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Play Therapy UK, The Coach House, Belmont Road,

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Reprographic and Design

APAC, Uckfield, East Sussex

Contact details

Sophia O'Neill sophia@apac.org.uk

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Editorial

Welcome to the long awaited latest edition of our research journal.

This is my last editorial as I'm handing over the baton to Sophia O'Neill who, I have no doubt, will do an excellent job with our research journal. This time we are only doing an electronic version which I hope you will engage with and, of course, feel free to write in to Sophia with any comments about any of the articles featured in this edition.

I know that I have said it before but, as the outgoing editor, I can say once again that one of the great privileges of the role is to be able to read some wonderfully creative and imaginative research projects. The first, by Fiona Lovely, is an article reflecting the ingenious use of comic strip or sequential art as a play therapy tool. The second article is an account of utilising group play therapy for Ukrainian refugee children. The theme of working with refugee children who have been traumatised by war and displacement is an important one and supports work done by Sarah Elliot who featured in our very first journal. The third article is another fascinating piece by Katherine Jackson on the use of den play. Although there appears to be have been little research in the area Katherine has explored what the metaphorical processes are and how these connect within play therapy.

The next article is produced by our new editor, Sophia, and Dr Stephanie Lambert. Almost ten years ago Stephanie and the late, and much missed Jeff Thomas, produced an article which reviewed the effectiveness of the PTUK and PTI model of play therapy. This new paper builds on that work by further analysing the most recent data concerning the overall effectiveness of IHM play therapy using robust statistical testing.

In addition to aggregate outcomes, the analysis includes multiple sub-group evaluations based on client scores to create a full picture of the positive impact of the intervention with children. It's a fascinating and illuminating picture. The final article for this edition is by Gemma Hookins and is a another intriguing study involving adolescents in Dubai giving the journal a truly international flavour! In her study Gemma explores the effectiveness of integrative holistic play therapy with adolescents diagnosed with autism and intellectual disabilities.

Dr John Bates
Johnbates5@icloud.com

Frame of Thought

An exploration of the comic strip format (sequential art) as a creative processing tool in play therapy

Fiona Lovely

Abstract

This study explores the potential use of the comic strip as a creative processing tool in play therapy. A comic strip is a sequential art form. Sequential art utilises images and dialogue in a narrative sequence, to convey an idea or story. Comic strip stories are mostly contained within frames or panels and often include printed dialogue in support of the story narration, but not always
(McCloud, 1994). Drawing and storytelling, components of the comic strip, are widely used in play therapy as creative tools, in support of communication and emotional expression (Case & Dalley, 2008; Gardner, 1993; Chandra & Rajaguru, 2016). The comic strip sequential art format, used within a therapeutic context may offer the client access to various narrative and expressive processing tools: visual imagery, written word, metaphor and symbols.

Results indicated that whilst drawing and storytelling are widely used as creative processing tools within play therapy, the use of the comic strip format was much less used or considered. All of the therapists interviewed voiced an interest in accessing further information about the use and potential benefits of the comic strip format as a therapeutic processing tool.

Recommendations include developing a protocol for using this modality as a processing tool, to address the barriers to access and understanding of its use and usefulness.

Keywords: Comic strip, sequential art, creative processing

Introduction

Comic strips act as visual platforms for common or collective experiences, fantasy stories, heroism, horror, and iconic content (Clark & Clark, 1991). Themes also active in client processing and children's play themes (Russell et al., 2007; Hughes, 2001). Drawing and storytelling, components of the comic strip, are widely used in play therapy as creative processing tools, in support of communication and emotional expression (Case & Dalley, 2008; Gardner, 1993; Chandra & Rajaguru, 2016).

The sequential art format, used within a therapeutic context, may offer the client access to various narrative and projective processing tools: visual imagery, written word, archetypes, metaphor, and symbols. These tools can serve as a means of externalizing lived experiences (Malchiodi, 1998). Bruner (2002) agrees that narrative processing serves to re-see and re-arrange the old story and give form to a new sequence of self-reflection and self-construction.

The comic strip method of processing can offer the client a tool to revisit and gain understanding and control of a past experience (Cattanach, 2008). Freud likens the child at play to an imaginative writer, creating and arranging his world experience in a more ordered way (Freud, 1953).

