted that required immersion into the intimate and personal world of others has long been noted as an innate difficulty of qualitative research (Creswell, 2007). For this study, I was the outsider entering the world of participants, their families, and, for two participants, their educational systems. With the outsider's perspective in mind and paired with not wanting to overburden participants, I at times likely accepted a slight loss of data. For instance, at times, my reluctance to overburden resulted in one session per

week due to family schedules, school holidays, or illness. Furthermore, I was perhaps too careful not to inconvenience families, i.e., after two requests, I did not require further responses to the weekly probe. Additionally, knowing the extent of time participants had already committed and not wanting to risk alienating these families, I allowed them to dictate the timing of the final session, which resulted in two interviews conducted much later than planned. If I had had more of an insider's role within these systems, I perhaps would have felt more comfortable persisting in my attempts to obtain these data.

One final limitation to this study included the brevity of the CCPT intervention. Eight weeks was a very short time period in which to expect significant results. Two sessions per week were conducted in accordance with Josefi and Ryan's (2004) recommendation. This resulted in a total of 16 sessions; however, Landreth (2002) recommended the mean number of sessions to be around 20. Furthermore, many of the changes noted occurred during the second half of sessions; thus, it would be advantageous for future research to be conducted over a longer period of time to better evaluate the benefits of CCPT.

Researcher Reflections

Every now and then, we come across people who are best described not only by the characteristics they hold but perhaps even more so by the effect their presence has on others. All three children within this study had profound effects on me as an individual and on my development as a CCPT therapist. This type of therapist transformation is unavoidable within the context of human-centered therapy. Rogers (1961) noted this as an unavoidable result of the client-centered process, indicating that in order to truly understand others, we have to be open to and willing to be changed ourselves--a process

that was evident as I worked toward providing the necessary therapeutic space for the children within this study.

Throughout this study as a participant observer, I solely focused my energy in sessions as a therapist, which was often extremely difficult due to intense sensory or repetitive behaviors or the profound sense of disconnection that at times seemed to permeate the therapeutic setting. While these characteristics were more often than not typical of individuals with ASD, I found it surprising how difficult it was to fully immerse myself and participate in these sessions. Sustaining my connection to the participants and maintaining my individual sense of regulation was directly influenced by the very characteristics of these children considered hallmarks of ASD. Accordingly, as my own sense of regulation and connection waned, these children too appeared to descend further into the realms of disconnection either through increased sensory/repetitive behaviors or a further retreat into their individual worlds. Interestingly, this experience lent direct support to Mundy and Crowson's (1977) indication that the environments created for children with ASD often result in further enforcing their maladaptive behaviors.

Understandably at times, children with ASD are denied certain experiences due to their unexpected behaviors and the anxiety these behaviors might create in their caregivers and others within their environment despite the child's developmental need for this type of play/activity. Within this study, I directly experienced brief snapshots of the discomfort caregivers might experience with certain behaviors their children display. As I experienced instances of these discomforting behaviors throughout sessions with each of the participants, I also found it quite difficult to remain nondirective. I found it took

mindfulness and restraint to refrain from redirection or more assertive attempts at connection with these children.

Consequently, additional guidance and support from my RPTS was required to create and carry out my own personal strategies in an effort to maintain my individual sense of regulation in these sessions, subsequently allowing more effective co-regulation with each participant. Furthermore, I found this lack of responsiveness created an atmosphere of disconnection which, in return, led to my own discomfort and further contributed to a participant's withdrawal. I again found it necessary to employ strategies such as focusing on their micro-expressions, noting the nuances of their vocalizations to maintain my own sense of engagement as well as facilitate a sense of connectedness in session. I relied on the support of my RPTS throughout this process and through his reflective supervision began to see how an adult's discomfort with these common ASD symptoms in children and their subsequent responses to stop or remedy these behaviors could in turn affect how these children respond (positively or negatively) to their caretakers.

Relying on the process of this relational intervention and trusting in the progress of CCPT, I established a way to accept my own discomfort and allowed these behaviors/needs to occur. Through the reflective supervision process, I developed strategies to regulate my own state of mind. I then took refuge in having these predetermined strategies to focus on providing a safe and accepting environment and trusting that by allowing each child to guide their own process, this would facilitate their growth toward self enhancement versus pushing normalcy (though at times it was tempting as their behaviors became uncomfortable to tolerate). Curiously, as I

implemented my own strategies to maintain regulation and connection, I became captivated by the power of “being with” these children could create. Through the process of this intervention and through the reflective supervision within this process, I began to see how powerful and transformational the simple task of allowing oneself to be fully present with another could be. Allowing these children to engage in their innately driven behaviors within the CCPT session while being present and immersed in the moment with them appeared to begin the deconstruction of the initial relational barrier. As this barrier began to crumble, I was witness to the emergence of new, more connected, autonomous, and developmentally appropriate behaviors.

The power of being with these children as we built our relationship and an increased sense of connectedness was evident through this brief period of time and led me ask more questions regarding how these children would have responded to an intervention that allowed more time for completion of more CCPT sessions or how the inclusion of parents and caretakers into this therapy would have impacted the experience of these children. Furthermore, as I reflected on the impact of CCPT and the nondirective power of truly “being with” each of these children, I began to see the importance of preparation and guidance for therapists, teachers, and parents to work toward sustaining their own regulation during these moments.

Implications

Supplement to Traditional Autism Spectrum Disorder Treatment Protocol

It appears that overall children with ASD experience positive outcomes while participating in CCPT. However, just as ASD is a heterogeneous disorder, results from

CCPT on children with ASD appear to be somewhat varied. While CCPT did not prove to produce spontaneous acquisition of neurotypical behaviors, it did result in positive outcomes for all three child participants. All participants showed increased social engagement, increased language use, increased academic participation, and increased positive affect. Other areas of notable improvement noted within individual participants included decreased disruptive behaviors and decreased sensory/repetitive behaviors.

While CCPT did result in a variety of positive outcomes for children with ASD, it would be impractical to think of this as a replacement for a traditional treatment protocol. Typical interventions for ASD most often include various methods of increasing desired skill acquisition and decreasing disruptive or undesirable behaviors. The philosophy of CCPT is not to create spontaneous skill acquisition or reduction but instead create a relationship that allows the fostering of internal motivation for personal enhancement within each individual. The very notion of CCPT envelopes the idea that every child regardless of innate deficits has the power to move toward enhancement and fulfillment of his/her inherent potential.

This appeared to be the case for all three participant within this study; through their work within CCPT sessions, they became more capable and able to grow in skills taught outside of session (i.e., their respective educational curriculum and specialized interventions). Thus, it seemed the addition of a relational intervention such as CCPT to the typical treatment protocol of ASD was advantageous as it likely not only further enhanced treatment results of other protocol interventions and provided increased support for the traditional treatment regimen but also created change based on a more intrinsic need likely resulting in more authentic and sustainable progress.

School-Based Intervention

The possibility of including CCPT as part of the treatment protocol for children with ASD within the educational setting proves both exciting and beneficial. Two of the cases within the current study were completed within the educational setting and were beneficial inclusions within the participant's daily routine. Furthermore, the educators of both study participants indicated significant changes in each respective child--changes that allowed increased academic participation, improved awareness and attentiveness, and enhanced social participation with peers and educational staff. Furthermore, one educator noted that often the child participant might have a difficult start to the day (i.e., disruptive behavior or extreme emotionality) but following the CCPT session, he/she seemed to experience improvement. This suggested potential with regard to strategically scheduling CCPT sessions during the school day to help counter and perhaps remediate difficult behaviors as they arise.

