

Let's Play! Counselling Professionals' Perspectives of Using Play Interventions in Clinical Practices

A Thesis Submitted to the
College of Graduate and Postdoctoral Studies
In Partial Fulfillment of the Requirements
For the Degree of Master of education
In the Department of Educational Psychology and Special Education
University of Saskatchewan

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ABSTRACT

Counselling professionals often incorporate play interventions when providing therapeutic support to children experiencing adverse circumstances (e.g., family crisis, illness, living in poverty, foster care etc.). It has been suggested that play enhances emotional (i.e. recognizing feelings of sadness, happiness, etc.) and cognitive development (i.e., improving memory, abstract thinking, self-awareness) (Hong & Mason, 2016; Vygotsky, 1973). Play has been found to have a positive effect on improving children's self-regulation in therapeutic settings (Kenney & Young, 2015; Marcelo & Yates, 2014; Pearson et al., 2007). Teaching children strategies of how to function under hardship can help them become more resilient individuals (Slingman, 1999). Currently there is limited information available that highlights specific skills and strategies counselling professionals are using in play-based interventions to foster improvement and help children learn positive adaptation (Baggerly & Parker, 2005; Marcelo & Yates, 2014; Pattison, 2006; Shaefer & Drewes, 2012).

This study sought to better understand counselling professionals' perspectives, specific techniques, and strategies used in play-based interventions. Data was collected through interviews with four counselling psychologists, and analyzed inductively to identify three themes across the data set (Braun & Clarke, 2006; Merriam, 2009): (1) Learn The Steps: Teaching The Prerequisites of Self-Regulation; (2) Build Your Skills: Enhancing Self-Awareness and Resiliency Through Play; and (3) Change Takes Time: Trusting the Play Process. These findings highlighted how meaningful play can help children build self-awareness skills, which can lead to positive adaptation. These initial findings can be used as a starting point to assist helping professionals, such as counsellors, to better support their child clients using play.

ACKNOWLEDGEMENTS

The thesis was successfully completed with the support, guidance, and participation of many important individuals.

First I would like to thank my thesis Supervisor Laureen McIntyre. Thank you for your patience, guidance, editing and support throughout this process. I would also like to thank my committee members ...

Second I would like to thank the department members of Special Education and Educational Psychology at the University of Saskatchewan. The department granted me financial support during certain points in my program. Further of the professors provided me with much guidance and taught me skills that are needed to be a competent practitioner in the field of Special Education.

Third, I would like to thank the four individuals who participated in my study. It was wonderful to work with you. Your knowledge and insights provided me with new knowledge. I am able to use your knowledge in my professional work as a Special Education teacher.

Fourth, I would like to thank my students whom I worked with this 2017-2018 school year as I wrote my thesis. I learned so much from each of you. Working with you has been a great pleasure. I look forward to continuing grow as professional in order serve all of you better in the future.

Finally, a big thank you to my family. My husband Joey, you have provided me with much encouragement, support, and positive reinforcement during my graduate studies. Thank for being there for me. To my mom, Ann Donald; dad Chris Donald and brother; Alex Donald. All of you have provided me with much encouragement, support, and patience during my time in University. Especially as I wrote my thesis.

DEDICATION

This thesis is dedicated to four loving people in my life, Ann Donald, Chris Donald, Alex Donald and Joey Langen. Thank you for your love, encouragement and instilling perseverance in me.

This thesis is dedicated to my previous and future students. I am working towards learning how to best support each of you during adverse times in your education so that you can learn to be resilient individuals.

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Chapter 1: Introduction

Children's mental health struggles are currently viewed to be one of the leading health issues across Canada (Canadian Psychiatric Association, 2005). Steele (2017) has even made the claim that past practices regarding students' adaptations in adverse circumstances, such as telling the child to ignore feelings of sadness or viewing the child as the problem are no longer effective for today's children, due to: an increase of mental diagnosis within children experiencing adverse circumstances (e.g., illness, family crisis, living in poverty etc.), technological advancements (i.e., children growing up using technology such as iPad, iPhone etc.), changing society (i.e., new generations of children being part of the community), and an increase knowledge of neuroscience and applying it to enhancing children's wellbeing. It has been noted that two out of every three children have poor self-regulation (Transforming Education, 2015), and long term effects of poor self-regulation can include having trouble: shifting cognitive mind sets, acting on impulse, dealing with emotion, and expressing oneself effectively (Greene, 2009). When children do have the opportunity to self-regulate, critical regions of the brain and the nervous system are either being calmed or stimulated (Shanker & Hopkins, 2017; Steele, 2017). This helps with the children's ability to recognize appropriate responses and behaviours (Oakes, 2012; Shanker & Hopkins, 2017; Transforming Education, 2015). The positive psychology discipline, found by Seligman (1999), is a discipline of psychology that investigates how people learn to positively adapt. This discipline is interested in understanding processes that lead to positive adaptive functioning (Seligman, 1999) typically by applying the knowledge that has been learned from people who positively adapt in adverse circumstances. Gable and Hadits (2005) described the positive psychology discipline as an area of psychological research that seeks to

understand “the conditions and processes that contribute to flourishing or optimal functioning of people, groups or institutions” (p. 104). By understanding processes associated with optimal functioning, researchers and practitioners can make attempts at altering distressed people or organizations and enhancing them (Pearson et al., 2008). For example, Greene (2004) found teachers who focus on building relationships with students experience less student behavioural problems within the classroom (i.e., aggression, outbursts, panic attacks). Teaching children skills to deal with hardship when they are young makes sense since they are at a crucial time in their physical and cognitive development (Pearson et al., 2008). That is, teaching self-regulation in early development (4 to 12 years of age) helps children more quickly learn the importance of being self-aware when being challenged, social skills, grit (i.e. perseverance, passion for achieving long term goals) and emotional intelligence (i.e. being in control of one's emotions, ability to express emotions) (Duckworth, 2016; Mischle, 1970; Newberg & Waldman, 2009). For example, in 1970 Mischel and colleagues conducted the famous marshmallow study. The purpose of the study was to explore the willpower of children. The researchers presented a plate of marshmallows to a preschool child. The researcher then explained to the child that he or she had to leave the room for a period of time. If the child did not eat any of the marshmallows while the adult was out of the room, the child would be granted two marshmallows. The researcher concluded that will power (or self-regulation) fails when exposed to a hot stimulus (like the marshmallow), leading the child to impulsive actions. Therefore, learning self-regulation skills (e.g., taking turns, waiting, sharing, how to act when you lose a game, practicing skills) teaches a child how to work through difficult points in his or her life at an early age. This means teaching children positive adaptation skills is important in assisting them to learn how to regulate their

behaviour by controlling their thoughts and actions (Steele, 2017). One way to teach children adaption skills is through the use of play (Pearson et al., 2008; Shafer & Drewes, 2012). Play is pleasurable for children and as well as a useful tool for teaching them various skills (i.e., turn taking, sharing, etc.) and supporting developmental changes (i.e., learning use language, problem solve, feeling and emotions responses to events) (Singer, Golinkoff, & Hirsh-Pasek, 2006).

Children's play has long been viewed as developmentally important (Vygotsky, 1967; Shaefer & Drewes, 2012). Pearson, Russ, and Spannagel (2008) viewed children's play as a natural companion to positive psychology. These researchers suggested that play involves many components essential for adaptive functioning. For example, during the play process a child can be seen to: organize his or her thoughts (i.e., as seen when a child acts out a story or situation in a logical manner), use divergent thinking (i.e., as seen when a child generates possible ideas for how to deal with a complex situation such as working with a classmate who has been mean to them), use symbolism (i.e., as seen when a child uses a play object to represent another object such as using a banana as a pretend phone), and engage in fantasy/make believe play (i.e., playing house, doctor, etc.) (Kelly- Vance & Ryalls, 2014; Pearson et al., 2008). In addition, understanding and implementing knowledge of the play process in therapy or prevention interventions may lead to stronger adaptive functioning in children (Pearson et al., 2008). When children engage in play they are given the chance to learn about others' expressions of emotion (e.g., a child and an adult are playing with puppets, and the adult's puppet is "sad"), their own emotions (e.g., recognizing they are angry when they lose a board game), emotional regulation (e.g., a child may act out a character when frustrated with friends but still goes to school), and what is enjoyable and comforting in the play experience (e.g., mindful colouring activities for

children) (Marcelo & Yates, 2014; Pearson et al., 2008; Shaefer & Drewes, 2012). These experiences can teach children how to be empathetic, and better understand, communicate with, and trust others. Counselling professionals are one group of professionals who work with children to help support their development (Greene, 2009; Steele, 2017; Winner, 2011). These professionals can provide children and their families with intervention and prevention programs that are easily integrated into day to day life, such as developmentally important play interventions (Shaefer & Drewes, 2012). As a teacher and a mental health professional, I have worked with inner city youth and students who have experienced intense trauma from a wide range of ages (3-17) for the last three years. These students have often had a diagnosed developmental disorder diagnosis, live in alternative care, experienced abuse or neglect, and as a result they act out (i.e., emotional outbursts, aggression, vandalism etc.). We know that chronic stress can negatively impact the brain and the nervous system (Perry, 2006; Shore, 2001) which can create a delay in the children's cognitive development (Steele, 2017). Chronic stress can limit one's ability to reason, which will affect a child's ability to make rational decisions, process what is happening, and self-regulate their reactions (Goldstein, 2012; Heller & LaPierre, 2012). The students I work with live tough lives. They need consistent empathy and support to help them ease the constant stress many are experiencing. However, I quickly learned quickly I cannot solve all my students' problems. What I can do is teach them strategies they can use to support themselves in continuing to function under any hardships they are experiencing. Play is one strategy that can be used to address self-regulation development in therapeutic settings (Kenney & Young, 2015; Marcelo & Yates, 2014; Pearson et al., 2007).

There have been several instances where I have had students who are extremely stressed at one moment but are able to become calm once they are engaged in some form of play. For example, I was recently working with a 12 year old student who had lived through a traumatic experience. She was going through a phase where she refused to do work, or remain in the class. Instead she would run away from staff when they tried to talk to her. Our school support team did our best to empathize with her and teach her ways to cope with her feelings. One way was giving her time to play with items in a calming kit we had created. Within this kit there was a stuffed kitty, slime, mindfulness coloring books, modelling clay, and a sketchbook. Once she had that play time, she was more likely to explain why she was upset, became less defiant and more approachable, and would complete her class assignments to the best of her ability. Giving this student supportive play time was an effective way of calming her so she could decrease her stress and continue to work throughout the day. Experiences with students such as this one made me want to further explore how other professionals, such as counselling professionals, view and use play in therapeutic interventions in my thesis research.

Limited information currently exists related to the specific skills and strategies counselling professionals are using in play-based interventions to foster improvement and help children learn positive adaptation (Baggerly & Parker, 2005; Marcelo & Yates, 2014; Pattison, 2006; Shaefer & Drewes, 2012). Additional research is needed related to how play-based interventions are being viewed, and used by, counselling professionals to improve children's adaptation skills using a positive psychology lens (Pearson et al., 2008).

Statement of Purpose

The purpose of this study was to look at the techniques and strategies being used by helping professionals in play-based interventions to promote positive adaptation within children who face adversity or to foster resilience (i.e., promoting "...good outcomes in spite of serious threats to adaptation or development" (Masten, 2001, p. 228). Specifically this study sought to explore the thoughts and experiences of counselling professionals related to how they have used play to help children develop positive adaptation skills. This study falls within the positive psychology discipline as it seeks to understand how counselling professionals can support children when learning how to positively adapt. Therefore, a basic qualitative research methodology was used to better understand participants' experiences and offer insight into strategies and techniques they have found useful when working with children experiencing adverse circumstances (Merriam & Tisdale, 2012). The research question that guided the study was:

What are counselling professionals' thoughts toward, and experiences of, using play intervention in the therapeutic process to foster positive adaptation?

Definitions

The following definitions are provided to add greater clarity to the key terms being used in this study.

Counselling. The Canadian Counselling and Psychotherapist Association (CPA, 2009) defined counselling as a skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth and the optimal development of personal resources.

Counselling professional. The term counselling professional was used to describe the participants within this study. The term counselling professional refers to “trained professionals who use psychological principles to enhance and promote the positive growth, well-being, and mental health of individuals, families, groups, and the broader community” (CPA, 2009, para.1). Counselling professionals are members of a governing body that uphold principles, values and/or conduct of conduct that they are to abide by. These governing bodies exist to regulate the profession and to protect the public (CPA, 2009). The participants in this study were all professionally trained in using counselling principals to help enhance their clients’ wellbeing and part of governing bodies that regulate their profession.

Play intervention. Play interventions can be defined in various was. When specifically looking at play in a therapeutic context, the most common definition used is play therapy. The Association of Play Therapy (2001) defined play “...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” (p. 20). DelPo and Frick (1998) defined play interventions to be a modality that helps children explore their internal and external world view through the following elements that foster change: (1) communication, (2) teaching modality, (3) abreaction of power (e.g., reliving stressful experiences), and (4) containing rapport building (DelPo & Frick, 1988; Reddy et al., 2013; Shaefer, 1993, 1999). This study uses DelPo and Frick’s (1998) definition of play interventions as it described all aspects of play typically being used in a counselling session.

When defining play in scholarly research, to date there has been no specific definition to describe what *play* means (Bughardt, 2011; Smith & Vollstedt, 1985). Defining play has ranged

from structural definitions, such as gestures and movement to being something that is functional, such as doing an activity that is enjoyable (Smith & Vollstedt, 1985). This study will use Mastrangelo (2009)'s conception of play that drew upon these varying definitions (e.g., Garvey, 1977; Rubin, Fein, & Vandenberg 1983; Smith & Vollstedt, 1985) to define play as: "...pleasurable and enjoyable; voluntary, intrinsically motivating and pleasurable; flexible and evolving, physical and engaging activity, has a make believe quality that is process oriented and is non-literal" (p. 14).

Coping strategies. Coping strategies can be defined as strategies that are being used to deal with adversity by being problem or emotion focused (Folkman & Lazarus, 1980, Lazarus & Folkman, 1984). Lazarus and Folkman (1980) created a ways-of-coping- model that distinguished the specific coping strategies adults use. They defined problem-focused and emotion-focused coping strategies. Problem-focused coping includes trying to manage or modify problems (i.e., an employee takes time to learn conflict resolutions skills to modify a hostile relationship with a co-worker). Emotion-focused coping strategies focus on reducing emotional stress (i.e., learning meditation to reduce anxious feelings) (Lazarus & Folkman, 1980).

Self-regulation. Self-regulation can be defined as an individual dimension that includes goal setting, planning, task persistence, environmental management as well as being attentive to one's behavioural, emotional reactivity (Rothbart & Posner 2005). Self-regulation is "...initiating, avoiding, inhibiting, maintaining, or modulating the occurrence, form, intensity, or duration of internal feeling states, emotion-related physiological, attentional processes, motivational states, and/or the behavioural concomitants of emotion in the service of

accomplishing affect-related biological or social adaptation or achieving individual goals” (Eisenberg & Spinrad 2004, p. 338).

Self-awareness. Fleming (1996) defined self-awareness as the involvement and interaction between thoughts (knowledge of the situation in an objective stance) and feelings (or an appreciation or unique interpretation of a situation in a subjective stance) (p. 2). Self-awareness includes being emotionally aware (e.g., recognizing when being sad, angry), accurately self-assessing (i.e., knowing what our strengths and limitations are) and having self-confidence (i.e., recognizing our own capabilities and self-worth) (Duckworth, 2017; Fleming, 1996; Seligman, 1999).

Chapter Organization

Literature related to the use of play-based interventions to foster children’s positive adaption is reviewed and organized in chapter 2 in two major sections: positive psychology and positive adaption, and supporting children’s development through play. In chapter 3, the methodology of the present study is outlined, including descriptions of the participants, and data generation and analysis procedures. The results of the study are presented in chapter 4 and discussion and analysis of the results including a summary of the findings, study strengths and directions for future research are in chapter 5.

Chapter 2: Literature Review

This chapter reviews literature related to the use of play-based interventions to foster children's positive adaptation. Section one focuses on helping professionals, the positive psychology model, and frameworks that strive to understand coping processes that lead to positive adaptation. Section two focuses on the process of play leading to positive adaptation, and explores the uses of direct and indirect play interventions to help the children become successful.

Positive Psychology and Resilience Opposed to Other Developmental Theories

There are various theories and models within the psychology discipline that identify how people adapt. Theories and models seek to explain concepts. Theories are based on generalized thinking or conclusion of something that has scientific evidence (Merriam, 2010). Models on the other hand are physical, verbal and/or visual representations of an idea. Theories and models within the science of psychology has made great strides in learning to understand what goes wrong within people, groups and institutions (Gable & Haidt, 2005). For example, there is the interpersonal model, which is a three stage process that includes the following: (a) the establishment of a complementary relationship (rapport establishment); (b) the removal of inappropriate (i.e., in keeping with the client's rigid behavioural pattern) complementary interactions (conflict stage); and (c) the establishment of a new, healthier complementary interaction (Tracey, 1993; Tracey & Ray, 1984). This model was shaped from the Stack-Sullivan's theory (1953) which concluded that a person's behaviour is to have his or her needs met through interpersonal interactions.

When seeking theoretical and/or model frameworks that fit within the positive psychology discipline, it was recommend that frameworks or illustrations include the following

components: biological makeup (e.g. intelligence quotient or IQ, predisposed genetics, nervous system), social factors (e.g., culture-subculture, friends, family and influence), and psychological wellbeing (e.g. conscious, stress, personality) that serve the developmental outcome (Gable, Hadit, Candland, Douglas, Baumeister, Roy , & Simonton, 2005). Theoretical frameworks can be defined as “the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs your research” (Maxwell, 2005, p. 33). Two developmental theories and one model were identified that incorporated the three recommended theories within the positive psychology model: (1) Gesell’s maturation theory (Weizmann & Harris, 2012); (2) Resiliency theory (Masten, 2001); and (3) the Biopsychosocial model (Engel, 1977).

Maturation theory suggests children’s emotional and behavioural outcomes within life depends predominantly on their maturing nervous system (Gesell, 1945; Weizmann & Harris, 2012). A child’s environment only slightly influences his or her outcome, but does not fundamentally shape or alter the process of how the child matures (Weizmann & Harris, 2012). As a child develops or grows, his or her nervous system matures, and his or her regulation of emotions and behaviour will improve (e.g., less angry outbursts, modeling appropriate behaviour). Gesell’s theory viewed that a child’s personality development is pulled back and forth between two opposite poles. It is similar to motor skill development (learning hand eye coordination) (Carins, 2011). For example, a child beginning at age three will experience a cycle of introverted and extroverted tendencies until the two tendencies balance out. Gesell believed that developmental progress requires temporary loss of equilibrium, but is followed by reintegration at higher levels of organization (Carins, 2011).

Maturation theory is considered a child-centered approach to fostering a child's development (Dalton, 2005; Weizman & Harris, 2012). A child-centered approach means that the child is an active participant in their learning and personal development. Examples of child-centered development includes a child choosing to take responsibility for chores, picking what game to play, and making their own choices. Counselling therapies with children are often child centered. Counselling using a child centered approached aims to teach children how to develop self-regulation on their own without direction, become more self-reliant, develop control, and develop confidence.

A resiliency framework focuses on understanding the processes of how individuals develop the characteristics that allow them to adapt positively in challenging situations (Masten, 2001). Ultimately, resilience investigates the processes of how children can adapt positively despite lived stresses (Masten, 2000, 2014). Resiliency is defined as adapting well in the “face of adversity, trauma, tragedy, threats or significant sources of stress” (American Psychological Association or APA, 2016) or as “a class phenomenon characterized by good outcomes in spite of serious threats to adaptation or development” (Masten, 2001, p. 228). Children who show resiliency are able to “adapt successfully to disturbances that threaten their development” (Masten, 2014, p. 15).