This study aimed to explore and evaluate the use of the comic strip format as a creative processing tool with play therapy clients. I was interested in obtaining data relating to the following questions:

(a) How widely is this technique used

(b) If it is being used, then how are play-therapists using this tool with clients

(c) What are its perceived benefits

(d) Are there any barriers to using this technique as a processing tool?

The objective of this study was to create the evidence- base and framework needed to justify a protocol for using sequential art in play therapy, to encourage its wider use, and improve practitioner confidence in its use. Lowenstein (1999) and Landreth (1991) both highlight the necessity of the search, by the therapist, for innovative activities to add to their repertoire.

Figure 1. Example of a four-panel comic strip (created by the researcher)

Definition of Terms

Eisner (1985) uses the term sequential art to describe comic strips. McCloud (1994, p.9) further describes them as "juxtaposed pictorial and other images in deliberate sequence, intended to convey information". A comic strip is a sequence of drawn images, usually contained within panels, also known as frames or boxes (see Fig. 1).

The space between panels is referred to as the gutter. Comic strips often include printed dialogue in support of the story narration, but not always (McCloud, 1994). Eisner explains it as, “Lettering, treated ‘graphically’ and in the service of the story, functions as an extension of the imagery. In this context it provides the mood, a narrative bridge and the implication of sound” (Eisner,1985, p.2).

Further depth of narrative and emotional information and communication can be relayed through the use of emanata and pictorial runes (Forceville, 2005). McCloud (2006) names pictorial runes as cartoon symbols. Emanata are the lines, squiggles, question marks and other symbols connected to the character to better depict an emotional state, whereas pictorial runes can denote motion, direction, speed and emotion (Forceville, 2011).

Comic strips generally utilize drawn panels as a means of “containing the reader’s view” (Eisner, 1985, p.44). However, the action and story content can also take place outside of the panels (Barry, 2019). The panel border can also “be used as part of the non- verbal language of sequential art” (Eisner, 1985, p.44). The shape and size of frames used can even denote certain feeling states and give the reader heightened clues regarding the subconscious focus (McCloud, 1994). McCloud (2000) writes that “A single panel – even a silent one – may speak volumes” (p. 34).

Figure 2. Example of *emanata*, denoting an *angry* feeling state. The lettering inside the speech bubble gives a further clue about the character's intentions (*Detail from a client comic strip)*.