Child-centered play therapy is a therapeutic intervention that fits seamlessly into the educational setting of any child. Landreth (2002) claimed the very goal of play therapy in schools is to "help children get ready to profit from the learning experiences offered" (p. 148). Furthermore, recent research by Blanco (2010) indicated significant academic improvement for students who participated in CCPT. For individuals with ASD, providing this intervention in the educational setting seems idyllic. This would not only allow the twice per week sessions to be more logistically feasible and allow professionals to more closely collaborate regarding children's needs but also has the potential to reduce disruptive behavior, increase academic and social participation, and

perhaps further enhance the outcome of the intense treatment protocol typically administered to children with ASD.

Therapist Preparation

While most therapists will have had the appropriate training in client-centered theory, prerequisite play therapy coursework and supervised experience are required prior to one's utilization of CCPT. Additionally, this study revealed the importance of not only continued supervision throughout one's implementation of CCPT but also the importance of therapist preparation prior to working with individuals who have ASD. The premise of CCPT is to allow the individual to guide his/her course of actions within the CCPT setting including those of sensory and repetitive behaviors. Allowance of these behaviors can at times become difficult as the therapist struggles to portray an unconditional acceptance of behaviors that are at times quite difficult to personally tolerate. Therapists should be prepared in advance for these difficult instances and with guidance should have various personal strategies in place to sustain personal regulation throughout sessions. As illustrated within this study, as I became dysregulated due to the intensity of sensory/repetitive behaviors or disconnection within the therapy session, each child's need for these behaviors escalated. Upon my own implementation of regulation strategies, I was better able to create the necessary, safe, accepting environment to support participants as they worked toward meeting their full potential.

Additionally, mindfulness and flexibility with regard to toy selection was essential. For example, various items might need to be modified or removed to address the sensory behaviors of a child and potential safety hazards (i.e., larger items to reduce choking hazards, removal of sand, etc.). Thus, consideration for each child's specific

needs while maintaining toys from all five categories recommended by Landreth (2002) is necessary.

Future Research

Interestingly, it was the power of “being with” children in a fully accepting, nonjudgmental, non-contingent way that allowed a sense of connectedness not often otherwise achieved. As ASD is a relational disorder, the potential power of creating enhanced and connected relationships with children who have ASD is clear. While positive growth was seen from twice a week 45 minute sessions for a minimal duration of only 16 sessions, more research is needed on a larger scale. A necessary question revolves around the possible advantages of an intervention with longer duration. While research suggested it takes an average of 20 play therapy sessions to resolve the problems of the typical child referred for treatment, more serious or ongoing problems might take longer to resolve (Landreth, 2002). Additionally, due to the timeline of improvement noted within this study, it seemed the first eight sessions were spent working toward the child gaining a sense of security and trust within the CCPT environment, whereas the most progress was noted within the last eight sessions. Thus, it would be beneficial to conduct more research regarding optimal frequency and duration of sessions.

Likewise, while this qualitative study produced large amounts of subjective data that led to the conclusion of potential benefits of CCPT for all three participants, a research design that included a stronger baseline and post-treatment objective data for comparison, such as a single case research design, would be helpful in further delineating potential benefits of CCPT for children with ASD. Including within the single case research design an objective, standardized measure of baseline academic, behavioral,

and/or adaptive functioning and subsequently collecting post intervention data with the same measures would provide clear, concrete data to further support the benefits of CCPT found within the current case study. Furthermore, it would provide additional insight and information to collect these behavioral measures across settings and individuals working with the child. Gathering objective input from not only the child's parents and educators but also the other specialists working with the child during the CCPT intervention would provide additional layers of information that could further support the generalization of enhanced skills seen within the current study.

Including all service providers such as those within the educational support system of students participating in the CCPT sessions seems ideal for gathering more in depth supplementary information in future research studies. More consistent communication with all service providers would not only allow the researcher to gather essential information regarding the child's progress across settings but also provide insight into progress regarding specific specialized skills that might not otherwise be observed. Moreover, consistent communication with all providing therapists allows the researcher to be better informed with regard to the prospect of observed progress resulting from the CCPT versus new interventions other therapists might have implemented during the same time frame. Therefore, similar studies that include a larger number of participants and collect more data from parents, teachers, and specialized therapists regarding changes outside of the CCPT sessions are needed.

Equally, I found the possibility of teaching parents and educators an intervention in which their relationship revolved around the idea of acceptance and "being with" to have great potential and would be a noteworthy future study. The brief intervention

provided within this study resulted in exciting improvements. Thus, it would be interesting to examine how more sustained interactions (i.e., those with parents, teachers, and even siblings and peers who have a longer duration of time with these individuals) of this same nature would impact children with ASD. With influential parenting trainings and educational interventions in place that focus on the idea of “being with” their children in safe accepting ways (e.g., Circle of Security Parenting; Kinder therapy), it would be advantageous to explore the impact of these interventions on children with ASD to further support, enhance, and inform the typical treatment protocol.

Similarly, the use of peers or siblings as therapists also seems promising. Currently, peer-mediated approaches represent the largest and most empirically supported type of social intervention for children with autism (Bass & Mulick, 2007). With peer mediated interventions proving so efficacious, the use of peers or sibling within a therapeutic setting also seems hopeful. Previous studies utilizing peers and siblings as therapists found encouraging results with regard to social play skill and language improvements (Bass & Mulick, 2007; Watson, 2011). Consequently, future research looking at the impact of teaching peers and siblings of children with ASD to utilize CCPT techniques within their daily environment might also prove beneficial to not only provide children with ASD more exposure to the powerful therapeutic relationship enhancing their relational engagement with their peers and siblings but perhaps also serving to further enhance their general skill progression.

Finally, the benefits of CCPT include the concept that when changes are intrinsic versus extrinsic, they are thought to be more sustainable over time. The current study did not allow for long term follow up to confirm the stability of the changes observed. It

would be advantageous in subsequent studies to include additional follow up with parents and educators after a longer period of latency, to gather information regarding the sustainability of changes experienced by study participants, and examine how the duration of CCPT sessions might affect the sustainability of those changes.

In summary, further research including longer duration, more rigorous study design, inclusion of participants' special service providers, use of parents, educators, peers, and siblings as therapists as well as additional, longer term follow ups are essential for gathering additional information of CCPT effectiveness. Results from these studies would serve to further inform the field of psychology as well as educators and guardians of the benefit of CCPT for children with ASD and provide additional insight for those professionals and parents who are continually searching for supplementary interventions to effectively improve the quality of relationships with these children.

Conclusion

In summary, within the last two decades, there has been a drastic increase in the prevalence of ASD. Correspondingly, researchers and educators have responded with an equally dramatic increase in research regarding the treatment of ASD. Most often this research has focused on behavioral interventions, which have repeatedly proven effective for the remediation of a variety of behaviors and skill deficits. However, there has been much less focus on the impact of relational interventions on ASD. Curiously, the core deficits of ASD can be considered relational, thus pointing toward the importance of incorporating an effective relational intervention into the typical treatment protocol. This study aimed to explore the impact of a relational intervention such as CCPT, which

allows individuals to guide and unlock their own potential for personal growth and enhancement, would have on children with ASD.