A resiliency approach recognizes that children's biological predispositions, and their psychosocial environment (i.e., cultural influences, parents, family members) can impact how they succeed post adversity (Masten, 2014). Various different strengths may include having a strong IQ or General Ability Index Score, an extensive support system, or being optimistic. When using a resiliency approach, helping professionals are working with the children to identify what their

particular protective factors are, or their internal abilities, and provides guidance on how to utilize them in times of adversity (Luthar, 2003; Luthar, Cicchetti, & Becker, 2000; Luthar, Cicchetti, & Donald, 2006; Masten, 2001; Masten & Obradovic, 2006; Waddell, 2007; Waddell et al., 2005; Werner, 2000). Identifying a person's protective factors can help a child from experiencing further mental health difficulties as well as focus their use of strategies during times of hardship (Benson, 2013; Franke & Giest, 2004). Ultimately, using a preventative approach in and identifying coping strategies can support children in becoming resilient.

Engle (1977) created the biopsychosocial model to explain his theory on how physicians can adequately respond to patient suffering (Borrell-Carrio, Suchman, & Epstein, 2004). His model serves as a way of understanding how mental and physical suffering can influence a person's wellbeing down to ones' molecular level (i.e. ones' bio-chemical makeup, genetics, hormones, neurotransmitters etc.; Barrell-Carrio et al., 2004). The model focuses on an individual's predisposed biological traits (i.e. family history of health complications), psychological wellbeing (i.e. stress levels, one's optimism), and socio cultural factors (i.e. environment one has been raised in) that influences their human functioning (Pham, 2014). The biopsychosocial model is applied mainly within health care settings. Physicians and health care practitioners use the model to illustrate possible causes of mental or physical health disorders. Essential features when practicing the biopsychosocial model include: recognizing social relationships play a key role in client outcomes, incorporating clients' self-awareness into the diagnostic process, incorporating client's life histories, and deciding which aspects of the biological, psychological or socio culture factors are playing a major role into clients' current welfare (Borrel-Carrio, Suchman & Epstein, 2004). Interventions that are implemented through the biopsychosocial

framework (e.g., cognitive behavioural therapy) focus on emphasizing to clients that they are in control of their wellbeing (Pham, 2014; Weidig & Michaux, 2014). The goal of the interventions focuses on reducing the biological components that are causing the pain, while enhancing clients' wellbeing (McInerney, 2002).

The maturation theory (Dalton, 2005; Gesell, 1945), biopsychosocial model (Engle, 1977) and resiliency theory (Masten, 2000) provide examples of ideas as to how individuals learn to adapt. The resiliency theory is the theory most closely aligned with the positive psychology discipline (Masten, 2001; Seligman, 2011). Resiliency theory uses a strong preventative compared to the biopsychosocial model and maturation theory. It identifies ways of how children learn to become resilient in spite of adverse circumstances. It is also being inclusive as it looks at how children's biological and genetic makeup influences decision making, how they have coped so far in their environment, and the systemic relationships that can positively influence them.

While the maturation and biopsychosocial theory are valuable, they do not emphasize how the genetic, psychological and social factors influence client success (Dalton, 2005; Barros Carrio, Suchman & Epstein, 2004). The maturation theory provides an important insight that children's genetic makeup will impact their physical and psychological wellbeing (Dalton, 2005). However, it does not seriously consider environmental influences, and how it impacts children emotions and behaviour (Dalton, 2005). For example, it is suggested that children who have had low literacy experience, interrupted schooling and traumatic experiences maybe expected to take up to 10 years to catch up to their average cognitive levels (Kanu, 2008). The maturation theory attributes the children's genetic make up to being the cause of their strong stress reaction and how they deal with it (Schore, 2017). When supporting children, there is

evidence that caring individuals (i.e. parent, teacher, friend) can positively influence children and it serve as a protective factors within the children's lives (Burns et al., 2015; Ivey, Ivey, & Zalaquett, 2012; Masten, 2001).

The biopsychosocial model has a similar perspective to the resiliency theory. In fact, some researchers have presented the idea that the biopsychosocial model can be used to illustrate parts of the resiliency theory (Nester, 2009, Schmit, Fox, Perz-Edgar & Hammer, 2009). It incorporates the same elements- the biological, social and psychological makeup of a person. A main difference between the two is that the biopsychosocial model looks at a person's wellbeing through a disease centered lenses, while the resiliency theory aims to investigate how individuals overcome challenges. Masten (2001) explained that when using a resiliency theory, it has the perspective that success does "not come from rare and special qualities, but from the everyday magic of ordinary normative human resources in the minds, bodies of children, their families, and their communities" (p. 235). When children have learned how to overcome adverse circumstances they have shown an example of being resilient.

Therefore, resiliency theory was the chosen framework used within the following study, because it seeks to understand what lead to resilient children (Masten, 1999, 2014). In previous research studies, resiliency theory highlights what has been done within the social policies or influences in approaches to foster success in children (i.e., Provision of safe foster homes, individualized curriculum) rather than individual qualities (Sroufe, Egeland, Carlson, & Collins, 2005). Unger (2017) identified that researchers and clinicians often overlook attributes that lead to children being successful unique in spite of adverse circumstances. Further there are examples of studies that have overlooked the impact of evidence based interpenetrations and how it created

resilient children (Blackstock & Trocmé, 2005; DuMont et al., 2007; Ungar, 2005; 2013; Webb & Harden, 2003). Ultimately resiliency theory was the best choice of theory to apply as the study sought to look at how play helped children learn positive adaption skills.

Various studies had reported that children knowing how to self-regulate plays an important role in learning strategies of how to overcome adverse times (e.g., Barkley 1997; Block et al. 1988; Kochanska & Knaack 2003). Effective self-regulation strategies support resiliency- as it helps children to know their limits, say no to peers and engage in less anti-social behaviour (Dishion & Patterson 2006; Wills & Dishion 2004). Therefore, children's understanding of self-regulation plays an important role in understanding how to foster resiliency (Gardener, Dishion & Connell, 2008).

Self-Regulation. Self-regulation strategies are healthy coping mechanisms that children use to build resiliency (Gardner et al., 2008; Steele, 2017). Investigating these coping mechanisms can help people better understand ways of dealing with stress during adverse times such as death, divorce, and abuse (Band & Weisz, 1988; Besegevis & Galanki 2010). This is important for researchers and practitioners as this knowledge can make attempts at altering distressed people or organizations and enhancing them through effective self-regulation strategies (Pearson et al., 2007). A child's cognitive development, and developmental skills for managing a range of emotions are ongoing (Masten, 2000). This means that in a therapeutic context, counselling professionals are to use strategies that benefit children's development (Capurso & Pazzagili, 2016; Pearson et al., 2007).

Three studies have identified processes that children use for self-regulation when trying to cope in times of adversity (Band & Weisz, 1988; Besegevis & Galanki 2010; Endred & Vikan,

2007). Band and Weisz (1988) sought to understand how children self-regulated themselves in times of stress. Seventy-three children from two separate private schools in North Carolina, between the ages 6, 9 and 12, were interviewed on the process of how they coped in times of adversity. Two models that were applied within the study included: 1) the *ways of coping model* which examined how children coped through stressful situations by using a problem focused and emotion focused approach; and 2) the *primary and secondary model*, which looked if whether children's coping strategies influenced the conditions there were in (primary) and the goodness of fit with the conditions (secondary). This study used mixed methodology which included: structured interviews, coding themes, and interpreting the results using chi-square statistics. Participants' responses were coded into primary and secondary themes. Results of the primary themes included: (1) direct problem solving, (2) problem focused crying, (3) problem focused aggressions, and problem focused avoidance. Secondary theme results included: social and spiritual supports, emotion focused crying, emotion focused aggression, and cognitive avoidance. Relinquished control included *doing nothing*. The findings of the study suggested that children cope with their problems in how their environment influences them (Band & Weisz, 1988). Out of the 73 children interviewed, 96.5% had a coping strategy, and only 7.7% found their coping to be ineffective. Results of the study suggested that children within early elementary used primary coping strategies. As age increased, children began resorting to secondary coping strategies. The overall results suggested that children's strategies of coping depend on their situational constraints and cognitive development.

Besegevis and Galanki (2010) examined the processes children used when coping with feelings of loneliness. One hundred and eighty children in second, fourth and sixth grade were

interviewed. The interviews were used to gain understanding on children's processes when coping with loneliness. A mixed methodology was used to conduct the study. The qualitative component consisted of structured interviews, while the quantitative research approach was used to calculate the common strategies used by children when coping through stress. The interview was prompted by three questions that helped establish the results in a concise way. The questions included: (1) When a kid feels lonely, what can he or she do to stop feeling that way? (2) When you feel lonely, what do you do to stop feeling that way? (3) Have you been lonely in the past? Do you remember what happened? What did you do? The analysis was guided through the 12-family theoretical framework of coping which employs 12 possible ways of how individuals respond through behaviour, emotion and attention to the internal and external life demands. The results of the study found that children's process of coping with loneliness includes reaching out, speaking with others when feeling lonely, changing cognitive thinking, seeking advice from adults, engaging in alternative activities that seek pleasure, or resorting to maladaptive thoughts such as helplessness or passive aggressiveness (i.e., I'm worthless, I am going to be bad at this, no one is going to help me anyway).

Endred and Vikan (2007) sought to understand children's reasoning when using certain coping strategies when experiencing sadness, anger or fear. Eighty-three children, half from kindergarten and half in grade 1 or 2, from Trondheim, Norway were interviewed. Eighty percent of children responded they use: changes to their environment, social interaction (e.g., finding someone new to play with, distraction activities (doing something different), non-functional response (e.g., an "I do not know" response), or cognitive techniques (e.g., smiling anyway or suppressed the feeling). The researchers were unable to state the results of the study

because participants were inconsistent in their responses (Endred & Vikan, 2007). There were a few responses of children who identified play as a distraction when experiencing sadness, anger or fear. This study provided an interesting insight into processes that children use when experiencing sadness, fear or anger from the viewpoint of the children.

In these three studies, children's coping processes included changing cognitive thoughts regardless of the situation, or seeking support (Bands & Weiz, 1988; Besegravies & Galanki; Endred & Vikan, 2007). All three studies used children as their participants being interviewed as part of their methodology for the studies. All three authors pointed out that their reliability may be questionable due to children self-reporting their coping strategies. That is, the children may have internally believed that those were the coping strategies they identified as using (Band & Weisz, 1988). Depending on their level of development, children may not be fully aware as to whether they are dealing with stress in healthy ways (Greene, 2009; Steele, 2017). After all, stress impairs functioning especially within children (Greene, 2009; Steele, 2017). It is recommended that when interviewing participants in studies, researcher need to be consistent in their ability to provide a response to the research questions (Merriam, 2002). Therefore, identifying coping strategies that are successful, the parts of the participant's story should be able to give a descriptive understanding (Merriam, 2002). The three studies indicated that investigators who are interested in exploring the process of children's coping should also consider asking supportive caregivers and not solely rely on the children's self-report (Band & Weisz, 1988; Besegevis & Galanki, 2010; Endred & Vikan, 2007;).

Counselling professionals are supportive figures who help who use ethical and recognizable strategies to help people cope in healthy ways (Corey et al., 2013). The three

studies provide examples of coping strategies that children used were identified but did not provide information on how it helps children move forward from the hardship (Band & Weisz, 1988; Besegevis & Galanki, 2010; Endred & Vikan, 2007). Counselling professionals are trained to have knowledge and experience of seeing client progress (Canadian Counselling Association, 2010). Yet, after sifting through the literature, no identified studies examined what counsellors do to teach children how to cope. There were numerous outcome studies, but none that identified the process or strategies counselling professional use within play (Shaefer & Drewes, 2012). Clearer knowledge underlying play in therapy will allow clinicians to borrow flexibility from theoretical positions to tailor treatment to a particular child (Kaudson et al., 1997; Shaefer & Drewes, 2012).

Caring individuals who listen without judgement is a very powerful tool in helping individuals cope with stressful times (Ivy et al., 2013). Seeking social support was identified as a coping strategy that helped children in times of stress (Besegevis & Galanki, 2010; Endred & Vikan, 2007; Band & Weisz, 1988). The role of counselling professionals is to provide a listening ear when helping people cope in hard times. Understanding the effect that social support has and its influence is an important factor to consider when identifying how people move forward from hardship (Greene, 2009; Steele, 2017).

Social support helping self-awareness. Supportive relationships help youth to learn the self-regulation skills of changing maladaptive thoughts, therefore reducing the risk of developing mental health troubles (Artch-Garde, Gonzales- Torres, Funete, Vera, Fernandez-Cabezas & Lopez- Garcia, 2017). However, learning to change thoughts is a skill that can take time to establish. Some individuals are genetically predisposed to being a happier person, and teaching

simple positive coping cognitive strategies without much investment can help these individuals thrive (Seligman, 1999). Unfortunately, there are others who are not as blessed in this genetic predisposed gift. These individuals need further support on implementing positive coping strategies, especially in times of adversity (Pitman & Karle, 2015). When these individuals have the influence of positive support, it empowers them to use their strengths in tough times and it teaches them how to thrive regardless of the situation (Masten, 2014; Seligman, 1999).

Four research studies were identified that measured the effect that social support has on reducing cognitive distortions within children (Mishna et al., 2016). These studies shared the common theme related to how social relationships gives children and youth the feeling of acceptance through peer and parental support.

First, Mishna et al. (2016) looked at peer support and the impact it can have when experiencing cyberbullying. Six hundred and sixty-nine students in grades 4, 7 and 10 within schools based out of Toronto, Ontario participated in the study. The study's methodology consisted of self-reports and a bivariate analysis. Youth who had strong peer support did not experience the strong negative emotional impact of cyber bullying. The bivariate analysis based on self-reports identified strong peer relationships gives students confidence, which mediated the effects of cyberbullying. Having positive social relationships teaches youth that to have confidence in themselves which in turn helps them feel empowered (Rosenfelid et al., 2006). A lack of strong relationships influence the negative effects of bullying, causing mental health difficulties within youth (Mishna et al., 2016).

Criss, Pettit, Bates, Dodge and Lapp (2002) investigated how youths' mental health could be influenced by peer support, and whether it serves as a protective factor when a family is

experiencing adversity. Using a resiliency based frame work, 585 families from Knoxville, Alabama, Nashville, Tennessee, and Bloomington Illinois were interviewed. Sociometrics were used to assess children's peer acceptance, friendship, and friends' aggressiveness within kindergarten and grade 1. Teachers provided ratings of children's externalizing behaviour problems in grade 2. A regression analysis was used to determine if peer support reduced externalizing behavioural problems, when having stressors at home, is due to peer support. Results suggested that peer acceptance and friendships reduce externalizing behavioural problems within children who are experiencing adverse family circumstances (e.g., divorce, death, job loss of a parents). The study identified how peer acceptance helps children who are going through tough times within their family (e.g., job loss, divorce, death in the family) work through family stressors (Criss et al., 2002). The study provides an example of how groups of peers can support children. Oftentimes, youth seek out one-to-one support without having a group supporting them.

Deutech, Ritz-Kruger, Hennebergerm Futch and Lawerence (2015) conducted a qualitative study that examined adolescent girls' experiences of group and one-to-one mentoring. The purpose of identifying this study was to examine how one-to-one support helps youth build self-awareness. The girls who participated in the study joined peer mentoring for purposes of improving academics and social-emotional skills. The study used basic interpretive qualitative interviews. The researchers wanted to identify themes that examined: (1) possible changes in socioemotional, cognitive, or identity development; and (2) if changes are reported, to what aspects of program participation do girls attribute those changes (i.e., interactions with their mentors, in the group, and/or with the program curriculum). The researchers found that the

majority of the girls experienced positive changes within their ability to build relationships learn and self-awareness when participating in group and one-to-one mentoring. The mentoring group played an important role in developing social and relational skills. It was reported that one-to-one mentors helped the participants to feel heard. It also improved academic grades. These girls did not have any mental troubles. Often times when youth do seek out support they are struggling with mental health. Understanding social support and how it influences mental health is an important factor to consider when investigating resiliency and ways individuals move forward from adversity (Seligman, 1999).

Finally, Esiman, Staddard, Henize, Caldwell, and Zimmerman (2015) investigated depressive symptoms of youth who experienced violence in Flint, Michigan in order to explore if the influence of parental or peer support can reduce depressive symptoms amongst youth who experienced violence. Eight hundred and sixty-four students from schools within Flint completed a self-report survey. The survey identified possible variables that triggered depression, and support when working through depression. These variables included violence observation, conflict with the family, mother support and friend support. The study's results were based on using a quantitative methodology. There was a significant effect size in youth having lower depressive symptoms when having their mother support after exposure violence. However, there was no indication that peer support changed youth depression. Esiman et al. (2015) suggested that learning how to address mental health trouble within a caregiving relationships may be more beneficial compared to peers.

Three of the four studies reviewed suggested that peer support plays can help children and youth in adverse times (Criss et al., 2002; Deustech et al., 2015; Mishna et al., 2016).

However, Mishna et al. (2016) pointed out that majority of the students who participated in the study did not actually experience online bullying. Speaking to school personnel or caregiving professionals could provide a more in-depth understanding of how social relationships can help victims of bullying overcome adversity (Mishna et al., 2016; Pepler, 2006). Further Criss et al. (2002) explained that youth resiliency was not actually measured in the study. This study only explored if peer support helped youth feel better when their family was in a time of adversity. Many youth predicted that if they were to be cyberbullied, their friends would be the ones to provide support. Esiman et al. (2015) found that peer support was not influential in helping children overcome depressive symptoms. Positive relationships between youth and caregivers have an impact in improving children's adverse times (Mishna et al., 2016). Therefore, all staff and personnel who work with children should educate themselves on the power of relationships, and techniques to develop a positive rapport with youth.

Ultimately, all four of the studies identified that positive social relationships in adverse times help children feel accepted (Criss et al., 2002; Deustech et al, 2015; Esimna et al., 2015; Mishna et al., 2016). According to Mishna et al (2016), there is a need within scholarly research to investigate how social support improves self-awareness within youth. Criss et al. (2012) recommended taking a preventative approach to reducing mental health. This is achieved by conducting studies that examine processes to enhance wellbeing in youth (Criss et al., 2012). Counselling professional roles are acting as a supportive person and they help coach people through the process of achieving a stronger wellbeing. The social support that counselling professionals provide include teaching children processes of coping that are developmentally appropriate (Reynolds, 2012). Using the resiliency perspective, it is specifically looking at how

people have overcome adversity and developed internal strength (Seligman, 2011). No studies were identified that has considered how counselling professionals support can help children experiencing adverse circumstances.

Roles of counselling professionals. The role of a counselling professional is to work hands on with clients and help them with their internal struggles through a therapeutic relationship (Corey, 2009). Various studies have found children and youth have expressed difficulty in finding supportive adults who are willing to listen (i.e., Hill, 1999; Lindsay, Chamber, Pohle, Beall, & Luckstead, 2013). For example, Pouslan, McDermitt, Wallis and Cobham (2015) conducted a qualitative study that investigated children and their parents' response to natural disasters. It was found that 22% of children had PTSD symptoms, but less than 50% of parents recognized any PTSD symptoms in their children. Only 29.5% of parents sought out counselling for their children.