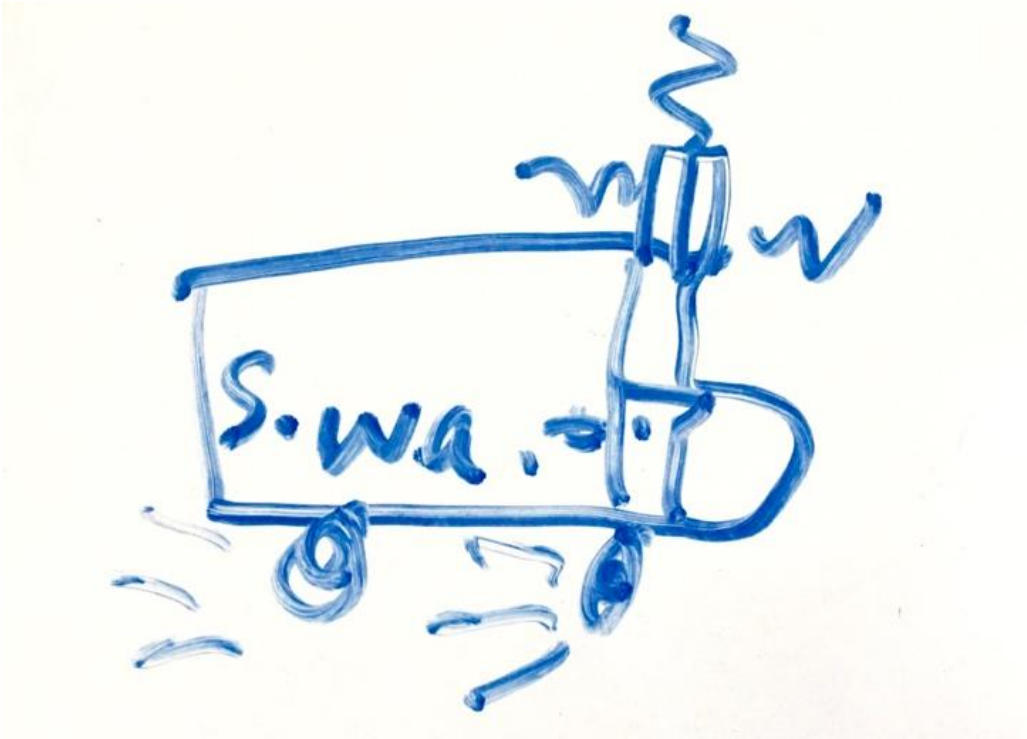

Figure 3. Example of *Pictorial Runes*, denoting speed and noise (*Detail from a client comic strip)*.

Literature Review

The central assumption governing the non-directive play-therapist's role is the abiding belief in the child's capacity for self-directed growth and expression (Landreth, 1991; Axline, 1947). The play-therapist's objective, according to Landreth (2002), is to engage with the client in ways which support an inner drive towards releasing "constructive, forward moving, creative, self- healing power" (O'Connor & Braverman, 1997, p.17).

Literature relating to the use of creative processing tools with children in therapeutic settings points towards the generally accepted effectiveness of this approach (Miller, 2014). However, in so much as it is accepted that the technique can facilitate the process, the choice to engage must be self-directed (Robbins, 1986).

Landreth (1991) makes the point that the therapist has a responsibility to communicate with the child using the child's medium of choice. Some clients are naturally drawn towards creative processing techniques (Malchiodi, 2003). The media of drawing and visual storytelling are included in this category
(Rogers, 1993; Schaefer, 1988).

Landreth (1991) names drawing as a tool for facilitating self-direction and self-evaluation. Malchiodi (2003) points to the child client as naturally being drawn to expressive creative modalities within the therapy space. "Child clients are already 'experts' at art ... [they] enjoy using expressive modalities to create stories and retell them to others" (Malchiodi, 2003, p.88).

Children love to tell and hear stories (Dahl, 1982). It is an efficient and universally - known format to communicate insights, values and ethics (Gardner, 1993).

Play-therapists use allegorical and metaphorical stories with clients, in support of resolution and integration (Pernicano, 2014; Burns, 2007). However, these stories are written by the therapist or sourced from already published books
(Burns, 2001).

The comic strip format lends itself well as a creative storytelling route for use by therapy clients (Chute, 2011). It presents access to various verbal and visual paths in support of the client's subjective expressive communication (Venkatesan & Saji, 2021). As highlighted by Venkatesan & Saji (2021), the comic strip allows the creator, when re-counting a personal story, to take control of the sequence of the re-telling: it is their story to tell.

Venkatesan & Saji (2021), note that sequential art "allows the author to recount experiences in narrative/subjective time sequence against the ideal of chronological/ objective time" (p.3).

The comic strip can accommodate the child in the leading role. The focus, abilities and self-directed choices can be changed frame to frame, as necessary. The child is the center of their own constantly evolving world story (Rogers, 1951). Landreth points to children's outer experiences being connected constantly to ongoing inner dialogues of ''thoughts, feelings and attitudes''
(Landreth, 1991, p.58). The client can imagine himself as hero, with extraordinary powers, overcoming adversity, feeling strong and in control (Russell, 2014). Landreth (1991) further makes the correlation between children feeling in control and the development of positive self-esteem. The comic strip format, used as a creative processing tool, could support future projections of hopeful change for the client; this change may include a new future self (Angus, 2011).

Clients drawn towards artistic expression, will often present a visual narrative of their lived experiences and fantasies (Golomb, 2011). The comic strip format and comic book characters are familiar to most children and adolescents
(Fletcher-Spear et al., 2011). Russell (2014) maintains that comic book superhero characters offer the reader the experience of "universal values ... Heroic Moments, Teaching Moments, Archetypal Moments, and Ideal Moments" (p.122). It is probable that all play-therapists have cartoon and superhero characters in their kit (Turner, 2005).