Child-centered play therapy offers children an environment full of unconditional, non-contingent acceptance and serves as a vehicle for their individual experience of uniqueness and self-worth. Similar to a case study by Josefi and Ryan (2004), results from this study have proven CCPT to be effective in the enhancement of a variety of skills. Skills shown to improve within this study included social engagement, autonomy, academic enhancement, decreased sensory behaviors, and increased positive affect, supporting the notion that CCPT could serve as a complementary intervention to the typical behavioral-driven treatment plan for children with ASD. While this study was limited to three participants and future research is needed to explore the additional potential benefits CCPT can offer to other children with ASD, positive growth toward each individual's optimal functioning was observed through the use of this child-centered intervention, thus proving that each of these children, regardless of reported deficits, has within themselves the power to transcend their current source of difficulties and move toward enhanced functioning. The relationship facilitated through CCPT served as the key to unlock this potential.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Aspy, R., & Grossman, B. G. (2012). *Designing comprehensive interventions for high-functioning individuals with autism spectrum disorders: The Ziggurat model*. Shawnee Mission, KS: AAPC Publishing.
- Association of Play Therapy [APT] (2015). *Play therapy makes a difference*. Retrieved from <http://www.a4pt.org/?page=PTMakesADifference>
- Attwood, T. (2003). Framework for behavioral interventions. *Child and Adolescent Psychiatric Clinics*, 12, 65-86.
- Attwood, T., (2006). *The complete guide to Asperger's syndrome*. London: Jessica Kingsley Publishers.
- Axline, V. (1974). *Play therapy*. New York: Ballantine.
- Badenoch, B., & Bogdan, N. (2012). Safety and connection: The neurobiology of play. In L. Gallo-Lopez & L. C. Rubin (Eds.), *Play-based interventions for children and adolescents with autism spectrum disorders* (pp. 3-18). New York: Routledge.
- Baggerly, J. (2004). The effects of child-centered group play therapy on self-concept, depression, and anxiety of children who are homeless. *International Journal of Play Therapy*, 13, 31-51.
- Baron-Cohen, S. (1995). *Mindblindness: An essay on autism and theory of mind*. Cambridge, MA: MIT Press.

- Bass, J. D., & Mulick, J. A. (2007). Social play skill enhancement of children with autism using peers and siblings as therapists. *Psychology In The Schools, 44*(7), 727-735.
doi:10.1002/pits.20261
- Bekoff, M. (2001). Social play behavior: Cooperation, fairness, trust and the evolution of morality. *Journal of Consciousness Studies, 8*, 8-81.
- Bellini, S., Akullian, J., & Hopf, A. (2007). Increasing social engagement in young children with autism spectrum disorders using video self-modeling. *School Psychology Review, 36*, 80-90.
- Benedict, H. E. (2001). *Benedict's expanded themes in play therapy*. Unpublished manuscript, Baylor University, Waco, TX.
- Beyer, J., & Gammeltoft, L. (2000). *Autism and play*. Philadelphia, PA: Jessica Kingsley Publishers.
- Blanco, P. (2010). Impact of school-based child-centered play therapy on academic achievement, self-concept, and teacher-child relationships. in J. Baggerly, D. Ray, & S. Bratton (Eds.), *Child-centered play therapy research: The evidence base for effective practice* (pp. 125-144). Hoboken, NJ: Wiley.
- Brandt, M. (1999). An investigation of the efficacy of play therapy with young children *Dissertation Abstracts International, A61*(07), 2603.
- Bratton, S. C., Ray, D. C., Rhine, T., & Jones, L. (2005) The efficacy of play therapy with children: A meta-analytic review of treatment outcome. *Professional Psychology: Research and Practice, 36*(4), 376-390.
- Bricker, D., & Cripe, J. (1992). *An activity-based approach to early intervention*. Baltimore: Brookes.

- Centers for Disease Control and Prevention. (2010). *Prevalence of autism spectrum disorder among children aged 8 years. MMWR, 63*(SS 2), 1-21.
- Charman, T., Swettenhaum, J., Baron-Cohen, S., Cox, A., Baird, G., & Drew, A. (1997). Infants with autism: An investigation of empathy, pretend play, joint attention, and imitation. *Developmental Psychology, 33*, 781-789.
- Collet-Klingenberg, L., & Franzone, E. (2008). *Overview of social narratives*. Madison, WI: The National Professional Development Center on Autism Spectrum Disorders, Waisman Center, University of Wisconsin.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches*. Thousand Oaks, CA: SAGE.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspectives in the research process*. London: SAGE.
- Danger, S., & Landreth, G. L. (2005). Child-centered group play therapy with children with speech difficulties. *International Journal of Play Therapy, 14*, 81-102.
- Dougherty, J., & Ray, D. C. (2007). Differential impact of play therapy on developmental levels of children. *International Journal of Play Therapy, 16*, 2-19.
- Elliott, J., & Lukes, D. (2008). Epistemology as ethics in research and policy: The use of case studies. *Journal of Philosophy of Education, 42*(1), 87-119.
- Evans, J. (1992). Children's leisure patterns: The shift to organized recreation. *Recreation Australia, 3*(4), 19-26.
- Fall, M., Balvanz, J., Johnson, L., & Nelson, L. (1999). The relationship of play therapy intervention to self-efficacy and classroom learning. *Professional School Counseling, 2*, 194-204.

- Fall, M., Navelski, L., & Welch, K. (2002). Outcomes of a play intervention for children identified for special education services. *International Journal of Play Therapy*, 11, 91-106.
- Franzone, E. (2009). *Overview of naturalistic intervention*. Madison, WI: National Professional Development Center on Autism Spectrum Disorders, Waisman Center, University of Wisconsin.
- Frost, J. L. (2010). *A history of children's play and play environments: Toward a contemporary child saving movement*. New York & London: Routledge.
- Frost, J. L., Worthman, S. C., & Reifel, S. (2012). *Play and child development* (4th ed.). Upper Saddle River, NJ: Pearson.
- Garvey, C. (1977). *Play*. Cambridge, MA: Harvard University Press.
- Garza, Y., & Bratton, S. C. (2005). School-based child-centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy*, 14, 51-80.
- Garza, M., Briley, S., & Reifel, S. (1985). Children's view of play. In J. L. Frost & S. Sunderline (Eds.), *When children play* (pp. 31-37). Wheaton, MD: Association for Childhood Education International.
- Getz, S. (1996). *Play therapy intervention with an autistic child as witness to intense trauma*. Conference presentation at the International Play Therapy Conference, Ede, The Netherlands.
- Gitlin-Weiner, K. (1998). Clinical perspectives on play. In D. P. Fromberg & D. Bergen (Eds.), *Play from birth to twelve and beyond: Contexts, perspectives, and meaning* (pp.77-92). New York: Garland.

- Gray, C. (1995). Teaching children with autism to “read” social situations. In K. Quill (Ed.), *Teaching children with autism: Strategies to enhance communication and socialization* (pp. 219-241). Albany, NY: Delmar.
- Greenspan, S., & Wieder, S. (2006). *Engaging autism: Using the Floortime approach to help children relate, communicate, and think*. Cambridge, MA: Da Capo.
- Guba, E. G. (1990). The alternative paradigm dialog. In *The paradigm dialog* (pp. 17-30). Newbury Park, CA: SAGE.
- Guerney, L. (2001). Child-centered play therapy. *International Journal of Play Therapy*, 10(2), 13-31.
- Gutstein, S. E., Burgess, A. F., & Montfort, K. (2007). Evaluation of the relationship development intervention program. *Autism*, 11, 397-411.
- Gutstein, S. E., & Sheely, R. K. (2002). *Relationship development intervention with young children: Social and emotional development activities for Asperger syndrome, autism, PDD, and NLD*. London: Jessica Kingsley Publishers.
- Hellendoorn, J., Van Der Kooij, R., & Sutton-Smith, B. (2004). *Play and Intervention*. Albany: State University of New York Press.
- Howlin, P., Baron-Cohen, S., & Hadwin, J. (1999) *Teaching children with autism to mind-read: A practical guide*. New York: John Wiley & Sons.
- Hoyson, M., Jamieson, B., & Strain, P. S. (1984). Individualized group instruction of normally developing and autistic-like children: The LEAP curriculum model. *Journal of the Division for Early Childhood*, 8, 157-172.
- Hughes, F. P. (1999). *Children, play and development*. Boston: Allyn & Bacon.