Counsellors aim to teach children ways to improve self-awareness and self-regulation (Steele, 2017). Counselling professionals have challenges to overcome when providing counselling to children during adverse times. Parents typically send their children to counselling on a voluntary basis, as they want someone to listen to their child so they can feel that they are being heard. Many parents are hesitant to have their child do continuous counselling because they are afraid of the counsellor being critical of their parenting (Heritage & Sefi, 1992; Silverman & Peralyka, 1995). Further, it has been argued that children are often hesitant when speaking with a counsellor (Hutchyby, 2005). This is can be due to either the children not wanting to betray their parents, or the child not being fully aware of a counsellors' role

(Hutchby, 2005). Further, children may not be developmentally able to engage in counselling (Hutchby, 2005).

For a counsellor to be effective when counselling children with mental health they have to be conscientious of using the right approach to connect with children (Hutchby, 2005; O'Brien & Burnett, 2000). Three studies were identified that aimed to investigate counsellor approaches, techniques and strategies to effectively counsel children. There were no studies that identified strategies using play-based interventions.

In the first study, Hutchby (2005) aimed to examine counsellors' use of active listening when counselling children between the ages of 4-12. The researcher wanted to investigate how not all children are prepared to discuss their feelings while in counselling. The intent of the study was to add to research that provides best practice advice when providing talk-therapy to children (e.g., Putcha & Portet, 1999; Schuman & Jordan 1999). The study took place in London, England. The number of participants was not identified in the study. The study used a thematic analysis and qualitative methodology. The counselling sessions between the counsellors and the children were transcribed. Based on the session transcriptions, the researcher aimed to identify conversational cues of when the child seemed ready to speak about their problems or was hesitant based on the data transcribed. The researcher went further to highlight how counsellors' responses impacted the counselling session. Hutchby (2005) concluded that children are most hesitant to speak in counselling when asked about their home life. The rationale for this is that they want to avoid topics that make them uncomfortable, especially if they recognize that their home life is struggling (e.g., financial problems, abusive, neglect; Hutchby, 2005). Hutchby (2005) recommended counsellors listen and avoid asking direct questions if suspecting struggles

at home. If one listens and shows empathy, the more comfortable the child will be and the more willing to talk.

When people respond negatively to children's problems (e.g., getting angry at the child, showing signs to the child that you are visibly upset) children are less likely to share problems. Further, if counsellors forget to listen to the child, and respond only to the child's external problems (e.g., if the family is poor, and the counsellor responds by making a referral to the food bank or; if child is in abusive situation and counsellor helps place them in a safe home), the emotional part of the child is still not being addressed (Hutchby, 2005). Listening to children with disabilities is particularly important because they are less likely to be included and accommodated in day to day life. Children with disabilities include a wide range of diverse symptoms such as lower IQ, reading difficulties, behavioural problems etc. For example, if a child with a low IQ says he or she is feeling sad because they are not doing well at school, and the counsellor makes accommodations for helping the child, the feeling *sad piece* is easily overlooked (Pattison, 2001).

Pattison (2006) investigated how inclusive counsellors were when counselling students with disabilities. The purpose was to identify and teach future counsellors how they can practice inclusion models within their counselling practice. The inclusion models the researchers used to identify counsellors' inclusion consisted of six indicators of inclusive counselling: (1) Proactive approach to the role of the counsellor, (2) Focus on relationship building, (3) Operationalize equal opportunities and policies, (4) Inclusive approach to initial assessment, (5) Flexible and creative approach to counselling, and (6) Continuing professional training and self-awareness. Three hundred and ninety-six counsellors across England completed a survey that examined their

approaches to being inclusive when counselling children. The study used a mixed based methodology analyzing data in two separate ways. The Statistical Package for the Social Science (SPSS) program was used to analyze the data including calculating the mean, medium and mode to determine the averages and percentage of counsellors using inclusive models. In addition, the authors also identified themes in participants` responses as to how the counsellors used the inclusion model in their counselling practice. It was found that 62% of counsellors rarely incorporated all of the indicators of inclusive counselling in their practice. It was determined that a major reason as to why there was a lack of counsellors practicing inclusion is that they did not know how to do so. Children with disabilities have various ways of learning how to express their thoughts and that there is no one-size fits all approach to counselling (Hutchby, 2005; Patterson, 2001).

O'Brien and Burnett (2000) investigated how counsellors can use a variety of activities based on Gardner's (1993) theory of multiple intelligences when counselling children. The purpose of this study was to explore the essence of counselling and to highlight techniques and environmental factors that are useful when counselling young children who do not have the language required for formal counselling. The study used a narrative based methodology. Ten counselling sessions with children from Queensland Australia were recorded to investigate how multiple intelligences can be used when counselling. After six months of counselling, the counselors wrote a full recollection of each sessions. Each provided a narrative that told the story of the counselling session. Text units from the counsellors' stories were allocated into categories used for analysis, and vignettes for case studies to help with training. Text units from the counsellors' narratives were allocated into particular intelligences (kinetic, interpersonal,

intrapersonal, logical, musical, verbal and visual). The interpersonal intelligence was the most beneficial to child clients. Interpersonal intelligence includes the child learning from person-to-person relationships, communicating through others (using various ways) and having empathy for their feelings and beliefs. O'Brien and Burnett (2000) highlighted how children's playing incorporated all of Gardner's multiple intelligences model.

The three studies provide information on strategies and techniques counsellors can consider when counselling children. Hutchby (2005) provided insights on the complexity of conversing with children in counselling, and how active listening is an effective way for them to feel heard. Patterson's (2001) study reminds counselling professionals of the importance of being inclusive within counselling. The study's results emphasize the importance of counselling professionals to seek training as to how to be inclusive when counselling. O'Brien and Burnett (2000) provided examples of valuable and effective documentation of counsellors using various forms of intelligences when counselling young children.

The three studies provide a range of strategies as to how counsellors can communicate with children when counselling. None of the studies provided explicit strategies for counselling children outside of talk-therapy. Nor were any studies identified that examined strategies of play. Hutchby (2005) reminded counsellors about the importance of active listening, however determining when a child is hesitant towards the therapist based on conversational cues is vague. Children are very diverse, and can each respond to the same situation in their own unique way, especially as to where they are developmentally (Greene, 2009; Patterson, 2001; Shaefer & Drewes, 2012). The configuration of the conversation is not concrete, as there are multiple ways to assess how a child is feeling besides listening to a conversation and signs of awkwardness

(Greene, 2009). For example, a child who is shy, has social anxiety, or has been identified with autism spectrum disorder (ASD) may be awkward in a conversation because that is just part of their nature (Patterson, 2001). Patterson's (2001) survey is a strong reminder to counselling professionals on the importance of inclusion. Patterson (2001) did note that the participants were randomly selected. Therefore, they may have never had the need to understand in an explicit way what the six indicators of inclusive counselling look like. Further, surveys that use answer options (e.g., somewhat agree, somewhat disagree) can be interpreted differently based on different respondents and researchers (Field, 2013). Further it was not specified as to whether the survey was asking counsellors about their use of different counselling theories. Counselling theories incorporate elements of how to help clients work through their emotional troubles (i.e., cognitive behavioural therapy consists of cognitive and behavioural exercises for the client to practice when feeling stressed). Often these exercises are accessible to counsellors, especially for those who work with people who have a disability (Corey et al. 2009; GreenBerger & Padosky, 2012). O'Brien and Burnett (2000) emphasized that intrapersonal intelligence (i.e., being with the client and acting out stories) was the most well preferred type of intelligence children used in counselling. The researchers did not explain in further detail as to how the other forms of intelligences impacted the counselling sessions. Instead the research explained how playing with child clients does incorporate all forms of multiple intelligences, as it does not require the child to be able to communicate effectively, and how it includes children of all developmental stages of life (e.g., art therapy- form of playing for adults). These strategies can be viewed as an effective way of helping children release emotions without verbally expressing themselves. Being with the child client, and not having them speak, think, feel or do things beyond their

developmental capacity appears to be an important part of for the counselling process being effective for children (Hutchby, 2005; O'Brien & Burnett, 2000; Patterson, 2001).

Play within the therapy is inclusive as it is a natural way for children to express themselves (Moore & Russ, 2016; Shaefer & Drewes, 2012; Vygostky, 1967). When children are playing, they are not expected to express deep emotions and talk about their feelings. Instead they just need to be present and are express creative thoughts. Therefore, play and a therapeutic relationship are companions since a therapeutic relationship fosters relationship and being present with a person (O'Brien & Burnett, 200). To date, no literature has been identified that investigates how counsellors are effectively using play in counselling sessions to support children. However, children's development has been shown to be well supported using play.

Supporting Children's Development Through Play

Play can be viewed as a natural companion to helping children learn positive adaption. Through play children can act out their thoughts, actions, intentions and feelings about their relations through words, plays, drawings and construction blocks. Hong and Mason (2016) explained how there is a connection between pretend play and its contribution to creating connections to emotions and cognitions within the brain. When an individual is processing something significant, their emotions serve as a messenger as to how to react to the situation (Campos, Frankel & Camras, 2004). Vygotsky (1933) proposed that play helps children build cognitive concepts. Waleder (1933) suggested that children deal with tough experiences by playing out an experience over and over again until it become manageable. Piaget (1973) suggested that children playing is their effort in having the environment match their worldview. Malchiodi (2014) explained that the tactile and sensory experience of using props and toys in

play provides children the opportunity to process their understandings. Further, play has been suggested to enhance academic learning as it helps them adjust to the school setting by enhancing children's readiness, learning behaviour and problem solving skills (Barros, Silver & Stein, 2009). It has also been suggested that play may increase children's capacity to store new information as their cognitive capacity is enhanced by experiencing drastic changes in activity (Barros et al., 2009).

Vygotsky (1967) viewed children's play as a form of self-regulation, as it gave meaning to some children's complicated thoughts and develop a sense of their surrounding world (Vygotsky, 1967). Particularly when children's play includes hope, empathy and creativity (Pearson et al, 2008; Shaefer & Drewes, 2012). These qualities have been documented to help individuals achieve optimal function (Greene, 2009; Pearson et al., 2008; Seligman, 1999). It builds between ideas, connects feelings, facts and new understanding about the world and how it works (Jachyra & Fusco, 2016; Kordt-Thomas & Lee, 2006). It helps individuals develop a sense of control, which lead to feelings of confidence and accomplishment (Schaefer & Drewes, 2012; Drewes, 2005). The following section identifies research studies that investigates play helping children reach positive adaption.

Various studies have investigated how play helps children with self-regulation and ways to cope with stress. Russ (2004) reviewed play intervention literature. It was concluded that playing in therapy helps children manage fears and reduce anxiety (Russ, 2004). Gaylar and Evans (2001) concluded that there is a positive relationship between pretend play and emotional regulation within preschool children. This was measured by rating scales that identified stressful situations (rated by the investigators) and emotional regulation (rated by the parents). The results

showed that the more children played outside of the experiment the stronger parents rating were towards emotional regulation.

Three studies in early 2000 examined how play helps children communicate and become optimistic. In a case study conducted by Franke and Geist (2004), it was found that playing social skill strategies improved a boy with autistic spectrum disorder's communication with other children and adults. Teaching play helped the boy to use different types of social skills when being in unique situations (i.e., including a fellow student who was left out). It was thought that by teaching him social skills through the use of dolls, puppets or through role-play, he was more likely to remember what is appropriate behaviour, instead of simply being told how he should act (Franke & Giest, 2004; Shaefer & Drewes, 2012). Tamis-LeMonda, Shannon, Ceberea and Lamb (2004) found that playing with an adult enhances children's ability to communicate with adult. It teaches the child various ways how to communicate with the adult when feeling stressed. Playing builds strong connections with other children as it exposes them to learning how to share, resolve conflicts, negotiate with one another, and advocate for themselves and others (McElwain & Volling, 2005). Shen (2002) examined how play therapy interventions decreased young girls internalizing behaviour after they experienced an earthquake in China. Following ten sessions of play therapy it was found playing out their helplessness significantly reduced the young girls' anxiousness and sadness as it gave a sense of how control their emotions while empowering them to move forward (Shen, 2002).

More recently, four more studies identified playing as helping with self-regulation. In a study conducted by Fehr and Russ (2013), it was found that aggressive play can be a form of catharsis. The researchers identified that when the child participants showed high levels of

pretend oral and physical aggression in play, they presented less hostility in the classroom (Trotter, Eshlman & Landreth, 2003; Fehr & Russ, 2013; Oppenheim, Nir & Emde, 1997). Children can release their feelings through emotional expressions (such as crying), or activity (punching bags, aggressive play; Schaefer & Drewes, 2012). However, there needs to be more understandings of how children are able to associate the healthy ways of releasing catharsis with potentially aggressive way (Fehr & Russ, 2013).

Marcelo and Yates (2014) observed if pretend play can improve preschoolers coping abilities, while reducing emotional and behavioural problems. Preschoolers fantasy and affect expression in pretend play were observed and rated by the Affect in Play Scale. After a one year follow up, results showed that the preschoolers improved flexible thinking when playing. There was also a reduction of internalizing behaviour problems. Hong-Gu et al (2015) conducted a study and found that play before a surgical operation can reduce children's anxiety about the postoperative pain. By playing with the toys and imitating the anxiety, but using coping skills, instead of disruptive behaviour, the children felt less scared about the operation (Hong-Gu et al., 2015). In another study Al-Yateem and Rossiter (2016) found that nurses who use play interventions significantly reduced children's levels of anxiety in acute inpatient setting. Divergent thinking helps with optimism as it teaches problem solving and creates solutions on ways to deal with issues (Carson, Bittner, Cameron, Brown & Meyer, 1994; Russ, 1988, 1998).

Play interventions. There are various forms of play interventions that helping professional can use to help children identify protective factors. Play interventions that helping professionals use to achieve these protective factors include direct and indirect play interventions (DelPo & Frick, 1988). It can be a complex process for helping professionals to choose which form of

intervention (DelPo & Frick, 1988). There are advantages and disadvantages to each of the type of interventions. For the purposes of this study it is important to understand how the difference between these two interventions influence the helping professionals' role in choosing play interventions to foster positive adaptation in children with emotional and behavioural difficulties.

Direct play. In direct play the adult plays an active role with the children (DelPo & Frick, 1988). It is often goal oriented and limited to only one or two sessions. Children can be taught how to respond during stressful times using direct play in five different ways (Shaefer & Drewes, 2012). First of all, direct play interventions promote the use of using proper social behaviour. This behaviour is instructed to the children and are developmentally friendly (Mastrangelo, 2009). Direct interventions meet Axline's (Frick & DelPo, 1988) second factor by how it provides the children with learning opportunities as the ideal behaviours are taught to the children (DelPo & Frick, 1988). Third, the use of direct interventions in a therapeutic setting gives children the opportunity to master the skills. The fourth way direct interventions follow Axline's factors is that the helping professional is able to correct children (DelPo & Frick, 1988). The fifth and final factor is that it gives children the chance to learn about themselves as they are learning about how to stop impulsive behaviour and learning about their behavioural choices (Mastrangelo, 2009). When using these interventions, they can serve as protective factors by teaching the children new skills that can benefit them when experiencing stress.

Direct play interventions are effective for skill and behaviour building (Mastrangelo, 2009). Understanding and applying proper behaviours in a social context can be a protective factor (DelPo & Frick, 1988; Mastrengelo, 2009). As the children play, the therapist models desired social interactions that promote cooperative play (Cordier, & Lincoln, 2014; Wilkes-Gillan,

Bundy). Helping professionals model through the use of puppetry, coloring books, films, games and dramatic presentations with the aim of changing the children's behaviour. Helping professionals can use direct play in situations that prepare children for hospitalization, surgery, medical or dental assistance to neutralize children's frightening or painful experiences (DePo & Frick, 1988).

Non-direct play. In non-direct play, the children take an active role, as they are in charge of the theme, context, process of play, selecting the materials and controls the place (DePo & Frick, 1988). Indirect play interventions are children's most natural form of playing. The use of indirect play interventions meet Axline's factors in the following ways (DePo & Frick, 1988). First, as discussed, play is an important part of children development. Studies have supported that play can increase children's ability to recognize their psychosocial and cognitive development. The interaction between the children and the helping professional helps the children become more self-aware which helps with their social and behavioural success (DePo & Frick, 1988). Second, indirect intervention provides children with learning opportunities as the adult gives corrective feedback (DePo & Frick, 1988). The third factor is the process of indirect play giving children the opportunity to re-experience the difficult events. The re-experiencing process gives children the ability to deal and master difficult experience (DePol & Frick, 1988). The fourth factor is that it gives children the chance to re-enact the stressful situation and act out corrective behaviour (DePo & Frick, 1988). The fifth factor includes giving children the opportunity to learn about themselves by reflecting on ideas, thoughts, feelings, beliefs, wishes and perceptions as they play (DePo & Frick, 1988). The spontaneous play helps children to learn ways of how to adapt to stress which can serve as a protective factors (Masten, 2014).

When using indirect play interventions, the play is spontaneous and incorporates the children's fantasies. The interventions are designed to provide children with opportunities to express ideas, thoughts, feelings, beliefs, wishes and perceptions. Building self-awareness qualities serve too as protective factors. The goal of non-direct play interventions is to help children in a therapeutic way to learn how to self-regulate their behaviours and no longer resort too aggressive and anti-social behaviour (Schaefer & Drewes, 2012).

Comparing direct and indirect play. There have been positive adaptations amongst children through the use of direct and indirect play techniques for children with emotional and behavioural difficulties. However, there is has been little discussion on the therapeutic process of using direct play and indirect play interventions (Bernard-Opitz, Ing, & Kong, 2014). The following studies of direct and indirect play interventions provide evidence of how either play interventions can work. These play interventions are not without limitations and can cause complexity on how helping professionals choose the interventions and it can serve as a driver for emotional and behavioural change (DeIpo & Frick, 1988). Further the effects of direct and indirect play interventions have been shown to be successful for short periods of time, and it is unclear if these interventions can teach children protective factors over the long term (Moore & Russ, 2006).

In a study conducted by Bernard-Opitz, Ing and Kong (2014), direct and non-direct play interventions were compared with one another in how they were used to address children with ASD's behaviour. The findings suggested the direct and non-direct play interventions affect children with ASD in different ways. When using direct instruction, six of the eight children in the study improved their compliance and social skills. On the other hand, when using indirect

play, only two of the children with ASD improved their behaviour. The researchers proposed that even though there were less successes with indirect play in children with ASD, it is important for practitioners and families to choose play interventions that are well planned, researched and suited to children's needs (Bernard-Opitz, Ing, & Kong, 2014). However, when it comes to choosing play interventions there is a gap in scholarly literature that examines how professionals effectively choose play interventions that support children in developing resiliency qualities (Bernard-Opitz et al., 2014; Gillaspie, 2014). Identifying studies that show how direct and indirect play can successfully impact children with emotional and behavioural difficulties is worth exploring to help identify the benefits of each (Bernard-Opitz et al., 2014).

There are various studies that examine how direct play influences children with emotional and behavioural difficulties. Not only have direct play interventions been shown support to utilize playtime for a setting to build skills (e.g., social skills, friendship-making, etc.) and of themselves have been widely accepted as valuable skills (Gillaspie, 2014). Kelly-Vance and Ryalls (2014) conducted a study that examined direct play intentions. These intentions included parents teaching specific play strategies to enhance their four to five year old children's play behaviour. Through the use of modeling, verbal reinforcement and encouragement over a course of six weeks, it was found that direct play increased new positive behaviours amongst the children. In another study, Suley et al. (2011) used direct play intervention for children with specific speech and language impairments. The purpose of this study was to identify how language and play are mutually reinforcing, meaning that by improving language, their play behaviours will improve. Suley et al., (2011) used an adult facilitated approach the included a story-play-review process. The studies result revealed that six children who received the

treatment showed an increase in play behaviour, compared to the control group who displayed weaker play abilities. As discussed earlier, speech and language impairments can often cause children to act out with problem behaviour.