The comic strip offers the client easy access to symbolic language in the form of cartoon symbols (McCloud, 2006). Much has been written about the use and value of symbols in the therapeutic space (Lowenfeld,1938; Carey, 2006). Symbolic communication can be accessed by the client and read by the therapist during expressive arts engagement (Furth, 1988). Furth (1988) places value on the symbol as a signal, to focus both the client and therapist's attention.

McCloud favours the word icon over symbol “to mean any image used to represent a person, place, thing or idea” used within the comic strip sequence (McCloud 1994, p.27). Symbols used by clients in drawings, according to Furth, serve to “share intimate information of their personal selves” (Furth, 1988, p.31).

The requirement on the reader of the comic strip is to “exercise both visual and verbal interpretive skills” (Eisner, 1985, p.2). The role of the therapist is to be sensitive to the client’s play expressions and verbalizations (Axline, 1947).

Comics can be ‘read' in a wider sense than that term is commonly applied (Eisner, 2008). According to Eisner, stories and storytelling, within the context of comic strips, can also serve the purpose of highlighting moral dilemmas and values; they allow the storyteller to “dramatize social relations and the problems of living, convey ideas or act out fantasies” (Eisner, 2008, p.1). Chute (2006) names the comic strip as a medium which can provide a new way of representing trauma. Comic content can explore the ‘unrepresentable’, not through omission of content, but from multiple visual perspectives, using many frames (Chute, 2016, cited by Malgorzata, 2018). Sousanis (2015), McCloud (1994) and Eisner (2008) agree that every inch of the composition in the comic strip holds meaning and value, for both the creator and the viewer.

Eisner points to each comic strip panel acting as a stage, with the reader’s interest being held by the creator’s story (Eisner, 2008). In the process of reading the comic, the reader “not only fills in the gaps between panels, but also works with the often-disjunctive back- and-forth of reading and looking for meaning” (Chute, 2008, p.452). The importance of the therapist being open to adapting materials and processes within sessions can facilitate any client to find their own creative voice through art (Malchiodi, 2003). Crenshaw champions the trial of new creative strategies with clients, pointing to therapists only being limited by imagination and creativity (Crenshaw, 2008).

The therapist gains access to the child’s inner world, named by the cartoonist Barry (2019) as a transit system: the transference of the inner world of the artist. Landreth (2002) cites the inner world of the child as being what the therapist strives to understand and is what grows the therapist/child relationship. The therapist is given the opportunity to map presenting conflicts, fears, and needs, and to determine how resourced and resilient the client is (Rogers, 1980).

The use of the comic strip format is growing in popularity in other fields of study and practice: Graphic medicine, which includes autobiographical narrative health experiences, health care research methodology and educational health-care graphics (Czerwiec, 2017; Venkatesan & Saji, 2021), as a reflective practice tool for professionals (Whiting, 2019), and in support of children with autism, through a technique known as Comic Strip Conversations (Gray, 1994).

Eisner, credited with composing the term 'sequential art', notes "the vocabulary of sequential art has been in continuous development ... from the first appearance of comic strips" (Eisner, 1985, p.1)

I found minimal research-based literature on the use of the comic strip format (sequential art) as a therapeutic tool with children. The Six-Part Story Method, an assessment and diagnostic tool, certainly presents some similarities in terms of a sequential storytelling and drawing method; however, it also contains a specific structured and instructional process (Lahad & Dent-Brown 2012).

Methodology

My study focus required that I embraced a flexible approach to methodological organization and interpretation of my findings. Much like a comic strip, the qualitative action and content can also take place outside of the frames (Barry, 2019).

Having reviewed the various research approaches, a mixed-method triangulation approach was considered best suited for this study.

Triangulation offers opportunities for merging and evidencing of results from a mixed methods approach. A multi-perspective data collection and analysis methodology best suited this study focus, exploring and merging assertions (questionnaire/interview), examples (case study), explanations (analysis), and significance (findings and conclusions) (Fallows, 2011).

Quantitative data was collected through an online survey. 18 respondents completed the survey, with additional space for comment about 'lived experience' of practitioners. The survey included eleven questions, using both tick-box and open-ended questions. The tick-box element was included in this survey to support data collection of each respondent's baseline use of creative

processing tools in general. The open-ended questions were included to gather opinion, attitude- and belief-based answers, relating to the respondent's own practice and experience. Open-ended questions were used in this instance to clarify the tick-box questions (Gendall et al., 1996).