- Hughes, F. P. (2010). *Children, play, and development* (4th ed.). Thousand Oaks, CA: SAGE.
- Johnson, L., McLeod, E., & Fall, M. (1997). Play therapy with labeled children. *Professional School Counseling, 1*, 31-34.
- Johnson, S. (2004). *Mind wide open: Your brain and the neuroscience of everyday life*. New York: Scribner.
- Jones, E. A., & Carr, E. G. (2004). Joint attention in children with autism to initiate and sustain cooperative play. *Research and Developmental Disabilities, 21*, 151-169.
- Jones, E. A., Carr, E. G., & Feeley, K. M. (2006). Multiple effects of joint attention intervention for children with autism. *Behavior Modification, 30*(6), 782-834.
- Jones, E. A., & Landreth, G. L. (2002). The efficacy of intensive individual play therapy for chronically ill children. *International Journal of Play Therapy, 11*, 117-140.
- Josefi, O., & Ryan, V. (2004). Non-directive play therapy for young children with autism: A case study. *Clinical Child Psychology and Psychiatry, 9*(4), 533-551.
- Knell, S. (1998). Cognitive-behavioral play therapy. *Journal of Clinical Child Psychology, 27*, 28-33.
- Knell, S., & Dasari, M. (2011). Cognitive-behavioral play. In S. W. Russ & L. N. Neic (Eds.), *Play in clinical practice: Evidence-based approaches* (pp. 236-263). New York, NY: Guilford Press.
- Koegel, R. L., & Koegel, L. K. (2006). *Pivotal response treatments for autism: Communication, social, and academic development*. Baltimore, MD: Paul.

- Koegel, L. K., Koegel, R. L., Harrower, J. K., & Carter, C. M. (1999). Pivotal response intervention I: Overview of approach. *Journal of Applied Behavior Analysis, 210*, 243-252
- Koegel, L. K., Vernon, T. W., Koegel, R. L., Koegel, B. L., & Paullin, A. W. (2012). Improving social engagement and initiations between children with autism spectrum disorder and their peers in inclusive settings. *Journal of Positive Behavior Interventions, 14*(4), 220-227.
- Kohn, A. (1999). *Punished by rewards: The trouble with gold stars, incentive plans, A's, praise, and other bribes*. Boston: Houghton Mifflin Company.
- Kottman, T. (2001). *Play therapy: Basics and beyond*. Alexandria, VA: American Counseling Association.
- Landreth, G. (2002). *Play therapy: The art of the relationship*. New York: Routledge.
- Landreth, G. (2012). *Play therapy: The art of the relationship* (2nd ed.). New York: Routledge.
- LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly, 14*(2), 149-163.
- Leekam, S., R., Nieto, C., Libby, S., J., Wing, L., & Gould, J. (2007). Describing the sensory abnormalities of children and adults with autism. *Journal of Autism & Developmental Disorders, 37*(5), 894-910.
- Levy, S., Ae-Hwa, K., & Olive, M. L. (2006). Interventions for young children with autism: A synthesis of the literature. *Focus On Autism & Other Developmental Disabilities, 21*(1), 55-62.

- Leyfer, O. T., Folstein, S. E., Bacalman, S., Davis, N. O., Dinh, E., Morgan, J, ...Lainhart, J. E. (2006). Comorbid psychiatric disorders in children with autism: Interview development and rates of disorders. *Journal of Autism & Developmental Disorders*, 36(7), 849-861.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: SAGE.
- Lord, C., Luyster, R., Guthrie, W., & Pickles, A. (2012). Patterns of developmental trajectories in toddlers with autism spectrum disorder. *Journal of Consulting & Clinical Psychology*, 80(3), 477-489.
- Lovaas, O. I. (1977). *The autistic child: Language development through behavior modification*. New York: Irvington Publishers.
- Mackenzie, N., & Knipe, S. (2006, October). Research dilemmas: Paradigms, methods and methodology. *Issues in Educational Research*, 16(2), 193–205.
- Massey, N., & Wheeler, J. J. (2000). Acquisition and generalization of activity schedules and their effects on task engagement in a young child with autism in an inclusive pre-school classroom. *Education & Training in Mental Retardation & Developmental Disabilities*, 35(3), 326-335.
- Mastrangelo, S. (2009). Harnessing the power of play: Opportunities for children with autism spectrum disorders. *Teaching Exceptional Children*, 42, 34-44.
- Merriam, S. B. (1998). *Qualitative research and case study application in education*. San Francisco, CA: John Wiley & Sons, Inc.
- Meyers, S. M., & Johnson, C. J. (2007). Management of children with autism spectrum disorders. *Pediatrics*, 120, 1162-1182.

- Miles, M. B., Huberman, M. A., & Saldana, J. (2014). *Qualitative data analysis: A methods source book* (3rd ed.). Thousand Oaks, CA: Sage.
- Mithaug, D. K., & Mithaug, D. E. (2003). Effects of teacher-directed versus student directed instruction on self-management of young children with disabilities. *Journal of Applied Behavior Analysis, 36*, 133-136.
- Mitteldorf, W., Hendricks, S., & Landreth, G. (2001). Play therapy with autistic children. In *Innovations in play therapy: Issues, process, and special populations* (pp. 257-270). New York: Brunner-Routledge.
- Mundy, P., & Crowson, M. (1997). Joint attention and early social communication: Implications for research on intervention with autism. *Journal of Autism & Developmental Disorders, 27*(6), 653-676.
- Muro, J., Ray, D. C., Schottelkorb, A., Smith, M., & Blanco, P. (2006). Quantitative analysis of long-term child-centered play therapy. *International Journal of Play Therapy, 15*, 35-58.
- National Autism Center. (2009). *National standards report: Addressing the need for evidence-based practice guidelines for autism spectrum disorders*. Massachusetts: Author.
- National Research Council. (2001). *Educating children with autism*. Washington, DC: National Academy Press.
- Neitzel, J. (2009). *Overview of antecedent-based interventions*. Chapel Hill, NC: The National Professional Development Center on Autism Spectrum Disorders, Frank Porter Graham Child Development Institute, The University of North Carolina.