Mallory et al. (2010) carried out a play skill intervention which aimed to increase divergent thinking in four and five years old who are at risk for developmental delays. The study aimed to increase play skills by encouraging complex play behaviours. The intervention consisted of prompting, modeling and reinforcement. Children's abilities were assessed by pre and post-tests through the Physical, Intellectual, Emotional, Capabilities, Environment, Social Self-Assessment (PIECES; Kelly- Vance & Ryalls, 2014). Results showed that two of the three children who received that play intervention increased their play abilities compared to the control group. These studies provided examples of the positive impact that teaching play skills to children with behavioural and emotional needs can have.

Direct interventions aim to change children's behaviour to help them to become more socially appropriate (Gallipse, 2014). Behavioural interventions also have shown to be more of a skill and behaviour builder than actual therapeutic interventions (Mastrangelo, 2009). Direct intervention plans often do not work through the children's emotional disturbances or use a strength-based approach; instead use a disease approach to treat the disorder (Ivey, Ivey & Zalaquett, 2015). For example, in Kelly-Vance and Ryalls' (2014) study that taught parents to use verbal reinforcement, modeling teaching specific strategies, it is not identified if parents and children were able to communicate with one another to talk about the root of their communication problem. Without knowing the cause of the problem, the direct interventions come across as a quick fix to the problem without actually solving it. Behavioural interventions

also typically use a *one size fits all* approach, which may not work for some children (Mastengelo, 2009). The Mallory et al. (2010) study had adults use modeling and promoting play with their children who were at risk for developmental disabilities. Developmental disabilities vary on a spectrum of severity, therefore it can be difficult to determine if the intervention is truly causing change or if the children are just going through the motions without grasping the concept (Bernard-Opz, Ing & Kong, 2014). When applying the definition of true play to modeling and prompting interventions, it has been suggested that these may be too adult directed and goal oriented to be considered as true opportunity for childrens' play (Delpo & Frick, 1988; Mastrangelo, 2009). There is the argument that direct interventions miss a key component of using play as a therapeutic tool, which is helping the children play through their emotional issues that are causing problematic behaviours (Mastrangelo, 2009).

Studies that look at the indirect benefits of play interventions are more limited compared to direct studies (Bernad-Opitz, Ing & Kong, 2014). These interventions however have roots in analytical therapies that have been used reputedly by children with emotional and behavioural difficulties to work through psychological traumas (Erikson, 1950; Freed, 1920; Walder, 1933). Moore and Russ (2006) suggested that indirect pretend play can lead to children developing positive emotional regulation and to maintain positive relationships when in stress (Moore & Russ, 2006). A meta-analysis conducted by Fisher (1992) found a significant effect size related to children's emotional regulation ability and how frequently they played. It is proposed that pretend play provides children with specific contexts of being able to practice emotional regulation without having to actually experience the event (Moore & Russ, 2006). In another study conducted by Galyer and Evans (2000), children who engaged in pretend play with an

adult for longer periods of time demonstrated stronger emotional regulation abilities in daily activities. Barnet (1981) investigated the effect of pretend play in reducing anxiety and the effect of peer presence. The study divided 74 preschoolers into two groups (i.e., anxious and non-anxious children). The settings the study took place in consisted of two conditions, a play center and story time. The play center condition was further divided into playing solitary or with peers. The study found anxious children were less anxious when playing alone than when playing with other peers. The study also found that the anxious children had the least amount of anxiety when they were playing in a fantasy. The authors concluded that solo pretend play may reduce anxiety (Bennet, 2000; Moore & Russ, 2004). Moore and Russ (2006) explained how avoidance coping strategies in children with post-traumatic stress can experience reliving their traumatic familiarity. Therefore, it was proposed that by playing children can process their negative experience through talking, playing and drawing (Moore & Russ, 2006; Terr, 1990). Moore and Russ explained that this framework can be applied to children through a study conducted by Jacobson and colleagues. Jacobson and colleagues (2001) found that avoidance coping strategies in adults who underwent a bone marrow transplant had greater severity of post-traumatic stress disorder (PTSD). The author suggested that since these adults did not cognitively process the event there is a “greater likelihood that the traumatic material would remain active and capable of precipitating intrusive thoughts and other symptoms” (p. 236). Ebrahim, Steen, and Parides (2012) conducted a study that investigated school counsellors’ barriers when using play therapy. The school counsellors were not registered play therapists. Ebrahim et al. (2012) found that when having these limitations, many school counsellors still used play within therapy and still found it to be helpful. Many of these studies discussed were used with non-clinical

emotional and behavioural diagnoses (Moore & Russ, 2006). Moore and Russ (2006) also explained how these studies suggest that playing through negative experiences is a normal part of childhood.

The various studies that looked at the use indirect play interventions have shown that children with emotional and behavioural difficulties can evolve positively. However, if these interventions are used ineffectively, they can negatively impact individuals beyond the impact of their initially diagnosis (e.g., time wasted, financial support wasted, possible regression in behaviour, frustration from support systems) (Bratton, Celballos, Sheely-Moore, Menay-Walen, Pronchenko & Jones, 2005). For example, Munro et al. (2006) found that after 32 sessions of play therapy, there was a significant decrease in behavioural problems amongst the children, and an improvement in the teacher-child relationships. While in Bratton et al.'s (2005) study, 54 preschoolers with disruptive behaviour were randomly assigned to either play therapy or a control reading intervention group. The preschoolers in the play therapy group attended 17 to 21 sessions to demonstrate a significant decrease in behaviour disorders. These studies are examples of play interventions being successful, however, attending that many therapy sessions is time consuming and costly for clients and their families. In addition, the significant results in decreasing preschoolers' emotional disturbances' in Bratton et al. (2013) and Murno et al., (2006) could be attributed to their age group as they were maturing which could positively affect their behaviour.

When looking at the Galyer and Evan (2000) study's methodology, the anxious children had their anxiety reduced, when pretend playing with their parents. To determine how much the children's anxiety reduced parents filled out an emotional regulation checklist pre and post play.

Parents may have been biased as they were the ones implementing the intervention. The study also only made note of the children's anxiousness being reduced when present and playing with parents. Helping professionals strive to make sure that their children are having success outside of the treatment. Barnnet (1981) examined that children's anxiety reduced when playing alone or with peers. However, this study classified the children to be anxious if they showed hesitation to being in a new place. This is not a very strong indicator in determining if these children were truly anxious. They did not know these children's experiences beforehand. These children also may have been tired when they arrived at the setting as they were preschoolers.

The use of play interventions both direct and indirect as a theoretic modality is a well-researched topic. Despite it being a popular form of treatment, the mental health needs of individuals with emotional and behavioural difficulties still remain unmet (Mendenhall & Frauenholtz, 2012). These studies are examples of how helping professionals lay the foundation for understanding the processes that can be used to help children build resiliency. However, understanding what helping professionals do in play interventions would help to enhance current mental health practices.

Summary

Supporting children's wellbeing during adverse times is an important step in taking a preventative approach in reducing mental health problems as adults (Steele, 2009). Counselling professionals who specialize in counselling children, work on the front lines of helping these child cope with adversity (Canadian Counselling Association, 2009). These professionals are educated in helping these children overcome barriers causing them great stress. Positive psychology is a research discipline that gives researchers the opportunity to investigate how

people flourish (Seligman, 2009). Positive psychology research has identified that people's development- biological social and emotional-contributes to how resilient they are able to become (Perry, 2006; Seligman, 2009). Therefore, when it comes to investigating how children develop resilience, counselling professionals can offer unique insights as to how to do this (Shaefer & Drewes, 2012; Green, 2009). They have valuable knowledge, skills and insights on strategies that are used to help children reduce feelings of stress.

Children can use self-regulation strategies as way to cope in stressful times (Steele, 2017). Self- regulation strategies can be used to help children: cope with environmental influences (Band & Wesiz, 1988); reach out to adults; improve cognitive thinking, helplessness, and/or passive aggressiveness (Besegevis & Galanki, 2012); or deal with distractions (Endered & Vikan, 2007). Supportive relationships are an important part of teaching children how to work through cognitive distortions such as stress (Seligman, 2007). These relationships can help children cope by providing them with the feeling of acceptance regardless of whatever is happening in their lives (Criss et al., 2002; Duetch et al., 2015; Esiman er al., 2015; Mishna et al., 2016). Supportive relationships can include anyone with whom children can develop a relationship (e.g., parents, family members, peers, etc.).

Play has been cited throughout the research literature as serving as a natural tool in fostering positive adaption (Moore & Russ, 2006). Various studies have discussed how it teaches children coping strategies, serves as a form of self-regulation, develops divergent thinkers, and teaches creativity and empathy (Marcell & Yates, 2014; Moore & Russ, 2006; Pearson et al. 2007.) There are various play interventions that help children develop these skills as forms of direct and/or indirect play interventions (Blundon & Shaefer, 2012; Depol & Frick, 1988). Counselling

professionals are typically the professionals who implement or facilitate these interventions (Ivy et al., 2015; Schaefer & Drewes, 2012).

Chapter 3: Methodology

Rational for Qualitative Research

The purpose of this study was to explore the perspectives and the processes of how helping professionals are using play interventions to foster positive adaptation in children. Qualitative research methodologies seek to answer questions about what an experience is like for a particular individual or group of people (Merriam, 2002). Specifically, it investigates the meaning of phenomena that is socially constructed by individuals during interactions with the world or their reality (Merriam, 2002). This study was qualitative in nature as it searched to improve current understanding of how helping professionals perceive and are using play interventions. This research methodology is particularly useful in exploring a phenomenon about which little is known (Strauss & Corbin, 1990).

The following study aimed to add to play-based intervention research by identifying helping professionals' thoughts of, and experiences with, play based interventions and how they help their child clients learn positive adaptation. The concept of resiliency relies heavily identifying how people develop positive adaptation (Masten, 2001). Through a thematic analytic approach to exploring qualitative data obtained through individual interviews, this research sought to identify the common themes expressed by helping professionals who were using play based intervention to foster children's positive adaptation in the face of adversity. The resulting qualitative description details what I have learned as a researcher during this endeavour. The research question that guided the study was:

1. What are counselling professionals' thoughts toward, and experiences of, using play intervention in the therapeutic process to foster positive adaptation?

Basic Interpretive Qualitative Research

Basic interpretive research is motivated by having a specific interest within a phenomenon and extending its knowledge (Merriam, 2009). Basic qualitative search is founded within a constructivist theory. Constructivist theory aims to identify how people acquire new knowledge (Merriam & Tisdale, 2016). Merriam and Tisdall (2016) recommended using basic interpretive qualitative research when seeking how people interpret their experiences, how they construct their worldview and meaning they attribute to their experiences. An example a study that used basic qualitative research include Kim (2014) which sought to uncover how Korean retirees engaged in transitioning into a post retirement career. Similar to Kim (2014), I too was wanting to investigate counselling professionals' knowledge on using play interventions and applying it to teaching resiliency.

Basic interpretive qualitative research was suited for this study as I strove to better understand helping professionals' perceptions of, and experiences with, using developmental play interventions. A basic interpretive qualitative approach, can be used to investigate how individuals interpret their experiences, construct their worlds, and the meaning to which they attribute to these experiences (Merriam & Tisdall, 2016). The purpose of the study was in Merriam an Tisdall (2016) recommendations when using basic interpretive qualitative research. Data was collected through interviews, and analyzed inductively to answer the research question (Merriam, 2009). Findings were the recurring themes that emerged from the data (Merriam, 2009). The goal of identifying these recurring themes that emerged in the data was to enhance current knowledge on the process helping professional go through when using play based interventions.

Participation Selections and Recruitment

Upon the University of Saskatchewan Ethics Board approval (BEH# 17-259), purposeful (i.e., choosing a selection of participants that share discoveries, understandings, and insights into the phenomenon; Patton, 2002) and snowball sampling (i.e., participants or other individuals who see advertisements passing on the advertisement and suggesting or recruiting other participants) were used to identify helping professionals who met the following inclusionary criteria: (1) has as professional designation that qualifies them to provide therapeutic treatment; (2) has children clients (4-12 years of age) and uses play interventions when providing therapeutic support; and (3) willing to share their thoughts and experiences of using play intervention and the process they use to foster positive adaption in children. The recruitment process included presenting the proposed study to ethic boards in various school divisions, health regions, community organizations, and private practices that employed helping professionals. This was done by making phone calls, sending emails, and presenting posters to these various institutions. Posters were also given to licensed practitioners who contacted the researcher expressing interest in the study. In addition, various educational and health licensed practitioners also identified and suggested other helping professionals who use play as part of their practice who may want to be part of the study. Prospective participants contacted the researcher if they were interested in participating in the study.

Data Generation

Collecting data using basic interpretive qualitative research is about asking, watching and reviewing information that is explained in common everyday terms (Merriam & Tisdale, 2016; Wolcott, 1992). However, since there is the possibility that data can be misleading to the

researcher, it is important that there is continuous ongoing analysis of data to limit the risk of data being unfocused, repetitive, and overwhelming (Leedy & Ormond, 2005; Merriam, 2009). Participant recruitment was halted when data saturation was achieved. This was determined when the researcher recognized that there was enough information to replicate the study (O'Reilly & Parker, 2012; Walker, 2012), new information was not being obtained (Guest et al., 2006), and when codes were beginning to be repetitive (Guest et al., 2006).

Interviews. Before the interview process began there was a pre-screening interview. In this interview, participants self-reported their professional experience and current professional role to determine whether they met the inclusionary criteria. This information was trusted by the researcher since helping professionals are typically held to a professional code of ethics, and if they were to provide misleading information they could be practicing in an unethical manner within their profession and be held accountable if reported (e.g., Canadian Psychological Association, 2017).

Two interviews took place that were approximately 1 to 1 1/2 hours in duration. A recording device was used to preserve each participant's story. The interviews took place in professional but confidential locations (i.e., participant's office, library study room, or classroom). During the first interview, participants were provided with a consent form describing the purpose of the study and were reminded: their consent was voluntary, they may ask to have the recording device turned off anytime, they will not disclose any confidential information, the name of the institution at which they work would not be released, they will still follow their profession code of ethics, and that they may ask to withdraw from the study prior to data analysis.

The first interview was conducted in a semi-structured format. The questions were based on issues and themes arising in the research literature on the process of positive adaptation, resiliency and the use of play interventions. The questions were worded in a flexible way that gave the counselling professional the opportunity to respond to the research question but also add meaning to their response (e.g., by providing examples, discussing related questions, etc.; Merriam & Tisdell, 2016). Probing questions were designed based on understanding how play promotes factors of resiliency. Factors that are identified to promote resiliency include: 1) creating a loving and trusting relationship; 2) having an encouraging support system; 3) making realistic plans; 4) developing communication skills and problem solving; and 5) capacity to manage strong emotions and impulses (APA, 2018). The aim of having these probing questions was for participants to provide a range of responses and reflect on their personal experiences with the intention of answering the research question (Merriam & Tisdell, 2016).

The follow up interview was typically one hour in duration. In this meeting, the researcher and each participant reviewed the transcribed data. This review gave each participant the opportunity to add, delete, or change any portion of the interview they desired. Pseudonyms were used for the participants, and any personal information was removed from the transcript to protect participant identities. Participants then signed the transcript release form and were encouraged to ask follow-up questions they may have had related to the interview.

Data Analysis

Merriam (1997) described data analysis as “the process of making sense of the data” (p. 175), which includes the researcher consolidating, reducing and interpreting data in an effort to create meaning from the data. The data produced from each of the interviews was analyzed

using a basic interpretive approach (Merriam, 2009). Further, this data was viewed and understood with the resiliency perspective discussed earlier. Specifically, thematic analysis was used "... both to reflect reality and to unpick or unravel the surface of 'reality'" (Braun, & Clarke, 2006, p. 81).

The data was analyzed to identify patterns and reoccurring themes across the data set (Merriam, 2009). Braun and Clarke (2006) suggested six effective phases occur throughout the analysis process. The first phase of data analysis is *familiarizing yourself with the data*, which consists of reading, transcribing and re-reading the ideas about the data (Braun & Clarke, 2006). During this phase, the researcher immerses him or herself in the data and repeatedly rereads it in order to be actively engaged in the themes that are emerging. In the second phase, *generating initial codes across the entire data set*, data was selected from the transcript and categorized into the codes (Braun & Clarke, 2006). The codes were based off the participants' responses related to how they perceived and used play interventions to help teach positive adaption. The third phase, *searching for themes*, involved grouping codes into potential themes. The key tenants of the resiliency framework were referenced when grouping codes from the participants' responses (e.g., resilience typically arises from common adaptation systems rather than rare or extraordinary processes, these common adaptation systems are the product of a history of biological and cultural evolution that give individuals adaptive functioning tools, etc.; Masten & Powell, 2003). Themes that emerged were common components that all participants used to promote resiliency within their clinical practice. The fourth phase, *reviewing themes*, consisted of identifying themes that were cohesive with one another and consistent with the initial codes that were first determined by the researcher when working through the data set (Braun & Clarke,

2006). The fifth theme, *defining and naming themes*, involved the researcher looking at what the essence of each theme means. This was done by going back to the collected data, organizing the themes into a systematized order, and making sure that the themes were consistent and cohesive with one another. The sixth phase, *producing the report*, involved recording the write up of the thematic analysis and providing sufficient evidence of the findings.

Analyzing data in this way provides flexibility as it allows for helping professionals to describe some of their perceptions of play and some of the reasons as to why they chose to use developmental play as a therapeutic modality when working with children who have emotional and behavioural troubles. In addition, the flexibility of this approach gave the participating helping professionals the opportunity to explain how they have seen developmental play teach children positive adaptation skills. This was in line with resiliency theory since this study explored how helping professionals' perceptions and experiences using developmental play to influence and expand children's coping skills.

Trustworthiness

Trustworthiness in research is based on the idea that there has been rigor in carrying out the study to ensure that the results found could be trusted and grounded within the data (Merriam & Tisdall, 2016). Components of ensuring gathered data can be considered trustworthy include: creditability, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility. Credibility involves establishing that research results are believable or that the data were congruent with reality (Lincoln & Guba, 1985; Merriam & Tisdall, 2016). Studies that are creditable have multiple perspectives of data interpretation to support accuracy of the data. For example, credibility within this current study was practiced by having two interviews,

an initial interview and the post interview. The first interview gave participants an opportunity to collaborate with the researcher and have their voice heard when describing how they support children clients through play. The second interview in particular gave the helping professionals the chance to clarify any misinterpretations and reiterate any misinterpretations that the researcher had during the first interview and rephrase any information. The length of the interviews gave participants to have a sufficient amount of time to express their experiences in a detailed way. The participants were given the opportunity to judge the credibility of the data they provided.

This study used findings and interpretations of human sources that have experienced the situation that is being researched (Krefting, 2015; Lincoln & Guba, 1985).

Transferability. Transferability refers to whether the findings of the study could be replicated again in qualitative research (Lincoln & Guba, 1985). It is the reader who determines if transferability occurred based on the descriptions provided within the study (Merriam, 2009) In order to provide the reader with such insight, the study contained a detailed description of the participants' background, and direct quotes from the participants' responses.

Dependability. Dependability aims to verify whether the raw data collected matches the study's findings (Moon, Brewer, Junachowski-Hartly, Adams, & Blackman, 2016). It is the reader who makes the decision of whether the study was dependable (Moon et al., 2012). To ensure dependability occurs the researcher could do the following: journaling, field notes, reflexivity (self-assessment), and memos. Dependably within this study was practiced in two ways. First, was the researcher used reflectivity when analyzing the data and determining results. The researcher spent a little less than a year reviewing participants' responses to self-assess if the

findings were dependable. The second was the researchers' use of field notes. The researcher would record thoughts about the study, possible results and interpretations of the participants' responses on the study. Notes were also recorded in a journal that made connections of the study to the researcher's occupation.