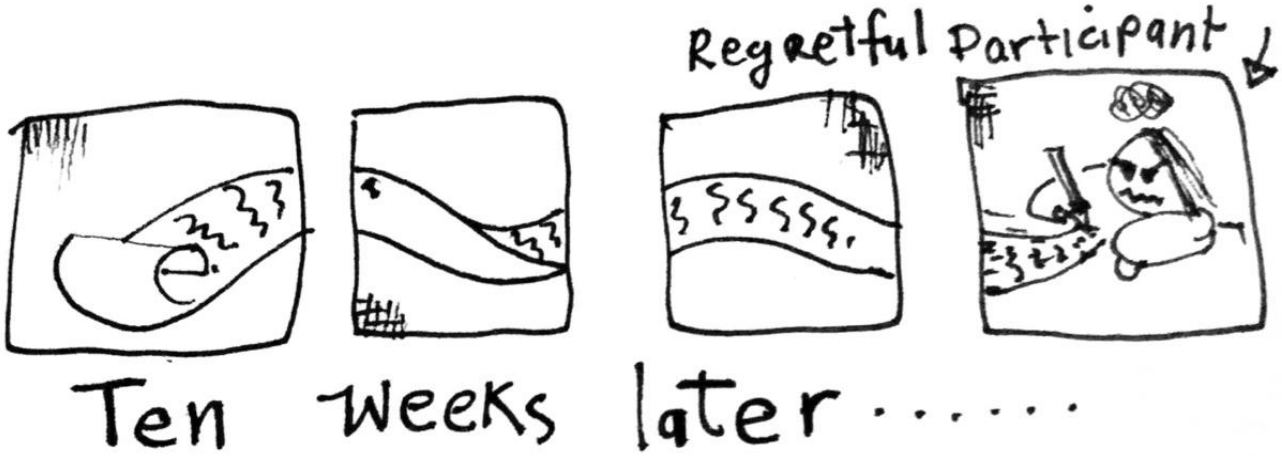

Figure 4: Survey completion: "Clear, short, specific" (Smith, 2007) (created by the researcher)

A subset of five survey respondents were chosen to be interviewed. A balance was sought between practitioners who had never used the comic strip as a processing tool and those who had some experience of using this technique with clients. 17 questions were used for the interview process, to gather practitioners varied opinions, beliefs and attitudes around the perceived value, accessibility and potential of the comic strip as a processing tool.

In light of the comic strip being a lesser-used creative processing tool, a single descriptive case study was included as part of the methodology, in order to offer practitioners access to a detailed analysis of using this sequential art format with a client.

The case study was mapped against current theoretical frameworks, related to non- directive play therapy principles and the use of creative processing techniques. These theoretical considerations are summarized in the literature review and inform part of the triangulation process.