- Newman, B., Tuntigian, L., Ryan, C. S., & Reinecke, D. R. (1997). Self-management of a DRO procedure by three students with autism. *Behavioral Interventions*, 12, 149-156.
- O'Brien, M., & Daggett, J. A. (2006). *Beyond the autism diagnosis: A professional's guide to helping families*. Baltimore, MD: Paul H. Brookes Publishing Co.
- Odom, S. L., Boyd, B., Hall, L., & Hume, K. (2010). Evaluation of comprehensive treatment models for individuals with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 40, 425-436.
- Odom, S. L., Brown, W. H., Frey, T., Karasu, N., Smith-Canter, L., & Strain, P. S. (2003). Evidence-based practices for young children with autism: Contributions for single-subject design research. *Focus On Autism & Other Developmental Disabilities*, 18(3), 166-175.
- Palmer, P. (1986). *The lively audience*. Sydney: Allen & Unwin.
- Panksepp, J. (2005). *Affective neuroscience: The foundations of human and animal emotions*. New York: Oxford University Press.
- Panksepp, J. (2010). Science of the brain as a gateway to understanding play. *American Journal of Play*, 2(3), 245-277.
- Park, S., & Lahman, M. K. (2003). Bridging perspectives of parents, teachers and co researchers: Methodological reflections on cross-cultural research. *Reflective Practice*, 4(3), 375-383.
- Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology*, 74, 116-143.

- Pretti-Frontczak, K., Barr, D., Macy, M. & Carter, A. (2003). Research and resources related to activity-based intervention, embedded learning opportunities, and routine-based instruction: An annotated bibliography. *Topic in Early Childhood Special Education, 23*, 29-39.
- Ray, D. C. (2007). Two counseling interventions to reduce teacher-child relationship stress. *Professional School Counseling, 10*, 428-440.
- Ray, D. C. (2008). Impact of play therapy on parent-child relationship stress at a mental health training setting. *British Journal of Guidance & Counseling, 36*, 165-187.
- Ray, D. C. (2011). *Advanced play therapy: Essential condition, knowledge and skills for child practice*. New York: Routledge.
- Ray, D. C., & Bratton, S. C. (2010). What the research shows about play therapy: Twenty-first century update. In *Child-centered play therapy research* (pp. 1-33). Hoboken, NJ: John Wiley & Sons, Inc.
- Ray, D. C., Henson R., Schottelkorb, A., Brown, A., & Muro, J. (2008). Impact of short-term and long-term play therapy services on teacher-child relationship stress. *Psychology in the Schools, 45*, 994-1009.
- Ray, D. C., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy, 16*, 95-111.
- Ray, D. C., Stulmaker, H. L., & Lee, K. R. (2012). Child-centered play therapy and impairment: Exploring relationships and constructs. *International Journal of Play Therapy, 2*, 13-27.

- Ray, D. C., Sullivan, J. M., & Carlson, S. E., (2011). Relational intervention. In *Play-based intervention for children and adolescents with autism spectrum disorders* (pp.19-35). New York: Routledge.
- Reyes, C., & Asbrand, J. (2005). A longitudinal study assessing trauma symptoms in sexually abused children engaged in play therapy. *International Journal of Play Therapy, 14*, 25-47.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103.
- Rogers, S. J., & Dawson, G. (2009). *Early start Denver model for young children with autism: Promoting language, learning, and engagement*. New York: Guilford Press.
- Rogers, S. J., Hall, T., Osaki, D., Reaven, J., & Herbison, J. (2000). The Denver model: A comprehensive, integrated educational approach to young children with autism and their families. In J. Handleman & S. Harris (Eds.), *Preschool education programs for children with autism* (2nd ed., pp. 95-135). Austin, TX: PRO-ED.
- Rubin, K. H., Fein, G., & Vandenberg, B. (1983). Play. In P. Mussen & E. M. Hetherington (Eds.), *Handbook of child psychology: Vol. 14, Socialization, personality, and social development* (pp. 693-774). New York: Wiley.

- Rubin, L. (2012). Playing on the autism spectrum. In *Play-based intervention for children and adolescents with autism spectrum disorders* (pp. 19-35). New York: Routledge.
- Ryan, J. B., Hughes, E. M., Katsiyannis, A., McDaniel, M., & Sprinkle, C. (2011). Research-based educational practices for students with autism spectrum disorders. *Teaching Exceptional Children, 43*(3), 56-64.
- Schilling, D. L., & Schwartz, I. S. (2004). Alternative seating for young children with autism spectrum disorder: Effects on classroom behavior. *Journal of Autism & Developmental Disorders, 34*(4), 423-432.
- Schlieder, M. (2007). With open arms: Creating school communities of support for kids with social challenges using circle of friends, extracurricular activities and learning terms. Shawnee Mission, KA: Autism Asperger Publishing Co.
- Schwandt, T. A. (2001). Dictionary of qualitative inquiry (2nd ed.). London: Sage.
- Schwartz, I. S., & McBride, B. J. (2008). Getting a good start: effective practices in early intervention. In *Learners on the autism spectrum: Preparing highly qualified educators* (pp. 66-87). Shawnee Mission, KA: Autism Asperger Publishing Co.
- Shearer, D. D., Kohler, F. W., Buchan, K. A., & McCullough, K. M. (1996). Promoting independent interactions between preschoolers with autism and their nondisabled peers: An analysis of self-monitoring. *Early Education and Development, 7*, 205-220.
- Sheridan, M. K., Foley, G. M., & Radlinski, S. H. (1995). *Using the supportive play model: Individualized intervention in early childhood practice*. New York, NY: Teachers College Press.

- Sigman, M., Dijamco, A., Gratier, M., & Rozga, A. (2004). Early detection of core deficits in autism. *Mental Retardation & Developmental Disabilities Research Reviews*, 10(4), 221-233. doi:10.1002/mrdd.20046
- Smith, A. (2005). *The brain's behind it: New knowledge about the brain and learning*. Norwalk, CT: Crown House.
- Smith, P. (2010). *Children and play*. West Sussex, UK: Wiley-Blackwell.
- Smith, P. K., & Vollstedt, R. (1985). On defining play: An empirical study of the relationship between play and various play criteria. *Child Development*, 56(4), 1042-1050. doi:10.2307/1130114
- Sponseller, D. (1982). Play and early education. In B. Spodek (Ed.), *The handbook of research in early childhood education* (pp. 215-241). New York: The Free Press.
- Stahmer, A. C., Ingersoll, B., & Carter, C. (2003). Behavioral approaches to promoting play. *Autism: The International Journal of Research and Practice*, 7, 401-413.
- Stake, R. E. (2006). *Multiple case study analysis*. New York: Guilford Press.
- Strain, P. S. (1987). Comprehensive evaluation of young autistic children. *Topics in Early Childhood Special Education*, 7, 97-110.
- Strain, P., & Hoyson, M. (2000). The need for longitudinal intensive social skill intervention: LEAP follow-up outcomes for children with autism. *Topics in Early Childhood Special Education*, 20, 116-123.
- Strain, P. S., Schwartz, I. S., & Barton, E. E. (2011). Providing interventions for young children with autism spectrum disorders: What we still need to accomplish. *Journal Of Early Intervention*, 33(4), 321-332.