Confirmability. Confirmability consists of the researcher remaining neutral when interpreting the data collected (Shenton, 2004). The researcher must demonstrate that the results are clearly linked to conclusions ways that can be followed, and replicated. Based on the Braun and Clarke (2006) thematic analysis, and field notes collected during data collection, it was interpreted by the researcher that participants shared experiences that could be developed into themes. Field notes were used for helping the research organize thoughts and rationalize decisions throughout the research process.

Ethical Considerations

The University of Saskatchewan Ethics Board reviewed the research application for this study to ensure that ethical research would occur. Participation in this study was voluntary. Before the interview process began there was a pre-screening interview. The researcher explained to the participants their rights to confidentiality, that pseudonyms would be used, and that any identifying information they disclosed would be altered or removed to help ensure they would not be able to be identified. During the first interview, participants were provided with a written consent form describing the purpose of the study and reminded that their consent was voluntary, and they should not to disclose any confidential information related to their counselling practices. Further the institution at which each participant worked would not be released and that they should follow their professional code of ethics. The participants' consent

to participate in the study was verbally reviewed during the follow-up session. The researcher's and supervisor's contact information was provided on the initial consent form, of which the participant were given a copy, to ensure they could contact them to answer any questions that arose during the research process. If participants withdrew before or during the interview sessions, they were asked to notify the researcher verbally or in writing and reminded they did not need to provide an explanation, and any verbal or written data that had already been recorded would be destroyed and excluded from the study prior the data analysis process. Once the data analysis process was completed, participants' data would not be able to be removed from the study.

The data was kept on a password-protected memory stick and within a closed folder to prevent any document losses and protect the data in the unlikely case the memory stick was misplaced. Data was stored separately from the participant consent forms. The audio recordings were stored on a password-protected memory stick by the researcher and will be stored in the thesis supervisor's (Dr. Laureen McIntyre's) office in a locked cabinet for the prescribed five years. Files on the memory stick will be deleted following the five years; the written documents will also be shredded at this time. The data on the memory stick will be deleted using a program that does not permit recovery of the data.

Chapter 4: Results

This chapter introduces the four counselling professionals who participated in the study and outlines their thoughts toward and experiences using play interventions in the therapeutic process to foster positive adaptation.

Participants were assigned pseudonyms to protect their confidentiality. Quotes from participants were often edited to increase the clarity or coherence of the statements and protect confidentiality. For example, names of people, groups, institutions or organizations mentioned by participants were altered or omitted, and repetitive words or statements (i.e., umm, so, you know, like) were removed.

Participants

Five participants responded to the researcher's advertisement. All five participants used play based interventions in a therapeutic context. However, one of the participants was unable to attend a follow up meeting. Therefore, only the data of four participants was used within the study. The first participant was Laura. She is a Clinical Psychologist who provides counselling services to individuals and families in Saskatoon's urban center population. Her main cliental consists of children who are in the foster care system or individuals with intellectual disabilities. She frequently supervises provisional psychologists who are specializing in counselling psychology. She has been using play within her therapy practice for over 20 years. She graduated from a Western Canadian university with a Doctorate of Clinical Psychology about 18 years ago. Laura explained that she uses play in counselling as a chance to connect with kids at their level, build rapport, and create a comfortable environment during the whole process of counselling.

Lucy was the second participant to be interviewed. She is a Canadian Certified Counsellor and provides counselling services within rural Saskatchewan as a school counsellor and in private practice. She had been using play based interventions for over seven years. She has numerous accreditations that support her counselling profession, including: a Bachelor of Arts degree in psychology, a graduate certificate in counselling, a Masters degree in counselling psychology, post Master's degree certificate in psychology, and a Doctoral degree in Educational Psychology. Lucy described counselling in general to be a form of play, since toys, drama, and games are incorporated to help children under 13 years of age interact and communicate with the world.

Jen, the third participant, currently works as a counsellor within a rural school division in Saskatchewan. Before being a counsellor, she worked 5 years for the government in the areas of child protections services, youth corrections and reviewed various policies that were aimed to protect children. She has a Bachelor of Social Work degree, and recently completed a Masters of Social Work degree with a counselling specialty. Jen defined play interventions as a way to connect with children at their level in order to make it a playful experience. She felt that to be successful within play one has to be willing to be playful when engaging in a relationship based around play (i.e., similar to using talk based therapy when building a rapport with an adult).

Maria, the fourth participant, is a counselling psychologist. She has worked as a counselling psychologist since she completed her Master of Education degree approximately 20 years ago. She currently works as a school counsellor and in a clinic as a private practitioner. Maria was an art teacher before she began her counselling career. In her practice, she focuses on children with mental health struggles. Maria defined using play interventions as strategies or

activities that invite the child to participate and express themselves in a natural, self-guided or direct way.

The participants in this study described their thoughts and experiences using play based interventions as a way to assist the children and youth with whom they work to overcome the obstacles they face in their lives and move them toward positive adaptation. Three major themes were identified as participants' stories were reviewed: (1) Learn The Steps: Teaching The Prerequisites of Self-Regulation; (2) Build Your Skills: Enhancing Self-Awareness and Resiliency Through Play; and (3) Change Takes Time: Trusting the Play Process. These themes are ordered numerically for organizational purposes (i.e., numbering does not indicate rank or level of importance), and are discussed and linked together using meaningful quotes from the participants.

Themes

Theme 1: Learn the steps: Teaching the prerequisites of self-regulation. Participants shared how they play various games with their clients to develop self-regulation skills using direct or indirect play, and emphasized the importance of the relationship regardless the type of play they are using. For example, Lucy and Maria teach prerequisites at the beginning of therapy by being more direct with clients as to what types of play they are going to do. As Lucy shared:

I pre-normalize things for them. When a child comes into my office for the first time, I talk about using art as a way to make a map of their life. I'll do little bit of drawing and they do describing their life if old enough.... I'll use crayons and construction paper to make a genogram. From there we play a game of Jenga, or something like that just to get kids familiar with the process and build a little bit of a rapport.

Jenga is a game she uses to enhance the relationship when first meeting with clients, since "You can see their facial expression, they're emotional, they are communicating much more than they

are intending too.” This helps her to have an understanding of where her client is currently functioning related to regulating emotions. Lucy gave an example of a timeline of that she uses when selecting games and activities with her clients at the beginning of therapy:

On the first day we work with Jenga, second day we work with puppets, third day sand tray, then on the fourth day they will come in, and have a sense of what there is and make an informed choice on what they need.

Maria’s main cliental are students who have behavioural troubles. Maria explained why she is more direct with clients during therapy:

My formal training is in Cognitive Behaviour Therapy, so I tend to be more directive in my approach to therapy. As a result, at times I will use play to model and teach strategies. Board games are an effective means to teaching many of the lagging skills that result in challenging behaviours, such as low frustration tolerance, turn taking, losing, impulsivity, etc. There are also games that teach self-control, such as Simon Says.

Maria explained that she picks the activities and games based on the clients. She prefers to give the child a game that will develop feelings of success, stating “...depending on who the client is, I will use toys and games. It may be a game that they can be successful at and not lean towards frustration. Sometimes depending on the stage I will push them into frustration.” She will directly point out the skills they are to be learning when playing, explaining:

I will identify the skills they are doing well when playing...you are listening, you are sharing, and you are following the rules....if I am working with older kids and using games, I will directly talk about the skills we are working on. Such as role modeling and playing to demonstrate skills. This helps them recognize ways to respond to situations.

On the other hand, Jen and Laura shared that they prefer to be indirect when first introducing them to play. Jen explained:

I prefer to be indirect when using play in therapy. ... because I like the whole concept of kids having... the developmental assists and the basic needs as there are so much stuff around problem solving and control, power and around autonomy.

Jen discussed the benefits of using indirect play in therapy, sharing that play:

Creates a sense safety that comes through establishing a relationship... the child knows what to expect in your space and interaction with you. And I find that has to be there before the kids will play with me in a way that is therapeutic and not just an opportunity to challenge things and...they will tend to be easily frustrated. They do all the things they do in the classroom if they do not have the skills to meet the situation.

She also shared an example of how she uses indirect play in counselling, stating:

With these kids you really have to give them a lot of support, you have to adapt the activity. Maybe that's a technique. I use lots of typical games that are playful and fun, but will recognize they need extra support...

Laura similarly embraced being indirect with her clients, explaining:

I like to give options and choice so they are using something in play that resonates with them. Like some kids love the Lego, but if I just present them with coloring, or the dolls, that does not resonate with them and it doesn't go very far.

Although Laura is indirect when playing in therapy, she will be direct with client when talking about issues. As she explained:

I often talk very explicitly about that stuff, and "that you are valued and that it's not your fault". Kind of talking them through that whole situation...even if they are not expressing it... I try to do that a little bit. And sit with them and talk about other kids I know that have been through things like these kids. Like I will say, "Someone who has been through something like this and feels like this about themselves... they think it's their fault, and you know what I learned when working with them, it is never the kids fault." So kind of... voicing stuff for them that they are thinking but cannot express.

In summary, the participants identified the importance of having a good relationship with their clients, while identifying their preferences in using direct or indirect play to teach self-regulation skills. The participants also discussed how they build on these skills and support their clients in becoming more self-aware.

Theme 2: Build your skills: Enhancing self-awareness and resiliency through play.

In the following theme, participants identified how they build clients' self-awareness, and use the client's self-awareness to support their resiliency. The participants had various approaches as to how they cultivate self-awareness in counselling sessions. Lucy, Laura and Jen gave examples of teaching self-awareness by reflecting or mirroring the child's play. As Lucy shared:

I work in some ways that are nonverbal. So much so that they are not able to talk about their feelings verbally, such as what they been through or are experiencing. So playing it out is another form of communication. But then I always ask questions like, "which toy is the most like you today?" Allowing them to think about the toys and in relation to themselves. And just to think about it differently. So thinking is behind communication... the best example I can give of is that I have these little Lego toys that go with my sand tray. They are super heroes. The boys, more so then the girls, end up playing with these superheroes. So I ask, "What is about the Hulk that you like? How can you be like the Hulk in your relationships with your brother? How can you be like the hulk with relationships"? With young girls they like the princesses, and yeah, and the baby toys. Like the little infant figure for the sand tray. They like to put it to bed and the very socialized maternal behaviours. And so I say things like, "You were a baby one time too. If you were a baby again, how would you want to be cared for?" questions like that.

Jen, similar to Lucy, wants to help children to be more self-aware, explaining that:

...maintaining and seeing the opportunities of working out problems [can happen] within the play. These opportunities can have therapeutic value. Sometimes it includes pausing and taking a moment. It helps by asking "notice how you feel about this?" Or talk about what is happening, like "Is that what you mean?" sometimes the child will have one puppet and I will have the other. I give my puppet a similar problem to what the child has. I will ask the child 'What would your puppet tell my puppet about how to handled this problem like some other problems?'

Laura explained that she teaches children self-awareness skills by identifying their interests and incorporating them into their play by following "...what they are enjoying...by using the toys and then things they are interested in". She also discussed how she does this in a clinical setting with a client who is not wanting to address an issue:

...some are the type of kid who does not want to talk about stuff, I'll sometimes ask when playing characters, "Hey Johnny did you do this?" I see if they can identify some of the issues and stuff we previously talked about. It helps to see if the learning is there at least and if they can verbalize what their characters have learned...It is a different thing being able to actually say it then using in the moment. But first is getting that cognitive understanding.

Laura recounted a story of how play helped one her young clients develop his self-awareness:

I had my character talk about what they have learned from their teacher or counselor when feeling anxious. When my character was modelling and experiencing having a panic attack or an angry outburst, they talked about using the techniques. ...and reaching out to their friend.

Maria also discussed how her approach to teaching self-awareness is "...age appropriate, but places these children in discomfort. These games are games of chance, such as checkers or war." This is done to help "...activate the frontal lobe and foster a flexible mindset." Maria expressed that when a child has executive functioning difficulties this often means that "...he or she is lagging behind [therefore] building social skills, self-control, and perspective taking is critical". She described some of the activities she uses to cultivate self-awareness, reporting:

[I do]...things in the office or what they were doing at home or what they are doing with peers. So whether or not we are going into gym together, playing basketball, Checkers or war...things that would be triggering their lagging skills. And then we talk about it, "how are you feeling now", "what are you telling yourself", "how are you telling yourself to be calm". And then we generate the feeling because now they are feeling it. I am not judging [how] they are feeling that way.

Maria also has clients identify how they are feeling:

[I use a] five-point scale for kids on [the autism] spectrum. It's a self-regulation tool. In a sense like zones of regulation but it's their own personal skills... same with Liana Lowenstien's work, called Butterflies in my Tummy. [It's a story that] kids connect with when feeling anxious or nervous.

Participants also discussed how self-awareness can lead to forms of resiliency. Positive psychology strategies, board games, activities with toys, or interactive stories surrounding safety

that are enjoyable to clients were commonly described as types of play to foster resilience. For example,

Lucy described how the game Jenga can play a role in developing resiliency, declaring: “Jenga is a good one for resiliency. You can explore if they knock the tower down and explore what that is like for them, and what the experience is like.” Lucy also described how playing with toys and making it relatable fosters self-regulation and safety. She then shared a story how playing out problems can help with self-regulation:

I had a little girl, at the school, she would have big melt downs. She was eight. Huge meltdowns.... together we worked a bunch of different alternative strategies that she can do. She and I brainstormed a bunch of different ways instead of banging her head against the desk.... We placed it (her strategies) on a poster board about a paper size. Her teacher had it in her desk.... One day... she was on the verge of a melt down and she chose to come outside to where I was with older students. She was really struggling. I think it was because her class earned reinforcement but she didn't, so she is having this disappointment melt down. After normalizing and validating her disappointment, I engaged her playfully and let her take photos with my big fancy camera. It was a way to show her that she is still a valuable person just because she did not receive the award. She took a picture of me and her teacher...at the end of the school year, I printed off all the photos...She said “I took this photo on the day I chose to talk to you instead of banging my head”.

Jen explained how interactive stories and games can “plant the seeds for better change”, stating:

I really feel like kids that are vulnerable, they can take a lot of steps forward. They have situations and context and experiences that set them way back. So I do not think they have a necessary developmental trajectory and we've launched them in this good direction and on course. I think it's more complicated than that. I am confident ...that if you find the right things to do with kids, they respond positively. That is what makes me confident in using play strategies. I think that play never hurts kids. It's how they learn and grow.

She went on to describe how she has used interactive play as a technique to help one of her young male clients build self-awareness to feel safe, sharing.

... he was just unchangeable. He was volatile, and out of control in grade 1. He had to be removed from the classroom, he had to be cut back to half days and have one on one support. ...When I was working with him for the first months of the school year, he was making good changes with me. He still wasn't able to go into the classroom setting, cope and use the skills. It took most... of the calendar year... his greatest need was blocking his ability to behave correctly, [to] be confident and learn. He had a lot of instability and threatening stuff happening outside of school. He did not know yet if school was as safe place. We did a lot of play around safe spaces, being held, reading stories of babies and animals being held...where bears find places to hibernate that would be safe. A lot of safety themes. He responded so positively when we played that stuff out. ...And this year...he has an EA [or Educational Assistant] floating in his classroom. He is there full days. He is not stabbing anyone with pencils.

Maria also shared how she encourages children to take risks while being in control of their actions. She explained that “many children feel out of control in their home and school environment. Having control in the therapy space tends to build self-confidence and the child becomes less defensive.” Maria described how she connects resiliency with self-awareness:

The kids I work with have challenging behaviours as a result of lagging skills in executive functioning. Therefore, building social skills, self-control, and perspective taking is critical. All these skills build resiliency – the flexibility to rebound back from discomfort. Many kids have a tough time tolerating discomfort – not having their way. Building flexible mindsets creates a willingness to take others perspectives and this helps for building resiliency.

Laura says that when she sees negative emotions arising during the play she will “try to coach them on ways to work through negative thoughts and start learning about positive thinking.” Laura also described some of the positive psychology strategies she uses to help with resiliency, including:

...getting them to think about gratitude, memories, or...to remember times when they were kind. Some of that positive psychology stuff is really helpful. It gets kids who are in a negative frame of mind to change into a positive mind and start that shift.

Laura felt that some of her clients are much more accepting playing character roles when handling hardship. She shared:

If the kid is like no, oh whatever, and pushing away, the work books, and then says “hey can I play with Lego?”, then I will join with that and then introduce the ideas that way

In summary, the participants identified play as a way to support self- awareness within clinics which influences their ability to be more resilient. They shared stories of how they have worked with their clients to develop self-awareness and resiliency skills in their clients. They also emphasized the importance of trusting the play process since learning positive adaptation can take time.

Theme 3: Change takes time: Trusting the play process. The participants each gave various examples that identified how positive adaptation takes patience. Lucy and Laura expressed how a trusting relationship between the therapist and client can serve as a form of positive adaptation. Maria, Lucy and Jen identified positive adaptation changes as how the child responds to conflict when playing.

Lucy and Laura viewed a trusting relationship between the client and therapist as a form of positive adaptation. Lucy explained, if they trust me enough to come to my office, and enjoy their time, that speaks volumes to the work. Especially for children who have attachment losses.” Lucy explained how “...just because I don’t understand what they are saying or playing in the sand tray, does not mean that they are getting nothing from being with me.” Lucy described how she uses assessment scales to record the therapeutic relationship and it’s relating to positive adaptation. She gave an example of how she records her clients’ positive adaptations when using play:

I use the SRS and ORS child versions. So you can see from that data how the therapeutic relationship is changing. It asks different things, like how about you and me today? How do you feel about your life? So you can monitor progress that way. And of course you can verify by using the parent and teacher report. To some extent there is less of a science

to it, but you can see progression in the way that kids play. So for example, a kid who, I had a little girl whose brother died. She was six. When she came in, a lot of her play was very much, repeating the way he died with the toys. And after 4 months of coming to see me every other week, she came in and said she wasn't going to do that anymore. Instead she was able to think about him remember him... without fixating. Grief work was the easier process to observe. But if you pay attention to how kids are playing you should see a shift.

She went further to describe her perspective of adaptive skills:

One of the biggest things that I used to gauge with is whether or not the kids enjoy coming to counselling. It should be something they enjoy. That's from the whole positive psychology piece. So if all I am doing is building a positive relationship with them and that's it, and we play toys that are not "therapeutic," as if there is such a thing as non-therapeutic, especially when it's done with a trusted adult or helper, so whether or not they enjoy, is a big thing. Umm, and I think about that in terms of adaptive ability and think about skills that they are learning and developing. Especially when I see students who have trauma or attachment difficulties. Just building a healthy relationship with someone is enough for me to think that that the work is beneficial. I mean if the relationships are damaged and the kids cannot enjoy their time spent with me as counsellor, then, we start looking what else might help.

Laura explained how valuing the relationship with the client helps positive adaptation by explaining how "... a good relationship makes them feel like they have power, and that you care about their opinions, many of these kid's experience having adults who are very controlling and directive". By valuing the relationship Laura can help "them see their value. And to coach them through those negative thoughts." Laura identified the frustration that can be felt when immediate change in a child's behaviour is not being observed:

I often feel the frustration of caregivers; they will tell me what I should do to prevent a young boy from hitting someone at school. It leaves me thinking if whether therapy is working? I have to go back and reflect on how 'there was this factor, this factor and this factor' that can cause stress...like his [a client's] brother got to visit his dad, but he didn't. External and situational things like that cause stress. But it does not really mean that therapy is not working right? And it's a slow process.