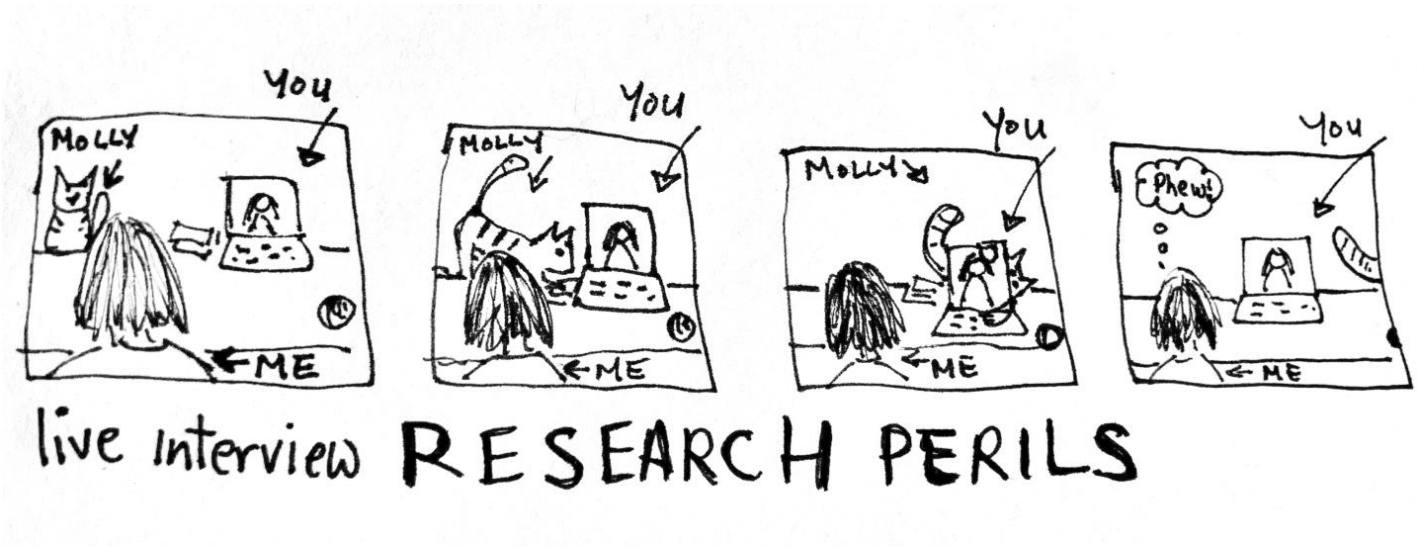

Figure 5: "Inductive logic" (Mertens, 2005) (created by the researcher)

Results and Analysis – Presentation of Findings.

Analysis of Quantitative Data

Play-therapists use a variety of creative processing tools within client sessions.

For the purpose of collecting data, as it pertains to the potentiality of adapting the comic strip as a creative processing tool, I focused on collecting data on therapist and client use of only three established creative processing modalities: drawing, visual storytelling, and word-based storytelling. Aspects of these three creative modalities were those considered most likely to be used if the comic strip format was chosen as a processing tool. Tables 2, 3 and 4 show the breakdown of frequency of therapist/client use of drawing, visual storytelling, and word-based storytelling. Use-specificity, within each of these techniques, is highlighted in Tables 2a, 3a, and 4a to show how each creative modality was utilized within the therapy space with clients. Tables 6 and 6a show the frequency of use of the comic strip as a processing tool and its use-specificity within sessions. A comparison table is also presented (see Table 7), to better

highlight the frequency of use across the four different creative processing techniques.

Tables 2a, 3a, and 4a show in more detail how the respondents and their clients utilized each of the highlighted creative modalities, in support of client expression, exploration, processing and integration as extoled by Landreth (2002).

The survey questions were completed by 18 qualified play-therapists. Table 1 shows the breakdown of respondents' years in practice, post qualification. There was no obvious correlation between years of experience and preference for, or use of, any of the creative modalities.