- Sutton-Smith, B. (1985). Play research: State of the art. In J. Frost & S. Sunderline (Eds.), *When children play*. Washington, DC: Association for Childhood Education International.
- Sutton-Smith, B. (1997). *The ambiguity of play*. Cambridge, MA: Harvard University Press.
- Tomchek, S. D., & Dunn, W. (2007). Sensory processing in children with and without autism: A comparative study using the Short Sensory Profile. *American Journal of Occupational Therapy*, 61, 190–200.
- Twachtman-Cullen, D. (2008). Symbolic communication: Common pathways and points of departure. In K. Buron & P. Wolfberg (Eds.), *Learners on the autism spectrum: Preparing highly qualified educators* (pp. 89-113). Shawnee Mission, KS: Autism Asperger Publishing Co.
- Tyndall-Lind, A., Landreth, G. L., & Giordano, M. (2001). Intensive group play therapy with child witnesses of domestic violence. *International Journal of Play Therapy*, 10, 53-83.
- United Nations, Human Rights Division. (1959). *Declaration of the rights of the child*. Retrieved from <http://www.un.org/cyberschoolbus/humanrights/resources/child.asp>
- VanFleet, R., Sywulak, A. E., & Caparosa Sniscak, C. (2010). *Child-centered play therapy*. New York, NY: The Guildford Press.
- Watson, M. J. (2011). *Using siblings and peers as therapists to increase language skills, specifically pragmatics*. Retrieved from http://opensiuc.lib.siu.edu/gs_rp/122

- Whalen, C., Schreibman, L., & Ingersoll, B. (2006). The collateral effects of joint attention training on social initiations, positive affect, imitation and spontaneous speech for young children with autism. *Journal of Autism & Developmental Disorders* 36, 655-664.
- Wieder, S., & Greenspan, S. I. (2001). The DIR (developmental, individual difference, relationship-based) approach to assessment and intervention planning. *Zero to Three*, 21, 11-19.
- Wolfberg, P. J. (1999). *Play and imagination in children with autism*. New York: Teachers College Press.
- Wolfberg, P. J. (2003). *Peer play and the autism spectrum: The art of guiding children's socialization and imagination*. Shawnee Mission, KS: Autism Asperger Publishing.
- Wong, C., Odom, S., Hume, K., Cox. A. W., Fettig, A., Kucharczyk, S., ...Schultz, T. R. (2014). *Evidence-based practices for children, youth, and young adults with autism spectrum disorder*. Chapel Hill: The University of North Carolina, Frank Porter Graham Child Development Institute, Autism Evidence-Based Group.
- Yin, R. K. (2014). *Case study research design and methods*. Los Angeles CA: SAGE.

APPENDIX A
PROPOSITIONS

19 Propositions

Proposition 1	Every individual exists in a continually changing world of experience of which he or she is the center.
Proposition 2	The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality".
Proposition 3	The organism reacts as organized whole to this phenomenal field.
Proposition 4	The organism has one basic tendency and striving- to actualize, maintain, and enhance the experiencing organism.
Proposition 5	Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.
Proposition 6	Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.
Proposition 7	The best vantage point for understanding behavior is from the internal frame of reference of the individual.
Proposition 8	A portion of the total perceptual field gradually become differentiated as the self.
Proposition 9	As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed-an organized, fluid but consistent conceptual pattern of perceptions of characteristics and relationship of the "I" or the "me," together with values attached to these concepts.
Proposition 10	The values attached to experiences, and the values that are a part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.
Proposition 11	As experiences occur in life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self, or (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization of given distorted symbolization because the experience is inconsistent with the structure of the self.
Proposition 12	Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of self.
Proposition 13	Behavior may, in some instances, be brought about by organismic experiences and needs that have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not "owned" by the individual.
Proposition 14	Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists there is a basis for potential psychological tension.
Proposition 15	Psychological adjustment exists when the concept of the self is such that all sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with concept of self.
Proposition 16	Any experience that is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.

Proposition 17	Under certain condition, involving primarily complete absence of any threat to the self-structure, experiences that are inconsistent with it may be perceived and examined, and the structure of self revised to assimilate and include such experiences.
Proposition 18	When the individual perceives all his sensory and visceral experiences and accepts them into one consistent and integrated system then he is necessarily more understanding of others and more accepting of others as separate individuals.
Proposition 19	As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system –based so largely on introjections that have been distortedly symbolized with a continuing organismic valuing process.

Rogers, 1951, pp. 481-533.

APPENDIX B
INSTITUTIONAL REVIEW BOARD APPROVAL



Institutional Review Board

DATE: May 1, 2014

TO: Katherine Carrizales, PhD
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [588504-3] Child Centered Play Therapy and Children with Autism
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED
APPROVAL DATE: April 30, 2014
EXPIRATION DATE: April 30, 2015
REVIEW TYPE: Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of April 30, 2015.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

Katherine -

Hello and thank you for making all of the requested revisions and additions.

There are no further modifications necessary. Please be sure to use all revised and developed materials from the review process in your participant recruitment and data collection.

Best wishes with your research. Please don't hesitate to contact me with any IRB-related questions or concerns.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX C
RECRUITMENT FLYER

**DO YOU HAVE OR KNOW A CHILD WHO HAS BEEN
DIAGNOSED WITH AN AUTISM SPECTRUM DISORDER?
(AUTISM, ASPERGER'S OR PDD NOS)**

They may be eligible to participate in a relational intervention study!

I am currently conducting a doctoral dissertation study to understand how with autism experience Child Centered Play Therapy (CCPT), and how this relational intervention may help young children with Autism Spectrum Disorders.



Who is eligible to participate?

Children ages 3 years to 7 years who have been diagnosed or identified by the school/educational system as having an Autism Spectrum Disorder (Autism, Asperger's or PDD NOS).

For More Information Contact:

Katherine Carrizales, EdS, NCSP,
Doctoral Candidate University of
Northern Colorado

Email: ktlundgren@hotmail.com;

kcarrizales@optionspsych.biz

Phone: 308-632-8547

Participation may include:

The child's participation in CCPT sessions across 8 weeks, 2 scheduled child observations, parent interviews, and weekly feedback regarding child's behaviors and progress.

*All participants will receive a \$45 gift card to a publishing company specializing in ASD resources



APPENDIX D

**CONSENT FORM FOR HUMAN PARTICIPANTS
IN RESEARCH**



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Child Centered Play Therapy and Young Children with Autism

Researcher:

Katherine Carrizales, PhD student, Department of School Psychology

Phone Number: (308)-672-0743 Email: lund1753@bears.unco.edu

Research Advisor:

Robyn S Hess, PhD, Professor and Department Chair of School Psychology University of Northern Colorado

Phone Number: (970) 351-1636 Email: Robyn.Hess@unco.edu

Dear Parents:

I am Katherine Carrizales, a doctoral student in School Psychology at the University of Northern Colorado. One of the requirements of my doctoral program is to carry out a research study which contributes new knowledge to our field. The topic I have chosen to research will examine the use of Child Centered Play Therapy with young children who have been diagnosed with an Autism Spectrum Disorder. For this study, I will provide 16 sessions of Child Centered Play Therapy to children who have previously been diagnosed with an Autism Spectrum Disorder. The results from this study will provide a better understanding regarding the experiences of these children and their families over the course of the Child Centered Play Therapy sessions. The knowledge gained through this study will be distributed to other psychologists and professionals in an effort to better explain the utility of Child Centered Play Therapy with children who have Autism.

If you grant permission, and if your child indicates to us a willingness to participate, your child will participate in 16 play therapy sessions. These sessions will be conducted twice per week for 8 weeks. Each therapy session, lasting approximately 50 minutes, will be carried out in a local educational setting. These therapy sessions will consist of Child Centered Play Therapy (CCPT). CCPT is a method of therapy that allows young children to engage in play utilizing specially selected, developmentally appropriate toys.

Each session may be video recorded though be assured this information is intended to be kept private and secure. Taped sessions will be viewed by the researcher, a registered play therapy supervisor and 1 - 2 graduate students who have been trained to conduct specific reviews of these tapes. The tapes will be kept in a locked facility and will be destroyed three years following the publication of this study. To further help maintain confidentiality all names will be replaced with pseudonyms and thus will not appear in any professional report of this research. Furthermore, any electronic files containing data or writing about the study will be kept on pass-word protected computers, and any paper documents will be kept in a locked cabinet at the play therapy supervisor's office building.