Jen, and Maria identified that change happens when a child responds in healthier ways to problems that have been presented when playing. Jen explained how she identifies a child is on their way toward improvement:

It's what the children do with the play. You can expose kids to experiences that are meant to adaption skills. But until they are in a narrow physiological state, where they can really practice those skills, it is not necessarily going to happen for them. It does not mean it's ineffective or you did not find the right angle. It's just that they are not ready to use the skills.

Maria explained how "...play items calm that system down [the child] and allows the kid to express more freely. Certain play items also give the child an opportunity to move around if needed." She further elaborated:

I can see improvement...it shows in their play. You know that when I am no longer sitting with a 10-year-old child that is using his finger to explain the stuff that is going on in his life... instead comes ready to play a game of cards.

In summary, the participants identified that positive adaptation begins with a positive relationship between the client and the therapist. As Laura discussed, a good relationship makes a client feel valued and can lead to positive adaption.

Summary

Participants revealed experiences of how they use play to support positive adaption. Three themes emerged during the data analysis that identified various approaches counselling professionals use: (1) Learn The Steps: Teaching The Prerequisites of Self-Regulation; (2) Build Your Skills: Enhancing Self-Awareness and Resiliency Through Play; and (3) Change Takes Time: Trusting the Play Process. The final chapter gives an overview of the study's findings and discusses participants' experiences related to play and positive adaption in connection to existing

research, practical implications, limitations and strengths of the study, and areas for future research.

Chapter 5: Discussion

Summary of Findings

The objective of this study was to understand how counselling professionals use play to foster positive adaption within children who experience adverse circumstances (i.e., how play in a therapeutic context can help children learn to be more resilient). The research question that guided the study was:

1. What are counselling professionals' thoughts toward, and experiences of, using play intervention in the therapeutic process to foster positive adaption?

The experiences of Lucy, Laura, Maria and Jen were captured with quotes and shared through the study.

The first theme, entitled *Teaching the Prerequisites of Self-regulation: Direct or Indirect Play*, highlights the importance of providing children with opportunities to safely recognize and manage their own stress levels. Participants shared that a child can learn this skill by playing in a safe space where he/she is supported by a caring adult. There were two preferences between indirect and direct play when forming the relationship. For example, Lucy explained that she is direct when forming the relationship. She aims to pre-normalize her clients to therapy by doing genograms, coloring, and then playing Jenga. She does this to assess her clients' reactions when "things" do not go their own way. Lucy and Maria felt playing games and spending time with a loving adult who addresses their stress helps children learn self-regulation skills. On the other hand Jen and Laura preferred to be more indirect when first working with a client. For example, Jen explained being indirect establishes a sense of safety.

Participants identified how positive adaption can be facilitated by helping a child learn

how to make an informed choice. They shared when a child is supported by a caring adult they trust, they then can learn strategies to make informed choices. For example, Jen explained that when she is playing with clients she will focus on games that are typical and fun, but will take time to recognize when the child needs extra support, or pauses and takes a moment to reflect on what is happening. She explained how she uses typical games that are playful and fun, but recognizes that some children need extra support. Or pause and take a moment. The participants also described that playing with concrete objects and role playing can help children make informed choices. For example, Maria shared how she will use play to role model the strategies of self-regulation with children who have low self-control. Laura gave the example of having children play with toys that resonate with them, but she will be explicit in telling a child that they are valued and “talk them through the whole process, even if they are not expressing it”.

The second theme that emerged, entitled *Build Your Skills: Self-Awareness and Resiliency*, highlights the importance of giving children opportunities to practice self-regulation strategies through play to support their resilience development. Participants shared ways to cultivate self-awareness through playing at the child’s level. Lucy, Jen and Laura shared examples of playing out the child’s feelings that resonates with them. For example, Lucy explained how for some work in a non-verbal way, and instead uses play as another form of communication. She explained how some are not able to talk about issues bothering them. Maria on the other hand plays at the child’s level but works towards placing the child in a state of discomfort. She gave the example of playing out a situation that can be trigger emotions.

The participants made connections of how self-awareness can help a child become resilient. Lucy gave the example of Jenga. She viewed that when knocking down the tower while

playing was, it is chance for the child and counselor to explore what the process was like for the child. Lucy also shared the story of a young girl creating her own art piece about self-regulation strategies on a poster board. She explained how “we worked a bunch of different alternative and strategies that she can do...bunch of different ways instead of banging her head against the desk...” The young girl followed through with her plan when she began to recognize she was feeling stressed. Jen gave the example of role playing interactive stories can plant the seed for better change. She explained how change may not happen right away because of their “developmental trajectory” but it can launch them in the right direction. Jen shared the story of playing with a young boy and incorporating themes related to safety. She described how, “We did a lot of play around safe spaces, being held, reading stories of babies and animals being held...” Maria explained how she connects self-awareness to resiliency. She explained that she works with her clients on ways to bounce back from discomfort, which builds resiliency. Laura explained how she teaches positive psychology strategies to support resiliency, such as teaching them about gratitude, and having a flexible mindset. These are strategies that can help establish a positive mindset.

The third emerging theme, entitled *Change Takes Time: Trusting the Play Process*, highlights the importance of trusting the play process. The participants provided examples of how change takes time. Often clients may not possess self-regulation skills, or immediately show self-awareness, when he or she is feeling stressed. The participants had either one of the two opinions when identifying stages of positive adaptation. Lucy and Laura identified positive change occurring when a child enjoys coming to therapy and playing. Lucy shared the examples of the sand tray and how just because she does not understand what the child is playing, it does

not mean that the therapy is not working. She also provided the example of using evidence based assessments in regards to the developing relationship. On the other hand, Jen and Maria identified positive change happening by how the child responds when playing with the therapist. This helps children recognize that the trusting adult will still care about them even if they have an emotional outburst in the therapy room or elsewhere. Based on the participants' observations of how play fosters positive adaption, the following section integrates participant's response with current studies. The participants' responses are integrated into themes that connect with current studies.

Integration of Findings with Existing Literature

Findings that emerged from the three main themes can be related to research literature within the following areas: developing self-regulation skills, play that increase self-awareness skills in connection to resiliency (e.g., using toys and games, indirect and direct play, etc.), and playing at the child's developmental level in order to promote positive adaptation. The participants highlighted three main strategies that can be used to build a child's self-awareness skills in order to support positive adaption: (1) recognizing when to be direct or indirect while forming a relationship; (2) playing at the child's developmental level to support self-awareness and resiliency (3) ways to identify positive change.

Direct, indirect play and the relationship. Participants expressed the importance of a strong relationships and forming the relationship through direct or indirect play interventions. There was a mix between participants' preferences of when to use direct or indirect play when teaching self-awareness based on the types of clients with whom they work. Lucy and Maria discussed direct play as the preferred form of play when working with a child who has executive

functioning difficulties. Each recognized that children with behaviour problems may not have the executive functioning skills to be self-aware. By giving them direction on alternative ways to work through stress, they are teaching self-awareness. Direct play included using board games or pre-planning what skills would be worked on with the child. The participants' preferences as to why they preferred direct play with these clients are similar to the findings of Mastrangelo (2009), DelPo and Frick (1988), and Benson (2013). These studies all described that direct play helps the child client learn socially appropriate behaviour through modeling and promoting. Playing board games, or games that require creativity and directing helps therapists gain access into children's emotional regulation, which helps to identify where they need help in regulating their emotions (Benson, 2013).

Indirect play preferences were used by the participants who focused on having children take charge in therapy. For example, Jen and Laura explained that they predominantly work with clients who have attachment and/or anxiety disorders. Therefore, they wanted their child clients to pick toys that are meaningful since this fosters trust and safety. That is, expressing their preferences enables a child to be free in how they want to respond while playing (Shaefer & Drewes, 2012). Participants specifically talked about giving children an opportunity to take control. In other research literature, learning how to take this control in an indirect way when playing has been linked to reducing anxiety and post-traumatic stress (Bennett, 2000; Moore & Russ, 2004, 2006). Specifically, Fisher's (1992) meta-analysis found frequently engaging in pretend play can significantly affect emotional regulation. The participants in this study emphasized that the play has to be enjoyable while giving them an opportunity to gain something

therapeutic from the play. If that occurs, then the negative emotions can reduce (Barnett, 1982; Mosavi & Koolalee, 2017; Shen, 2012).

The participants emphasized the importance of relationship regardless of using direct or indirect play. Lucy explained her process of having the child become comfortable within therapy. Maria is selective in how she will direct her clients because of the relationship. Jen and Laura are indirect in play because they want to foster the relationship and establish a sense of safety. Laura however will explicitly talk about issues openly while reminding the child they are valued. Using the relationship to establish a sense of comfort is similar to Hutchby's (2005) recommendation for attentive listening. Laura discussed that she is explicit with children about issues and talks with them through the process. She found this technique to be beneficial when voicing concerns that cannot be expressed. This was against Hutchby's (2005) recommendations of avoiding direct questions and conversations if suspecting struggles at home. Hutchby did recommend the importance of listening and empathy, which helps the child become more willing to talk.

Play at the child level to support self-awareness. The participants identified that playing with various toys or games in a supportive environment helps to foster a child's self-awareness skills. Specifically, supporting an individual's self-awareness skill development can help him/her identify his/ her triggers (Greene, 2008). As Pearson et al. (2016) explained, the first step in identifying healthy coping strategies for an individual is for him or her to be self-aware. For example, if an individual is able to recognize when they are feeling overwhelmed he or she can be taught healthy coping strategies to calm down. Existing reviews of the literature have found that supportive environments with engaging toys promotes self-awareness (Bronson

& Bundy, 2001; Fallon, Fallon, & Sibobban, 2013; Marcelo & Yates, 2014). In addition, Fallon and Sibobban (2012) found that children in adverse circumstances are more likely to engage in non-play behaviours when not being in a supportive environment. However, once a child is self-aware of their emotional reactions, therapists can work on helping him/her to learn coping strategies (Greene, 2009).

Participants provided examples of how self-awareness helps foster resilience in children. When a child is aware that he or she is stressed, he or she can use coping strategies learned in counselling. Identifying stress and working through it is an example of showing resiliency (Bradberry & Greive, 2009; Masten, 2000). Maria gave the example of walking children through triggering situations. She did this as a way to plan alternative ways of how to respond to stress. Franke and Giest (2004) expressed similar results within their study. They identified role playing social situations helped a boy with ASD learn how to communicate more effectively when feeling over whelmed.

Change takes time. The participants touched on how they identify positive adaption. Laura and Lucy evaluated positive adaption based on the relationship with clients. Specifically, establishing a strong relationship with the child, fostering a sense of safety and trust, and giving the child opportunities to be in control will help him/her be more resilient. Building a strong relationship with a therapist has been found to help the professional recognize a child's developmental capabilities (Greene, 2008). Once this relationship is developed, the participants shared that they typically began to see the outcomes of therapeutic play. Lucy gave the example of using ORS and IRS scales to evaluate the relationship. Based on these scales, if the child is enjoying therapy typically there is improvement. Laura explained that external factors in life

happen, which can create setbacks. She identified however that a strong relationship gives a sense of power regardless of what is happening in the child's life.

Maria and Jen evaluated positive change based on how the child evolves when playing in counselling. Jen used the example of assessing change through play by what the child client does when playing during counselling. She explained that change may not happen right away outside of therapy, but when it changes in therapy he or she is improving. Maria provides an example of how she saw positive change in the way she played with a 10-year-old boy. The change may not happen until they are at a developmental state where they can apply it in real life. The Waelder (1932) study provided similar results. The author described that playing out situations over and over again helps prepare children for ways of responding to situations. Further, planning and visualizing ones response to stress has been documented an effective strategy when dealing with stress (Bradberry & Grieves, 2009; Greene, 2008). Playing out a response can serve as a form of visualization for children (Schaefer & Drewes, 2012).

The participants identifying that positive adaption takes time has also been found in other research studies (e.g., Baggerly, 2004; Greene et al., 2004; Steele, 2010). For example, Baggerly and Parker (2004) found that when a play therapist acknowledges children's struggle and efforts, children develop feelings of pride and motivation which fosters a sense of capability to do well. Greene et al (2004) investigated how collaborative problem solving between an adult and a child (i.e. having a conversation of why a child is easily triggered, and what to do) improves dysregulated children's response to stress. While Steele (2017) discussed how children with a history of trauma may respond to stressful situations using the only coping mechanism they know, which includes internal (i.e., negative self-talk, period of depression) or external (i.e.

yelling, running away, aggression etc.) behaviour. This is similar to Laura's comments on how she has used play in a way that resonates with the child and to work through strategies of how he or she can respond to stress.

Green (2008) and Perry (2009) identified that children will cope with stress in more resilient ways when they have the skill set to do so. These research findings were similar to the observations made by the participants when connecting with ways that are developmentally appropriate and that foster resilience. For example, Jen explained that "until a child is in the narrow physiological state where they really can practice those skills, it's not going to happen." Learning resiliency in this form is aligned with the positive psychology discipline which identifies that when people are supported by others, it helps with their ability to flourish to the full capacity (Duckworth, 2016; Gable & Hadits, 2005; Seligman, 1999).

Strengths and Limitations

As with any research, the current study has its strengths and limitations. Potential limitations in this study, included using a single methodology for collecting data, participants not having formal certification within play intervention, and only having female participants. The first limitation was only using a single methodology of collecting data was the semi structured interview. Conducting observations or asking for data from the counsellors would not have been appropriate for this particular study due to time constraints. Counsellors are supposed to abide by confidentiality and not release any information about their clients. Further if observations and data were part of the study methodology, the participants would have to seek parental consent. This would be very time consuming, and potentially cause hesitation when participating in the study.

Various strategies were used to establish credibility in the study, therefore making the single methodology valuable in collecting data. These included: (1) using multiple data sources, as each participant had one initial interview and one follow-up interview; (2) the length of each interview and time between interviews, so as to relieve participants of initial anxiety and make participants more comfortable in sharing their experiences honestly; (3) comparing and cross-checking of data with relevant literature at different times.

A second potential limitation was that only four participants (two direct and two indirect play intervention therapists) were interviewed, and none of them had a formal certificate identifying them as a play specialist. However, all of the participants had experience using play in their therapeutic practices and were repetitive in their perspectives of how play fostered positive adaptations. When there were conflicting viewpoints, participants were split within their perspectives (i.e. Laura and Jen preferred indirect play at the start of therapy, opposed to Lucy and Maria who were more direct). Decisions as to whether data saturation has been reached are commonly based on the researchers' sense of what they are hearing within the interviews, this decision can therefore be made prior to the coding and category development (Saunders et al., 2018). Further, the therapists received training in play interventions through practice, supervision, readings and courses.

The third limitation was that no males were included within the study. No male therapists responded to the recruitment posters. However, these counselling professionals represented diverse training and years of experience using play regularly within their practice. Overall, the participants could provide examples of how they were successful within their practice of using

play interventions. Future studies should strive to include both male and female perspectives to explore if gender can influence counsellors' perspectives related to using play interventions.

Two strengths emerged from the study. The first strength was that the study provides an answer to an identified research gap. As previously discussed Shaefer and Drewes (2012) explained that there were few process studies that identify mediators within play and therapy that result in desired change for client. The study answers this gap within the second and third themes. The second theme identified that playing various games (i.e., Jenga, role playing etc.) and making connections to how the child reacts enhances self-awareness. Learning self-awareness can serve as a mediator when helping one become more resilient (Duckworth, 2016; Hammon, 2015).

The second strength within the study was how it provides a range of approaches, techniques, and suggestions that counselling professionals can use when providing children with play interventions. The participants' provided examples for other helping professionals (e.g., teachers, counsellors, occupational therapists, etc.) as to how play interventions can be used within their own professional practice. A personal example that occurred is that the elementary school that I am working at is now incorporating 50 minutes a day of play time from kindergarten to grade 8. The purpose of this time is to help students learn self-awareness, self-regulation, and develop positive relationships with their teachers.

Further, each participant provided a rationale as to why they prefer to use direct or indirect play. Based on the counselling professionals' preferences, and/or client they are working with they select whether direct or indirect is more suited to their approach, as long as they are focusing on a good relationship with their client. Another example of a technique that was

suggested was Laura's example of explicitly talking about a situation when using indirect play. Hitchby (2005) recommended for therapists not to use this technique as it was suggested to make kids feel hesitant to opening up to therapist. Laura however found it to be beneficial as it provides a supportive voice in a child's life that they may not have otherwise.

Implications for Practice

The results of the study are applicable to other helping professionals who work with children in their practice (e.g., teachers, specialist, health care practitioners, etc.). This study shines a light on important concepts that foster positive adaption in children, including self-awareness, self-regulation strategies, allowing children to use play to explore, the power of therapeutic relationships, and the importance of playing at children's developmental level. When children can work on developing these concepts in a judgement free zone they can learn how to work through challenges and be more resilient (Greene, 2009; Pearson et al., 2016). Further, it provides an understanding that change does not occur right away when children are learning to be resilient. The participants believed that therapeutic play is making an impact as long as the child enjoys coming to therapy, and has a good relationship with the counselling professional (Hutchby, 2005; Perry, 2009, Selingman, 2007).

Implications of Future Research

Two main implications of future research emerged. The first has been that the study provides processes and techniques that counselling professionals can use when playing with children and work towards becoming more resilient. These results add to existing literature within play intervention research that focuses on play helping children work through adverse times (i.e. Baggerly, 2004; Delpo & Frick, 1987; Perry, 2009) with focus on the role of the

counselling professional. Given that there are limited studies that connect play and resilience, future research using quantitative studies incorporate assessment tools, like the IRS and ORS rating scale, as well as interviews with counselling professionals are recommended. The assessment results completed pre and post therapy can indicate whether there is growth in the child's wellbeing based on counselling professionals' response and assessment results.

The second implication for future research could consist of interviewing male and female helping professionals that have a certified play intervention training (e.g., Baggerly, 2004; Bratton et al., 2013). Having a certification within play therapy helps counsellors be aware of new knowledge forming in the counselling field, aware of potential harm, and attitudes and beliefs when supporting children (Corey et al., 2019; Shaefer & Drwese, 2012). It may difficult to find participants with formal play training, as finding proper supervision can be costly, and rare depending on the region the research is recruiting within (Shen, 2012). However, formally trained play intervention specialists may be able to address the question as to how to best determine when positive change is happening.

Conclusion

Findings from this study provide examples of how counselling professionals' perspectives and approaches to using play within therapy can help children to learn positive adaption skills (i.e., games that help children recognize their own behaviour, making informed choices when playing games, etc.). Believing in a child's capabilities, recognizing a child's current developmental level, and providing a child with support has shown to have the largest effect in helping children improve mentally, physically, emotionally and academically

(Selingmna, 2007). Ultimately when counselling professionals play with clients in a zone free of judgement, they can begin to help foster positive adaption through compassion and empathy.