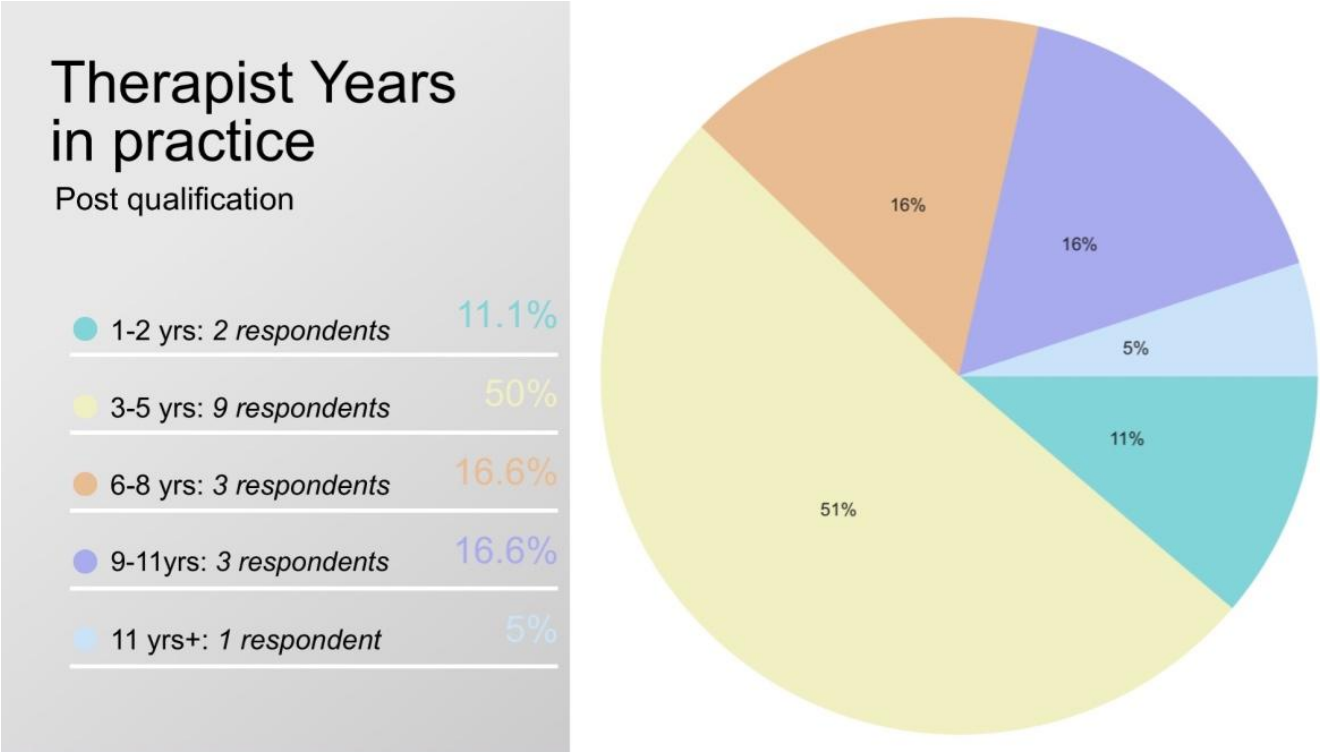

Table 1: Respondents' years in practice, post qualification.

Drawing

All respondents used drawing as a creative processing tool within their practice (see Table 2). The majority (44%) of respondents used this tool frequently within sessions. Table 2a indicates the variety of ways respondents used drawing within the therapy space, including as a means to process clients' feelings and life experiences, for example, "[Whilst client is drawing], what might those feelings look like? What colour they may be?"