I for see no risks to subjects through their participation in this study. One prior case study utilizing CCPT with a young boy diagnosed with ASD indicated positive effects. Although currently there is not specific information regarding the effect of CCPT on the concurrent behavioral interventions/programs your child may be receiving. However, CCPT does have a long history of use with young children and has been cited as an effective treatment for a variety of presenting problems by a number of researchers within the field of psychology.

Please feel free to phone or email me if you have any questions or concerns about this research and please retain one copy of this letter for your records.

Thank you for assisting me with my research.

Sincerely,

Participation is voluntary. You may decide not to allow your child to participate in this study and if (s)he begins participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

Child's Full Name (please print)

Child's Birth Date (month/day/year)

Parent/Guardian's Signature

Date

Researcher's Signature

Date

APPENDIX E

**ASSENT FORM FOR HUMAN PARTICIPANTS
IN RESEARCH**



ASSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Hello, I am Katie Carrizales and I am a student at the University of Northern Colorado.

I am doing a study to learn about how children with Autism experience play therapy. What we learn in this research may help other children with Autism.

I would like to ask you to help by being in a study, but before I do let me explain what will happen if you decide to help me.

If you agree to be in this study, you and your mom/dad and I will meet me here two times a week for 8 weeks. When we meet we will work with lots of different toys and activities from my play kit. You will get to choose many of the things that we do, and decide how to use many of the things that I bring.

I will video tape our time together so that I can better remember and see what kinds of things we worked on and so that we can compare what we did from session to session. When I tell other people about my study, I will not use your name, and no one will be able to tell who I'm talking about.

It's possible you will feel nervous when we start, but your mom/dad will stay close by while we work, and after a while you might look forward to our time together working and playing.

Your mom/dad says it's okay for you to be in my study. But If you don't want to be in the study, you don't have to be. What you decide won't make any difference with how I, your mom and dad or others think about you. I won't be upset, and no one else will be upset, if you don't want to be in the study. If you want to be in the study now but change your mind later, that's okay. You can stop at any time. If there is anything you don't understand you should tell me so I can explain it to you

You can ask me questions about the study. If you have a question later that you don't think of now, you can call me or ask your parents to call me or send me an email.

Do you have any questions for me now?

Would you like to be in my study and begin working with the play kit?

NOTE: The child should answer “Yes” or “No.” Only a definite “Yes” will be taken as assent to participate.

Name of Child: _____

Parental Permission on File: ☐ Yes ☐ No
(If “No,” do not proceed with assent or research procedures.)

Child’s Voluntary Response to Participation: ☐ Yes ☐ No

Signature of Researcher: _____ Date: _____

Signature of Witness: _____ Date: _____

(Optional) Signature of Child: _____

APPENDIX F
SUPERVISION CONTRACT



Anne Talbot, Psy.D. *Licensed Psychologist
Specialist in Neuropsychology*
Mark Hald, Ph.D. *Licensed Psychologist*
INDEPENDENT CONTRACTORS
Charlotte Ingram, MA, LMHP, ATR
Licensed Mental Health Practitioner, Art Therapist – Registered
Lori Rodriguez, MSW, LCSW
Licensed Clinical Social Worker
Carrie Howton, MSEd, LIMHP,
Licensed Independent Mental Health Practitioner
Katherine Carrizales, Ed.S., PLMHP,
Provisionally Licensed Mental Health Practitioner

**Play Therapy Supervision of Katherine Carrizales, Ed.S., PLMHP, Doctoral Candidate
by Mark Hald, Ph.D.
Effective July 2014**

Supervision:

Mark Hald, Ph.D. will provide Katherine Carrizales, PLMHP with face-to-face play therapy supervision. Billing for supervision will be at the rate of \$90.00 per hour and a statement will be sent monthly to Mrs. Carrizales.

The purpose of this play therapy supervision is for doctoral dissertation. This supervision does not meet requirements for LMHP licensure supervision. It will meet requirements for the Registered Play Therapist credential through the Association for Play Therapy.

Doctoral Candidate responsibilities:

The Doctoral Candidate will remain fully licensed, obtain appropriate continuing education, and maintain professional liability insurance. Clinical files must be maintained in accordance with HIPAA rules and regulations.

Mark Hald, Ph.D.
Play Therapy Supervisor

7-1-14.

Date

Katherine Carrizales, Ed.S., PLMHP
Doctoral Candidate

July - 1 - 2014

Date

APPENDIX G

PLAY THERAPY SESSION SUMMARY NOTES

PLAY THERAPY SESSION SUMMARY	
Date/Session# _____/____	Child/Age _____
Presenting Concerns _____	
Counselor _____	
SUBJECTIVE: (Feelings Expressed)- Underline all that Apply (including capitalized words) indicate predominate feelings) by circling	
HAPPY: relived, satisfied, pleased, delighted, excited, surprised, silly	CONFIDENT: proud, strong, powerful, determined, free
SAD: disappointed, hopeless, pessimistic, discouraged, lonely	HESITANT: timid, confused, nervous, embarrassed, ashamed
ANGRY: impatient, annoyed, frustrated, mad, mean, jealous	CURIOUS: interested, focused
AFRAID: vulnerable, helpless, distrustful, anxious, fearful, scared, terrified	FLAT: restricted, contained, ambiguous

OBJECTIVE:

- A. **TOYS/PLAY BEHAVIOR** Underline all that apply, give brief description of play. In the blank, indicate meaningful/sustained play with *; indicate discontinued play as "DP", indicate return play as "RP", indicate any therapist initialed activity as "TH"

Toys used	<u>Sensory</u>	<u>Symbolic</u>	<u>Duration</u>	<u>Frequency</u>
Hammer/woodworking				
sandbox/water/sink/shaving cream				
<u>Puppets/theater</u>				
<u>Kitchen/cooking/food</u>				
<u>Easel/paint/chalkboard</u>				
<u>Crafts table/clay/markers/paints/etc</u>				
<u>Bop bag/beanbag</u>				
<u>Dress up/jewelry/hats/masks/wand</u>				
<u>Doll house/doll family/ bottle/pacifier/baby</u>				
<u>Cash register/money/telephone/camera/flashlight</u>				
<u>Medical kit/ bandages</u>				
<u>Musical instruments</u>				
<u>Vehicle/planes/cars</u>				
<u>Animals/domestic/zoo/alligator/shark/snake</u>				
<u>Soldiers/knife/sword/handcuffs/rope</u>				
<u>Sand tray/ miniatures</u>				
<u>Blocks/barricade</u>				
Additional Objective Behaviors	Frequency			
Imitation				
Joint attention				
Reciprocity				
Child initiation interaction (smiling, gestures, talking, mutual play)				

- B. **SIGNIFICANT VERBALIZATION:** ::CH=child initiated TH=Therapist initiateded.

C.

LIMITS SET: Write limit set beside the category & indicate # of times limit set # Ex: threw sand on floor/set once) If ultimate limit was set, describe.