References

- Al-Yateem, N., & Rossiter, R. C. (2017). Unstructured play for anxiety in pediatric inpatient care. *Journal for Specialists in Pediatric Nursing*, 22(1), 22-29. doi:10.1111/jspn.12166
- Anderson, J. A., Kutash, K., & Duchnowski, A. J. (2001). A comparison of the academic Progress of students with EBD and students with LD. *Journal of Emotional and Behavioural Disorders*, 9, 106–115. doi:10.1177/106342660100900205
- Asher, S. R., & Paquette, J. A. (2003). Loneliness and peer relations in childhood. *Current Directions in Psychological Science*, 12, 75–78.
- Axline, V M (1947). Nondirective therapy for poor readers. *Journal of Consulting Psychology*. 11(2) 61-69. <http://dx.doi.org/10.1037/h0063079>
- Axline, V. M. (1947). *Dibs in search of self: Play therapy*. New York: Ballentine Books.
- Baggerly, Jennifer, & Parker, Max. (2005). Child-Centered Group Play Therapy with African American Boys at the Elementary School Level. *Journal of Counseling & Development*, 83(4), 387-396. <https://doi.org/10.1002/j.1556-6678.2005.tb00360.x>
- Barros R M., Silver E J., Stien R E. K, (2009). School Recess and Group Classroom Behaviour. *Pediatrics Official Journal of the American Academy of Pediatrics*, 123(2)431-6. doi: 10.1542/peds.2007-2825
- Band, E. B., & Weisz, J. R. (1988). How to reel better when it feels bad: Children’s perspectives on coping with everyday stress. *Developmental Psychology*, 24(2), 247–253. <http://psycnet.apa.org/doi/10.1037/0012-1649.24.2.247>

- Bernard-Opitz V., Ing S & Kong, (2004). Comparison of Behavioural and Natural Play Interventions for Young Children with Autism. *The National Autism Society*, 8(3) 319-333. doi: 10.1177/1362361304045212.
- Besevegis, E., & Galanaki, E. P. (2010). Coping with loneliness in childhood. *European Journal of Developmental Psychology*, 7(6), 653–673. doi:10.1080/17405620903113306
- Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology - Research & Practice*, 36(4), 376-390. doi:10.1037/0735-7028.36.4.376
- Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive Behaviours. *International Journal of Play Therapy*, 22(1), 28. <http://dx.doi.org/10.1037/a0030318>
- Barnett L A., & Storm B. (1981). Play, Pleasure and Pain: The Reduction of Anxiety through Play., *Leisure Sciences*, 4(2) 161-175. <http://dx.doi.org/10.1080/01490408109512958>
- Brauner, C., & Stephens, C. (2006). Estimating the prevalence of early childhood serious emotional/ behavioural disorders challenges and recommendations. *Public Health Reports* 121(3), 303-310. doi:10.1177/003335490612100314
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi: 10.1191/1478088706qp063oa
- Bronfenbrenner, U (Ed). (2005). *Making human beings human: Bioecological perspectives on*

human development. Sage Publications: Thousand Oaks, California.

Burns M K., Warmbold-Brann, Zaslofsky, A.(2015). Ecological Systems Theory in School Psychology Review. *School Psychology Review*, 44(3), 249-261. doi: 10.17105/spr-15-0092.1

Calkins, S.D. (1994). Origins and outcomes of individual differences in emotion regulation. In NA. Fox (Ed.), *The development of emotion regulation: Biological and Behavioural considerations*, (pp.53-72). Monographs of the Society for Research in Child Development, 59(2-3, serial No 240).

Cantwell D P., & Baker L., (1988). Anxiety Disorders in Children with Communication Disorders: Correlates and Outcomes. *Journal of Anxiety Disorders*, 2(2), 135-146.
[https://doi.org/10.1016/0887-6185\(88\)90020-5](https://doi.org/10.1016/0887-6185(88)90020-5)

Cairns, Robert B.; Cairns, Beverley D.. *Lifelines and risks: Pathways of youth in our time*, Chapter ix, 315 Pages. New York, NY, US: Cambridge University Press, 1994.

Carroll. (2000). Evaluation of therapeutic play: A challenge for research. *Child & Family Social Work*, 5(1), 11-22. doi:10.1046/j.1365-2206.2000.00136.x

Crain, W *Theories of development: Concepts and applications 6th* Pearson Education, Inc. New Jersey 2011

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among qualitative approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Cochran, J. L., Cochran, N. H., Fuss, A., & Nordling, W. J. (2010). Outcomes and stages of

- child-centered play therapy for a child with highly disruptive Behavioural driven by self-concept issues. *Journal of Humanistic Counseling, Education and Development*, 49(2), 231-246. doi. 10.1002/j.2161-1939.2010.tb00100.x
- Corey, G. (2009). *Theory and Practice of Counseling and Psychotherapy* (9th ed.). Belmont, CA: Thompson Brooks/Cole.
- Corey G., Corey M S., Callanan P. (2015). *Issues and Ethics in the Helping Professions* (9th Ed.). Belmont California.: Brooks/Cole.
- Cordier, R., Munro, N., Wilkes-Gillan, S., & Docking, K. (2013). The pragmatic language abilities of children with ADHD following a play-based intervention involving peer-to-peer interactions. *International Journal of Speech-Language Pathology*, 15(4), 416-428. doi:10.3109/17549507.2012.713395
- Criss, M. M., Pettit, G. S., Bates, J. E., Dodge, K. A. and Lapp, A. L. (2002), Family Adversity, Positive Peer Relationships, and Children's Externalizing Behaviour: A Longitudinal Perspective on Risk and Resilience. *Child Development*, 73: 1220–1237. doi:10.1111/1467-8624.00468
- Coplan, R. J., Prakash, K., O'Neil, K., & Armer, M. (2004). Do you 'want' to play? distinguishing between conflicted shyness and social disinterest in early childhood. *Developmental Psychology*, 40(2), 244-258. doi:10.1037/0012-1649.40.2.244
- Council for Exceptional Children. (2011). Special Ed topics. The Voice and Vision of Special Education. Retrieved from <http://www.cec.sped.org/Special-Ed-Topics/Who-Are-Exceptional-Learners>
- Cross, M. (2004). *Children with emotional and behavioural difficulties and communication*

difficulties– There's always a reason. London: Jessica Kingsley.

Dalton T. (2005). Arnold Gesell and Maturation Controversy. *Integrative Physiological & Behavioural Science*, 40(4), 182- 204. doi:10.1007/BF02915215

Delpo, E. G., & Frick, S. B. (1988). Directed and nondirected play as therapeutic modalities. *Children's Health Care*, 16(4), 261-261.

http://dx.doi.org/10.1207/s15326888chc1604_3

Dekker M C., Nunn R J., Einfeld S E., Tonge B J., & Koot H M. (2002). Assessing Emotional and Behavioural Problems with Intellectual Disability: Revisiting the Factor of the Structure of the Developmental Behaviour Checklist. *Journal of Autism and Developmental Disorders*, 32 (6), 601-610. doi:10.1023/A:1021263216093

De Lorimier, S., Doyle, A., & Tessier, O. (1995). Social coordination during pretend play: comparisons with nonpretend play and effects on expressive content. *Merrill-Palmer Quarterly*, 41(4), 497-516. Retrieved from <http://www.jstor.org/stable/23087938>

Ebrahim, C., Steen R., & Paradise, L. (2012). Overcoming school counselors' barriers to play therapy. *International Journal of Play Therapy*. 21, 202-214.

<http://dx.doi.org/10.1037/a0029791>

Eisman, A. B., Stoddard, S. A., Heinze, J., Caldwell, C. H., & Zimmerman, M. A. (2015). Depressive Symptoms, Social Support and Violence Exposure Among Urban Youth: A Longitudinal Study of Resilience. *Developmental Psychology*, 51(9), 1307–1316.
<http://doi.org/10.1037/a0039501>

Endrerud, M. S., & Vikan, A. (2007). Five- to seven-year-old children's strategies for regulating anger, sadness, and fear. *Nordic Psychology*, 59(2), 127–134.

- Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science* (New York, N.Y.), 196(4286), 129-36.
- Erikson E. (1963). *Childhood and society*. New York: W. W. Norton & Company.
- Farmer, T. W., Lane, K. L., Lee, D. L., Hamm, J. V., & Lambert, K. (2012). The social functions of antisocial behavioural: Considerations for school violence prevention strategies for students with disabilities. *Behavioural Disorders*, 37(3), 149-162.
<https://doi.org/10.1177%2F019874291203700303>
- Fehr, K. K., & Russ, S. W. (2013). Aggression in pretend play and aggressive behaviour in the classroom. *Early Education & Development*, 24(3), 332-345.
Retrieved from <http://dx.doi.org/10.1080/10409289.2012.675549>
- Fisher, R. (1998). Thinking about thinking: Developing metacognition in children. *Early Child Development and Care*, 141(1), 1-15. doi:10.1080/0300443981410101
- Francke, J., & Geist, E. A. (2004). The effects of teaching play strategies on social interaction for a child with autism: A case study. *Journal of Research in Childhood Education*, 18(2), 125-140. <https://doi-org.cyber.usask.ca/10.1080/02568540409595028>
- Gable, S., Haidt, J., Candland, Douglas K., Baumeister, Roy F., & Simonton, Dean Keith. (2005). What (and Why) Is Positive Psychology? *Review of General Psychology*, 9(2), 103-110. DOI: 10.1037/1089-2680.9.2.103.
- Gall, M.D., Gall, J.P., & Borg, W.R. (2007). *Educational research* (8th ed.) Boston: Pearson
- Gaffrey, M.S., Barch, D.M., Singer, J., Shenoy, R., & Luby, J.L. (2013). Disrupted amygdala reactivity in depressed 4 to 6-year-old children. *Journal of the American Academy of*

Child and Adolescent Psychiatry, 52(7), 737-746.

<http://doi.org/10.1016/j.jaac.2013.04.009>

Gaffrey, M.S., Luby, J.L., Belden, A.C., Hirshberg JS, Volsch J, Barch DM. (2011). Association between depression severity and amygdala reactivity during sad face viewing in depressed preschoolers: an fMRI study. *Journal of Affective Disorders*, 129(1-3), 364–70.

Galyer, K. T., & Evans, I. M. (2001). Pretend play and the development of emotion regulation in preschool children. *Early Child Development and Care*, 166(1), 93-108.

<http://dx.doi.org/10.1080/0300443011660108>

George, C. L. (2010). Effects of response cards on performance and participation in social studies formiddle school students with emotional and behavioral disorders. *Behavioral Disorders*, 35(3), 200-213. Retrieved from <http://cyber.usask.ca/login?url=https://search-proquest-com.cyber.usask.ca/docview/877031541?accountid=14739>.

Gillaspie M. (2015). Teaching Play Skills to Young Children with Challenging Behaviours. Retrieved from Retrieved from ProQuest Digital Dissertations

Gove, W. (1994). Why we do what we do: A biopsychosocial theory of human motivation. *Social Forces*, 73(2), 363-394.

<http://web.b.ebscohost.com.cyber.usask.ca/ehost/pdfviewer/pdfviewer?vid=1&sid=f117513d-2e4a-4733-b873-8c986ef041e7%40pdc-v-sessmgr02>

Grey, I. K., Berzenski, S. R., & Yates, T. M. (2012). Coping in context: The influences of resource availability on coping effectiveness among emancipated foster youth. Paper

presented at the Society for Research in Child Development: Transitions from adolescence to adulthood themed meeting, Tampa, FL.

Graziano, P. A., Slavec, J., Ros, R., Garb, L., Hart, K., & Garcia, A. (2015). Self-regulation assessment among preschoolers with externalizing behavioural problems. *Psychological Assessment*, 27(4), 1337. <http://dx.doi.org/10.1037/pas0000113>

Gunter, L., Caldarella, P., Korth, B. B., & Young, K. R. (2012). Promoting social and emotional learning in preschool students: A study of strong start pre-K. *Early Childhood Education*, 40, 151 – 159. DOI 10.1007/s10643-012-0507-z

G.ncü, A., & Gaskins, S. (2006). An integrative perspective on play and development. In G.ncü, A. & Gaskins S. (Eds.), *Play and development: Evolutionary, sociocultural, and functional perspectives*. The Jean Piaget symposium series. (pp. 3–17). Mahwah, NJ, Lawrence Erlbaum Associates (xiv, 310).

Guralnick, M. J., Connor, R. T., Hammond, M. A., Gottman, J. M., & Kinnish, K. (1996). The peer relations of preschool children with communication disorders. *Child development*, 471-489. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/8625723>

Hallahan, D. P., Kauffman, J. M., & Pullen, P. C. (Eds.). (2009). *Exceptional learners an introduction to special education* (11th ed.) Allyn and Bacon.

Hill, M. (1999). What's the problem? who can help? the perspectives of children and young people on their well-being and on helping professionals. *Journal of Social Work Practice*,

13(2), 135-145. Retrieved from <http://cyber.usask.ca/login?url=https://search-proquest-com.cyber.usask.ca/docview/217592857?accountid=14739>

Hoffman J D., and Russ S W, (2016). Fostering Pretend Play Skills and Creativity in Elementary School Girls. *Journal of Aesthetics, Creativity and the Arts*, 10 (1), 114-125.

doi: 10.1037/aca0000039

Hong R., & Mason C M. (2012). Becoming a Neurobiologically-Informed Play Therapist.

International Journal of Play Therapy, 25(1), 35-44.

<http://dx.doi.org/10.1037/pla0000020>

Hong-Gu H., Zhu L., Wai-Chi C., Li W J., Li H C W., Ko S S... Wany W. (2014). Therapeutic Play Intervention on Children's Perioperative Anxiety, Negative Emotional

Manifestation and Postoperative Pain: A Randomized Controlled Trial. *Journal of*

Advanced Nursing 71(5), 1032-1043. doi: [10.1111/jan.12608](https://doi.org/10.1111/jan.12608)

Hortwitz S M., Leaf P J., Leventhal J M., Forsyth B., Speechley K. (1992). Identification and Mangement of Psychosocial and Developmental problems in community-based, primary care pediatric practices. *Pediatrics*, 89(3), 480-485. Retrieved from

<https://www.ncbi.nlm.nih.gov/pubmed/1371342>

Hutchby, I.(2005). "Active Listening": Formulations and the Elicitation of Feelings-Talk in Child Counselling. *Research on Language and Social Interaction*, 38:3, 303-329, DOI:

10.1207/s15327973rlsi3803_4

Iannotti, R. (1978). Effects of role-taking experiences on emotion, altruism and aggression.

Developmental Psychology, 14(1) , 119–124. doi: 10.1037/0012-1649.14.2.119

Ivey, A.E., Ivey, M.B., & Zalaquett, C.P. (2015). *Essentials of intentional interviewing:*

Counseling in a multicultural world (3rd ed.). Belmont, CA: Brooks-Cole.

Jacobsen P B., Sadler F, Booth-Jones M, Soety E., Weitzner M.,Fields K.(2002). Predictors of post trauma stress disorder symptomatology following bone marrow transplantation for cancer. *Journal of Consulting and Clinical Psychology*, 70(1), 235-240. doi: 10.1037//0022-006X.70.1.235

Jachyra, P., & Fusco, C. (2016). The place of play: From playground to policy to classroom well-being. *Sport, Education and Society*, 21(2), 217-238. doi:10.1080/13573322.2014.896331

Kanu Y (2008). Educational Needs and Barriers for African Refugee Students in Manitoba. *Canadian Journal of Education*, 31(4). 915-940.

Retrieved from https://search-proquest-com.cyber.usask.ca/docview/215372453/fulltextPDF/E77D6581FC5D4F29PQ/1?account_id=14739.

Kelly-Vance, L., & Ryalls, B. O. (2014). Best practices in play assessment and intervention. In A. Thomas & J. Grimes (Eds.). *Best practices in school psychology* (6th ed.; pp. 549-560). Bethesda, MD: National Association of School Psychologists.

Krefting L.(1991). Rigor in Qualitative Assessment: The Assessment of trustworthiness.

American Journal of Occupational Therapy, 45(5) 214-225. Retrieved from <https://pdfs.semanticscholar.org/643c/6521f1e78e395313cbe3cdbc285b3e16c9fa.pdf>

Lane, K. L., Barton-Arwood, S. M., Nelson, R. J., & Wehby, J. (2008).

Academic performance emotional and behavioural disorders served in a self-contained setting. *Special Education and Communication Disorders Faculty Publications*. Paper 44.

Retrieved from <http://digitalcommons.unl.edu/spcedfacpub/44>.

- Landreth, G. L. (1993). Child-centered play therapy. *Elementary School Guidance & Counseling*, 28(1), 17-29. Retrieved from <http://www.jstor.org/stable/42869126>
- Leedy, P.D. & Ormrod, J.E. (2005). *Practical research: Planning and design* (8th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
- Lillard, A. S., Lerner, M. D., Hopkins, E. J., Dore, R. A., Smith, E. D., & Palmquist, C. M. (2013). The impact of pretend play on children's development: A review of the evidence. *Psychological Bulletin*, 139(1), 1-34. doi:10.1037/a0029321
- Lincoln, Y.S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 3. Risk, disorder, and adaptation* (2nd ed. pp. 739–795). Hoboken, NJ: Wiley.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71, 543–562. doi: 10.1111/1467-8624.00164
- O'Connor, C., & Stagnitti, K. (2011). Play, behaviour, language and social skills: The comparison of a play and a non-play intervention within a specialist school setting. *Research in Developmental Disabilities*, 32(3), 1205-1211. doi: 10.1016/j.ridd.2010.12.037.
- O'Brien, P., & Burnett, P. C. (2000). Counselling children using a multiple intelligences framework. *British Journal of Guidance and Counselling*, 28(3), 353-371
- O'Conner K. (2012). Ecosystemic Play Therapy. In Schaefer C. E. (Eds.) *Foundations of Play*

- Therapy* (253- 271). Hoboken, New Jersey: Wiley.
- Malchiodi, C. A. (2014). Creative arts therapy approach to attachment issues. In Malchiodi C A., & Crenshaw A D (Eds.), *Creative arts and play therapy for attachment issues* (3–18). New York, NY: Guilford Press
- Mallory J M, (2010). Incorporating Divergent Thinking Training in Play Interventions for Preschool Children with Developmental Risks. Retrieved from ProQuest Digital Dissertations.
- Marcelo A K., & Yates M T. (2014). Prospective relations among preschooler’s play, coping, and adjustment as moderated by stressful events. *Journal of Applied Developmental Psychology*, 35 (3) 223-233. <http://dx.doi.org/10.1016/j.appdev.2014.01.001>
- Mastrangelo, S. (2009). Play and the child with autism spectrum disorder: From possibilities to practice. *International Journal of Play Therapy*, 18(1), 13. <http://psycnet.apa.org/doi/10.1037/a0013810>.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227-238. <http://dx.doi.org/10.1037/0003-066X.56.3.227>
- Masten, A. S. (2014). Global perspectives on resilience in children and youth. *Child Development*, 85(1), 6-20. doi:10.1111/cdev.12205
- Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, 53(2), 205. Retrieved from <http://dx.doi.org/10.1037/0003-066X.53.2.205>
- Mazzoni E., & Benvenuti M. (2015). A Robot- Partner for Pre-School Children Learning

English Using Socio-Cognitive Conflict. *Journal of Educational Technology and Society*, 18(4), 474-485. Retrieved from <http://www.jstor.org/stable/pdf/jeductechsoci.18.4.474.pdf>

McGinty, Walker M., & Bloch R M.(2008). Sensitivity of a System of Care in Recognizing Communication Disorders in Children with Serious Emotional Disorders. *Community Mental Health Journal*, 44(4) 295-302. doi: 10.1007/s10597-008-9130-2

Mendenhall A N., & Frauenholtz F.(2013). Mental Health Literacy: Social Work's Role in Improving Public Mental Health. *Soc Work*, 58(4), 365-368. Retrieved from <https://doi.org/10.1093/sw/swt038>

Merriam, S. B. (1997). *Qualitative Research and Case Study in Education*. San Francisco: Jossey-Bass.

Merriam, S. B. (2002). *Qualitative research in practice: Examples for discussion and analysis*. San Francisco: Jossey-Bass.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Merriam S B., Tisdell E J. (2016). *Qualitative research: A guide to design and implication*. San Francisco, CA: Jossey-Bass.

Milteer, R. M., Ginsburg, K. R., (2012). The importance of play in promoting healthy child development and maintaining strong parent-child bond: Focus on children in poverty. *Pediatrics*, 129(1), e204-13. doi:10.1542/peds.2011-2953

- Moore, M., & Russ, S. W. (2006). Pretend play as a resource for children: Implications for pediatricians and health professionals. *Journal of Developmental & Behavioural Pediatrics*, 27(3), 237-248. doi: 10.1097/00004703-200606000-00011
- Nash J B., & Schaefer, C E., (2011). Therapeutic Powers of Play and Play Therapy. In Schaefer C. E. (Eds) *Foundations of Play Therapy* (3- 16). Hoboken, New Jersey: Wiley.
- Nelson, J. R., Benner, G. J., Lane, K., & Smith, B. J. (2004). Academic achievement of K–12 students with emotional and behavioural disorders. *Exceptional Children*, 71, 59–73.
- Oppenheim, D., Nir, A., Warren, S., & Emde, R. (1997). Emotion regulation in mother-child narrative co-construction: Associations with children’s narratives and adaptation. *Developmental Psychology*, 33, 284–294. Retrieved from <http://psycnet.apa.org/journals/dev/33/2/284/>
- Panksepp, J., & Biven, L. (2012). *The archaeology of mind: Neuroevolutionary origins of human emotions*. New York, NY: Norton
- Panksepp, J. (2012). What is an emotional feeling? Lessons about affective origins from cross-species neuroscience. *Motivation and Emotion*, 36(1), 4-15. Doi. 10.1007/s11031-011-9232-y
- Paquette, D., & Ryan, J. (2001). Bronfenbrenner’s ecological systems theory. Retrieved from http://www.floridahealth.gov/alternatesites/cms-kids/providers/early_steps/training/documents/bronfenbrenners_ecological.pdf
- Pattison, S. (2006). Making Every Child Matter: A model for Good Practice in Counselling Children and Young People with Learning Disabilities. *Pastoral Care in Education*, 24(2), 22-27. Doi:10.1111/j.1468-0122.2006.00361.x.

Pellegrini A D., Nathan P (2010). *The Oxford Handbook of the Development of Play* (9–18).

Oxford University Press: New York, NY.

doi:10.1093/oxfordhb/9780195393002.013.0002

Pearson, B.L, Russ, S. & Cain Spannagel S. (2008). Pretend play and positive psychology:

natural companions. *Journal of Positive Psychology*, 3(2), 110-119. DOI:

10.1090/17439760701706017

Piaget J. (1973). *The Psychology of Intelligence*. Totowa, NJ: Little-field and Adams University Press.

Piaget, J. (1983). Piaget's theory. In P. Mussen (Ed.), *Handbook of child psychology* (1), 103-128. New York: Wiley.

Piaget, J. (1959). *The language and thought of the child* Psychology Press.

Pittman C M., & Karle E M. (2015). *Rewire you Anxious Brain: How to use Neuroscience to end Anxiety, Panic and Worry*. Oakland, California: New Harbinger Publications, Inc.

Phillips J C., & Russell R K. (1994). Research Self-Efficacy, the Research Training Environment, and Research Productivity among Graduate Students in Counselling Psychology. *The Counselling Psychologist*, 22(4), 628-641. doi:

[10.1177/0011000094224008](https://doi.org/10.1177/0011000094224008)

Rapee R M., Kennedy S., Ingram M., Edwards S., & Sweeny L. (2005). Prevention and Early Intervention of Children with Anxiety Disorder in Inhibited Preschool. *Journal of*

Consulting and Clinical Psychology, 73 (3), 488-497. <http://dx.doi.org/10.1037/0022-006X.73.3.488>

Ray D., Bratton, S C., Rhine T., & Jones, L. (2001). The Effectiveness of Play Therapy: Responding to the Critics. *International Journal of Play Therapy* 10(1) 85-108. [doi/10.1037/h0089444](http://dx.doi.org/10.1037/h0089444)

Reid, R., Gonzalez, J. E., Nordness, P. D., Trout, A., & Epstein, M. H. (2004). A meta-analysis of the academic status of students with emotional/behavioural disturbance. *The Journal of Special Education*, 38, 130–143. doi: <https://doi.org/10.1177/00224669040380030101>

Reynolds, C. R. (2011). Perspectives on specialization in school psychology training and practice. *Psychology in the Schools*, 48(9), 922-930. doi:10.1002/pits.20598

Rodger, S., & Ziviani, J. (1999). Play-based occupational therapy. *International Journal of Disability, Development and Education*, 46(3), 337-365. doi:10.1080/103491299100542

Roulstone S. & Wren Y. (2001). Investigation of Theoretical Models and Therapy Activities: Phonological Differences. *International Journal of Language & Communication Disorders*, 36, 441-446. doi: 10.3109/13682820109177926

Russ, S. W., & Kaugars, A. S. (2001). Emotion in children's play and creative problem solving. *Creativity Research Journal*, 13(2), 211–219. http://dx.doi.org/10.1207/s15326934crj1302_8.

Rutter, M. (1999). Resilience concepts and findings: Implications for family therapy. *Journal of Family Therapy*, 21(2), 119 – 144. doi: 10.1111/1467-6427.00108

- Saunders B., Sim J., Kingstone, T.... Jinks C. (2018). Saturation in Qualitative research: exploring its conceptualization and operationalization. *Quality and Quantity*. 52(4), 1893-1907 DOI: 10.1007/s11135-017-0574-8
- Schaefer, C E., & Drewes A A. (2011). Therapeutic Powers of Play and Play Therapy. In Schaefer C. E. (Eds.) *Foundations of Play Therapy* (3- 16). Hoboken, New Jersey: Wiley.
- Schore A. (2017). All Our Sons: The Developmental Neurobiology and Neuroendocrinology of Boys at Risk. *Infant Mental Health Journal*, 38(1), 15-52. doi: 10.1002/imhj.21616
- Schwean V., & Rodger S. (2012). Children First: It's Time to Change! Mental Health, Promotion, Prevention and Treatment Informed by Public Health, and Resiliency Approaches. *Canadian School and Counselling Psychology*, 28(1), 136-166. doi: 10.1177/0829573513475773
- Schupp C W., Simon D., & Corbett B A. (2013). Cortisol Responsivity differences in children with autism spectrum disorder during free and cooperative play. *Journal of Autism Development Disorder*, 43(10), 2405-2417. doi: 10.1007/s10803-013-1790-2.
- Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression and adjustment. *International Journal of Play Therapy*, 11(1), 43-63. doi:10.1037/h0088856
- Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75. doi: 10.3233/EFI-2004-22201.

- Slingman M E P., Steen T A., Park N., and Peterson C., (2005). Positive Psychology Progress: Empirical Validations. *American Psychologist*, 60(5) 410-421. doi: 10.1037/0003-066X.60.5.410
- Statistics Canada. (1999). *Diversity in the classroom: Characteristics of elementary students receiving special education*. Education Quarterly Review, 1999, Vol. 6, No. 2. Retrieved from <http://www.statcan.gc.ca/pub/81-003-x/81-003-x1999002-eng.pdf>
- Stiles, M. (2013). ‘Do we make ourselves clear?’ developing a social, emotional and behavioural difficulties (SEBD) support service's effectiveness in detecting and supporting children experiencing speech, language and communication difficulties (SLCD). *Emotional and Behavioural Difficulties*, 18(2), 213-232. doi:10.1080/13632752.2012.716573
- Sualy, A., Yount, S., Kelly-Vance, L., & Ryalls, B. O. (2011). Using a play intervention to improve the play skills of children with a language delay. *International Journal of Psychology: A Biopsychosocial Approach*, 9, 105-122. Retrieved from http://www.psyjournal.vdu.lt/wp/wp-content/uploads/2012/01/2011-09_6.pdf
- Templeton, T. N., Neel, R. S., & Blood, E. (2008). Meta-Analysis of Math Interventions for students with emotional and behavioural disorders. *Journal of Emotional and Behavioural Disorders*, 16(4), 226 – 239. doi: 10.1177/1063426608321691.
- Trotter, K., Eshelman, D., & Landreth, G. (2003). A place for bobo in play therapy. *International Journal of Play Therapy*, 12(1), 117–139 DOI: 10.1037/h0088875
- Vygotsky, L. S (1987). *Mind and Society: The Development of Higher Mental Press*. Cambridge, MA: Harvard, University Press.
- Watson, M. W., & Peng, Y. (1992). The relation between toy gun play and children's aggressive

- Behavioural. *Early Education and Development*, 3(4), 370-389.
doi:10.1207/s15566935eed0304_7
- Waelder, R. (1932). *The psychoanalytic theory of play*. *Psychoanalytic Quarterly* (2), 208–224.
- Watson, M. W., & Peng, Y. (1992). The relation between toy gun play and children's aggressive Behavioural. *Early Education and Development*, 3(4), 370-389.
doi:10.1207/s15566935eed0304_7
- Weizmann F., & Harris B. (2012). Arnold Gesell: The Maturationist. In Pickern W E., Dewsbury D A., & Wertheimer M (Eds). *Portraits of Pioneers in Developmental Psychology 7th Edition* (1-20). New York, NY: Psychology Press
- Wilkes-Gillan, S., Bundy, A., Cordier, R., & Lincoln, M. (2014). Evaluation of a pilot parent-delivered play-based intervention for children with attention deficit hyperactivity disorder. *American Journal of Occupational Therapy*, 68(6), 700-709.
<http://doi.org/10.5014/ajot.2014.012450>
- Von Glasersfeld, E. (1995). *Radical constructivism: A Way of knowing and learning*. London, UK: Falmer Press
- Xie, Hongling, Farmer, Thomas W., & Cairns, Beverley D. (2003). Different Forms of Aggression among Inner-City African-American Children: Gender, Configurations, and School Social Networks. *Journal of School Psychology*, 41(5), 355-75. [https://doi-org.cyber.usask.ca/10.1016/S0022-4405\(03\)00086-4](https://doi-org.cyber.usask.ca/10.1016/S0022-4405(03)00086-4).
- Zygouris N. (2011). Event Related Potential in Depressed Children and Adolescents. Prolong P300 Latency and Abnormal Brain Asymmetry (Abstract). *Neuroscience Letter*, 500 (Supplement), 20-21. <http://doi.org/10.1016/j.neulet.2011.05.122>

Appendix A
Recruitment Poster

Helping Professionals thoughts and experiences of Using Play Based Interventions



**PARTICIPANTS NEEDED FOR
RESEARCH IN *Play Based Intervention Study***

We are looking for volunteers to take part in a study exploring how *Helping Professionals use Play Based Interventions to foster Positive Adaption Abilities amongst children and youth (ages 4 to 17)*

Are you an Helping Professional who uses Play-Based interventions?

- *Are you a helping professional who provides therapeutic treatment using play interventions?*
- *Would you be willing to discuss your experiences using play-based interventions in a confidential research interview?*

Your participation would involve 2 interview sessions,
each of which is approximately 45-60 minutes.

In appreciation for your time, you will receive
a \$20 gift card.

For more information about this study, or to volunteer for this study,
please contact:

Emily Donald at

Email: ekd565@mail.usask.ca



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Appendix B
Participant Consent Form



Participant Consent Form

You are invited to participate in a research study entitled: “Lets play! Helping Professionals use of Play-Based Interventions within their Clinical Practice”

Researcher: Emily Donald (B.Ed, Graduate Student), Department of Educational Psychology & Special Education, University of Saskatchewan (email: ekd565@mail.usask.ca.)

Supervisor: Dr. Laureen McIntyre (Thesis Supervisor), Department of Educational Psychology & Special Education, University of Saskatchewan (email: laureen.mcintyre@usask.ca; office phone number: 306- 966-5266))

Purpose(s) and Objective(s) of the Research:

The purpose of the research is to explore helping professionals use of play based intervention and how it foster’s positive adaption abilities in children with emotional and/or behavioural difficulties.

Procedures:

You are being asked to participate in one 45-60-minute interview and one follow-up meeting. All interviews will be conducted at a time and place that is accessible for you. The interviews will be audio-recorded via computer software. During the interview, you are encouraged to speak freely and honestly about your experiences using mindfulness.

- It is your right as a participant to withdraw your participation from the study at any time. You are encouraged to ask questions or for clarification of the study’s goals, procedures, and your role at any time.
- It is your right as a participant to request that the recorder within the interview be turned off at any time.
- Interviews will be transcribed with all names being changed to pseudonyms (different names) to protect your confidentiality. You are asked to refrain from using any individual students’ names within the interview. However, if a name is mentioned it will also be changed to a pseudonym to protect the child’s identity.
- The data will be analyzed alongside the other participants’ data for themes or patterns and will be presented in a manner that supports confidentiality and anonymity.
- You will be provided with a shortened version of the interview at our follow-up meeting, which is expected to take 30 minutes to 1 hour. The information from your recordings will only be shared amongst the researcher and the thesis supervisor.

- The findings of this study will be primarily used for the completion of my thesis requirements for my graduate program. However, the de-identified findings may also be provided in small meetings or in future publications.

Potential Risks: (see guidelines section 6)

Any risks related to participation in this study are low. It is possible that you may feel discomfort from your participation in this study. In addition, despite measures to protect your confidentiality (i.e., changing your name, removing demographics, not listing your school division or city/town), it is always possible that individuals reading future publications of these findings may draw links to your participation. This is, however, unlikely. To address these risks, the interview will be approached sensitively and respectfully. Throughout the process, your continued participation will remain your choice and you can choose to withdraw from the study at any point that you feel uncomfortable before the data analysis process. It is always your choice to not answer a question or to end a discussion. You are encouraged to ask questions at any point within the interview and to contact the researcher or the supervisor at any point following the interview sessions. If you feel negatively toward the study and would prefer to discuss these feelings elsewhere, you may contact

Saskatoon Mobile Crisis Intervention

Telephone: 306-933-6200

The Mobile Crisis Intervention Centre is a 24-hour telephone counselling service for individuals that are in distress or are experiencing a crisis moment within their lives. The counsellors are willing to visit individuals in their homes if this is desired and convenient.

Potential Benefits:

Being able to talk about your experiences of the techniques, strategies etc. you use within your professional practice of using play-based intervention. Your experiences are to represent successful ways how you have seen your children and youth clients (age 4-17) with emotional and behavioural trouble move forward in face of adversity and learn how to adapt positively. Further your experiences can be used to enhance knowledge on the therapeutic process of play-based interventions. Additionally, you will be contributing to an area of research that need descriptive information on the therapeutic process (Lillard et al., 2012).

Compensation:

As a token of appreciation for your time and insight, you will be provided with a \$20 gift card to a bookstore of your choice. Additionally, any costs that you incur for parking will be covered.

Confidentiality:

To protect your confidentiality and anonymity: transcripts and summaries of interviews will be (a.) password protected on the researcher's computer and stored on the University of Saskatchewan Secure Cabinet on PAWS, (b.) a coding system will be used to keep your name and contact information separate from data collected during the interviews with the data link being destroyed upon completion of data collection, (c.) any potentially identifying information will be altered to support anonymity, and (d.) you will have the opportunity to review the final transcript and summary of your sessions where you will be asked to sign a data release form authorizing its use in future presentations and/or publications.

Although excerpts from your interviews will be shared with the public, your name and identifying information will be altered through the use of a pseudonym and omission of details. It will not be possible to connect your name as signed on the data release form with the information that you provided as they

will be maintained separately. The interview tapes will not be identified using your real name. If you are concerned that any part of the interview may be identifiable, you have the right to choose to add, change, or delete any information from the transcript, as it may otherwise be used for the thesis report or the shortened interview.

Storage of Data: To protect your privacy, the information obtained during this study will be stored in a locked filing cabinet in Dr. Laureen McIntyre's (the thesis supervisor's) office. After 5 years, the data is no longer required and will be destroyed.

Right to Withdraw: Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Your right to withdraw from the study will apply until the results have been summarized, at which point the data will be separate from your real name.

If you do decide to leave the study, you will not be affected professionally or personally in any way. Any information that you have provided will be destroyed upon exit. Your right to remove your information will continue until the document has been completed and been made available to the public. After this point, it may not be possible to remove your information from the study.

Follow up: (see section 11)

- If you wish to obtain results from the completed study, please provide your email address that the researcher can send a copy of the report through.

Email address

Questions or Concerns:

Feel free to contact the researcher or the supervisor at any time throughout and following the study if questions or concerns arise. You can contact the researcher (Emily Donald) through email at ekd565@mail.usask.ca or through phone at 306-290-5973 and the supervisor (Dr. Laureen McIntyre) at 306-966-5266.

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board (**Certificate #17-259**). Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent to Participate: Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records. During your follow-up session, the information from this consent form will be reviewed and any questions regarding your rights as a participant, your role in the study, or the purpose of this study will be addressed.

Name of Participant _____
Signature _____
Date

Researcher's Signature _____
Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix C

Interview Guide

Participant Background Information (Goal- to give a rich history of their background and how they came to this spot of using play interventions):

- Name:
- Occupation:
- Qualifications of implementing play interventions to children with emotional and behavioural disorders:
- Years of Post-Secondary Education:
- Years of Professional experience:
- Years of Supervision:
- How long have you been providing therapeutic treatment to children with Emotional and Behavioural difficulties and/or disorders?
- What are the age ranges that you use play interventions with?
- What has drawn you to working with young children with emotional and behavioural difficulties?

Clarifying play interventions

- Describe how you define play interventions?
- How do you introduce the concept of using play to express oneself to children with emotional and/or behavioural difficulties?
- What do you do to prepare for your clients who are children who have emotional and behavioural difficulties and/or disorders?
- Describe the setting that the play interventions take place in?

Therapeutic Process (Goal- Identifying what helping professional do within the therapeutic process to teach positive adaption abilities):

- What are important factors do you believe are important to establish when beginning the therapeutic process using play interventions?
- What do you believe are essential aspects of making play interventions successful for children? (e.g., relationships, strategies, techniques etc.)
- Do you have preference to when using specific types of play interventions (eg. indirect or direct)? If so, how come?
- Do you have specific techniques and strategies that help children build resiliency?
- What techniques do you use within play interventions to help children with communication?
- What techniques or strategies do you use to help children identify protective factors so that they can use these when experiencing hardship outside of the treatment sessions?
- How do you monitor progress when clients are using play interventions?
- How do you know when the processes and strategies you are introducing to children in play interventions are successfully teaching positive adaption abilities in times of hardship?

- Would you use any other form of intervention that does incorporate play when working with children? Why or why not?
- Each client is so diverse, and children are constantly growing. What are signs that you notice in these children of how they are showing improvement? Can it be difficult to determine due to children's maturation?
- What makes you feel confident in using play-based interventions and in maintaining long term success in helping children with emotional and or behavioural difficulties/disorders?
- Describe a time when you were confident in your play-intervention practice and that it has helped a child learn strong coping techniques and strategies in spite of tough times. Use this opportunity to focus on yourself and what you were doing, as your work helped to facilitate the positive change.

Questions for Follow-up Meeting

- 1. After looking over the shortened version of the interview and your quotations is there anything you have thought of that you would like to add, change, or delete?
- 2. Have you had any new thoughts or ideas since our last interview?

Appendix D
Data Release Form

Data/Transcript Release Form

I, _____, hereby authorize the release of the transcript and transcript summary of my interview to Dr. Lauren McIntyre and Emily Donald to be used in the manner described in the consent form.

PLEASE CHECK ONE OF THE FOLLOWING OPTIONS:

____ I authorize the release of data without reviewing the transcript/transcript summary from my interview with the student researcher.

____ I authorize the release of data only after I have been provided the opportunity to review, add, alter, or delete information as appropriate from the transcript/transcript summary of my interview with the student researcher.

I acknowledge that the transcript/transcript summary accurately reflects what I said in my interview. I have received a copy of the Data/Transcript Release Form for my own records.

Participant

Date

Student Researcher

Date