PROTECT CHILD (HEALTH/SAFETY)
 PROTECT ROOM/TOYS
 REALLY TESTING

PROTECT THERAPIST:
 STRUCTURING
 SOCIALLY UNACCEPTABLE BX

DYNAMICS OF SESSIONS Rate 0=low, 10=high); Child's play/activity level: _____ Intensity of play: _____
 Inclusion of therapist/level of contact _____

Destructive	1	2	3	4	5	6	7	8	9	10	Constructive
Messy/Chaotic	1	2	3	4	5	6	7	8	9	10	Neat/Orderly

ASSESSMENT General Impressions/Clinical Understanding

SOMATIC COMPLAINTS	TACTILE STIMULATION	SUBSTANCE ON:	BATHROOM BREAKS
Headache	Water	Self	Urination(Frequency)
Stomach Ache	Sand	Counselor	Bowel Movements
Pain	Paint	Objects	
Discomfort with Clothing	Glue		
	Other		

Benedict Themes: (developed by Helen E. Benedict Ph.D., Baylor University, 2000 and 2002) used by permission

AGGRESSIVE	ATTACH/FAMILY	SAFETY	EXP/MASTERY	INTERPERSONAL
G>B	CON	BUR	EXP	COOP
AGG	SEP	BURY	MAS	COOP
JD	SEP-R	BR	FAIL	COMP
POW	NUR+	BR-S		SHAR
SEEK	NURS	BR-H	SEXUALIZED	HELP
D-AG	NUR-	FX	SEX-O	PRO
D-N	NUR-A	FX-	SEX-T	IND
DEV	NUR-N	SFX	CUR	CNT
	NUR-S	BRG		IM-CNT
P-CODES	SLE	FALL	NON-PLAY	IM
D/U	STO	CLN	ART	BND
STG	AD	MESS	GAME	BND
ROLE		SOB	T-A	FUS
DIS		DAN	X	AFF
		SAF-C		ANG
		SAF-P		SAD
		SAF-RES		REJ
		ESC		PCON
				RUF
				TEA

OVERALL CHILDS BEHAVIOR/AFFECT WAS:

Sad/depressed/angry	1 2	3 4	5 6	7 8	9 10	Happy/content/satisfied
Anxious (fearful)insecure/hesitant	1 2	3 4	5 6	7 8	9 10	Confident/secure
Angry/Low frustration tolerance	1 2	3 4	5 6	7 8	9 10	High frustration tolerance
Dependent	1 2	3 4	5 6	7 8	9 10	Autonomous/Independent
Immature/regressed/hyper mature	1 2	3 4	5 6	7 8	9 10	Age Appropriate
External locus of control	1 2	3 4	5 6	7 8	9 10	Internal locus of control(Self-controlled
Impulsive/easily distracted	1 2	3 4	5 6	7 8	9 10	Purposeful/focused/curious
Inhibited/Constricted	1 2	3 4	5 6	7 8	9 10	Creative/Expressive/imaginative/Spontaneous/Free
Isolated/Detached	1 2	3 4	5 6	7 8	9 10	Connected/Sense of belonging
Flat Affect	1 2	3 4	5 6	7 8	9 10	Animated Affect
Inflexible/Concrete thinking	1 2	3 4	5 6	7 8	9 10	Flexible and Fluid Reasoning

E CONCEPTUALIZATION OF CLIENT AND CLIENT'S PROGRESS:**IV PLANS/RECOMMENDATIONS:** (Include talking with parent/school—requesting records, etc.)**RESEARCHER FIELD NOTES:**

APPENDIX H
OBSERVATION FORM

DISSERTATION OBSERVATION SUMMARY	
Date# _____	Child/Age _____
Presenting Concerns _____	
Counselor _____	
SUBJECTIVE: (Feelings Expressed)- Underline all that Apply (including capitalized words)indicate predominate feelings) by circling	
HAPPY: relived, satisfied, pleased, delighted, excited, surprised, silly	CONFIDENT: proud, strong, powerful, determined, free
SAD: disappointed, hopeless, pessimistic, discouraged, lonely	HESITANT: timid, confused, nervous, embarrassed, ashamed
ANGRY: impatient, annoyed, frustrated, mad, mean, jealous	CURIOUS: interested, focused
AFRAID: vulnerable, helpless, distrustful, anxious, fearful, scared, terrified	FLAT: restricted, contained, ambiguous

A. **SIGNIFICANT VERBALIZATION:** ::CH=child initiated TH=Therapist initiateded.

B.

LIMITS SET: Write limit set beside the category & indicate # of times limit set # Ex: threw sand on floor/set once) If ultimate limit was set, describe.

PROTECT CHILD (HEALTH/SAFETY)

PROTECT ROOM/TOYS

REALLY TESTING

PROTECT THERAPIST:

STRUCTURING

SOCIALLY UNACCEPTABLE BX

BE Note frequency and duration of the following:

REDIRECTION:

PROMPTING: Physical verbal

Social Interaction: Initiated

Peer Initiated

DYNAMICS OF OBSERVATION Rate 0=low, 10=high); Child's play/activity level: _____ Intensity of play: _____ Inclusion of therapist/level of contact _____

Destructive	1	2	3	4	5	6	7	8	9	10	Constructive
Messy/Chaotic	1	2	3	4	5	6	7	8	9	10	Neat/Orderly

ASSESSMENT General Impressions/Clinical Understanding

SOMATIC COMPLAINTS	TACTILE STIMULATION	SUBSTANCE ON:	BATHROOM BREAKS
Headache	Water	Self	Urination(Frequency)
Stomach Ache	Sand	Counselor	Bowel Movements
Pain	Paint	Objects	
Discomfort with Clothing	Glue		
	Other		

OVERALL CHILDS BEHAVIOR/AFFECT WAS:

Sad/depressed/angry	1 2	3 4	5 6	7 8	9 10	Happy/content/satisfied
Anxious (fearful)insecure/hesitant	1 2	3 4	5 6	7 8	9 10	Confident/secure
Angry/Low frustration tolerance	1 2	3 4	5 6	7 8	9 10	High frustration tolerance
Dependent	1 2	3 4	5 6	7 8	9 10	Autonomous/Independent
Immature/regressed/hyper mature	1 2	3 4	5 6	7 8	9 10	Age Appropriate
External locus of control	1 2	3 4	5 6	7 8	9 10	Internal locus of control(Self-controlled
Impulsive/easily distracted	1 2	3 4	5 6	7 8	9 10	Purposeful/focused/curious
Inhibited/Constricted	1 2	3 4	5 6	7 8	9 10	Creative/Expressive/imaginative/Spontaneous/Free
Isolated/Detached	1 2	3 4	5 6	7 8	9 10	Connected/Sense of belonging
Flat Affect	1 2	3 4	5 6	7 8	9 10	Animated Affect
Inflexible/Concrete thinking	1 2	3 4	5 6	7 8	9 10	Flexible and Fluid Reasoning

RESEARCHER FIELD NOTES:

APPENDIX I
INTERVIEW FORM

Initial Interview Questions:

- Q1 What are your main concerns about your child right now?
- Q2 What concerns do you have about your child's possible reaction to a new setting such as the play therapy room?
- Q3 Does your child exhibit any sensitivity to lights, sounds or textures? Does your child have specific preferences to light sound or texture?
- Q4 What are your child's current interests/favorite toys, etc.
- Q5 Describe how your child typically plays with these toys.
- Q6 If you had to pick three words to describe your child what would they be?
- Q7 What services has/is your child received to address his/her ASD??

Routine Based Information:

Questions built to gather information regarding the guiding question of the study:

Daily Routines Information

Q 1. How does your day begin?

Q2. What is your child doing? What is everyone else doing?

Q3. What happens next?

Q4. How is your child participating in this activity?

Q5. How much does your child do for him- or herself?

Q6. How is your child interacting [use simpler terms if necessary] with others at this time?

(Repeat for each major routine throughout a typical day)