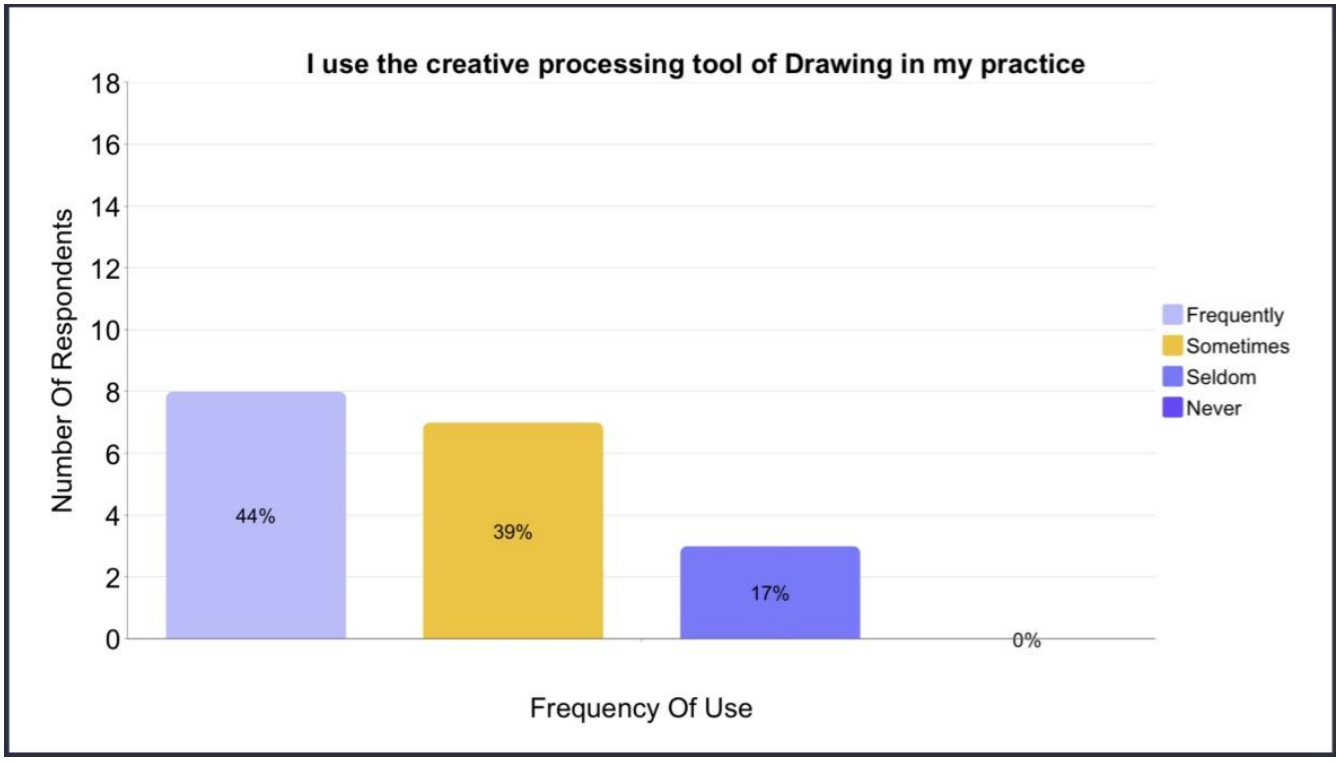

Table 2: Frequency of use of Drawing as a creative processing tool with clients.

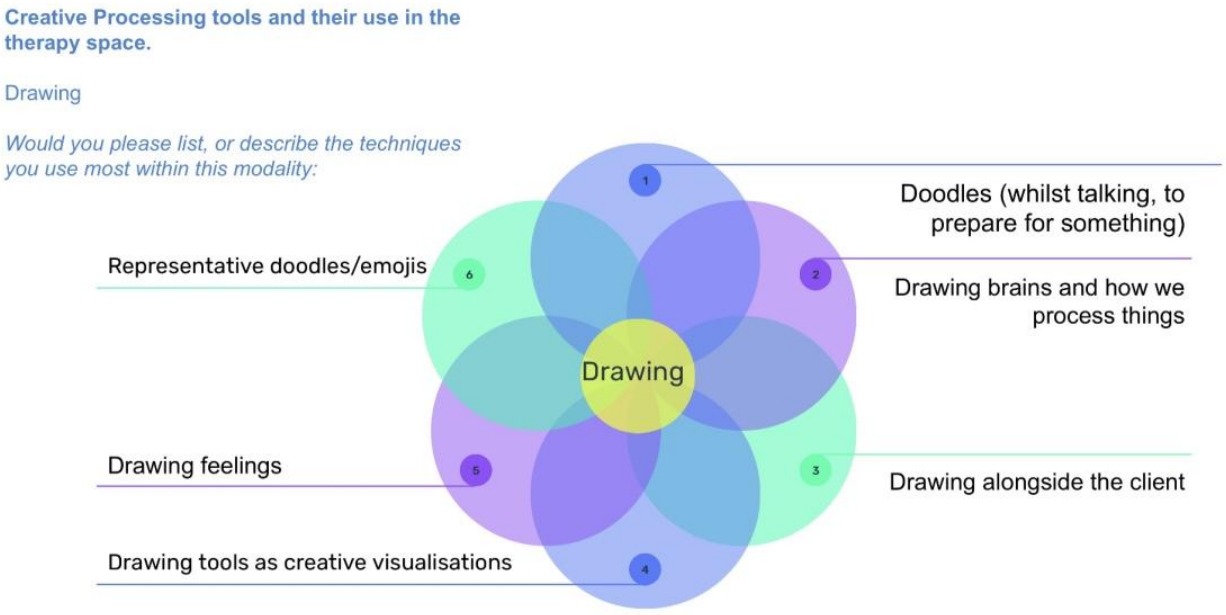

Table 2a: Breakdown of preference/use specificity responses for the use of Drawing as a creative processing tool in the therapy space.

Visual Storytelling

All respondents indicated experience of using visual storytelling, content involving use of images, symbols or illustrations, as a creative processing tool within their practice (see Table 3). The majority (56%) used this tool sometimes within sessions. Table 3a indicates the variety of ways respondents used visual storytelling within the therapy space such as meaningful images and representative doodles, for example: house, tree, or person, and emojis.

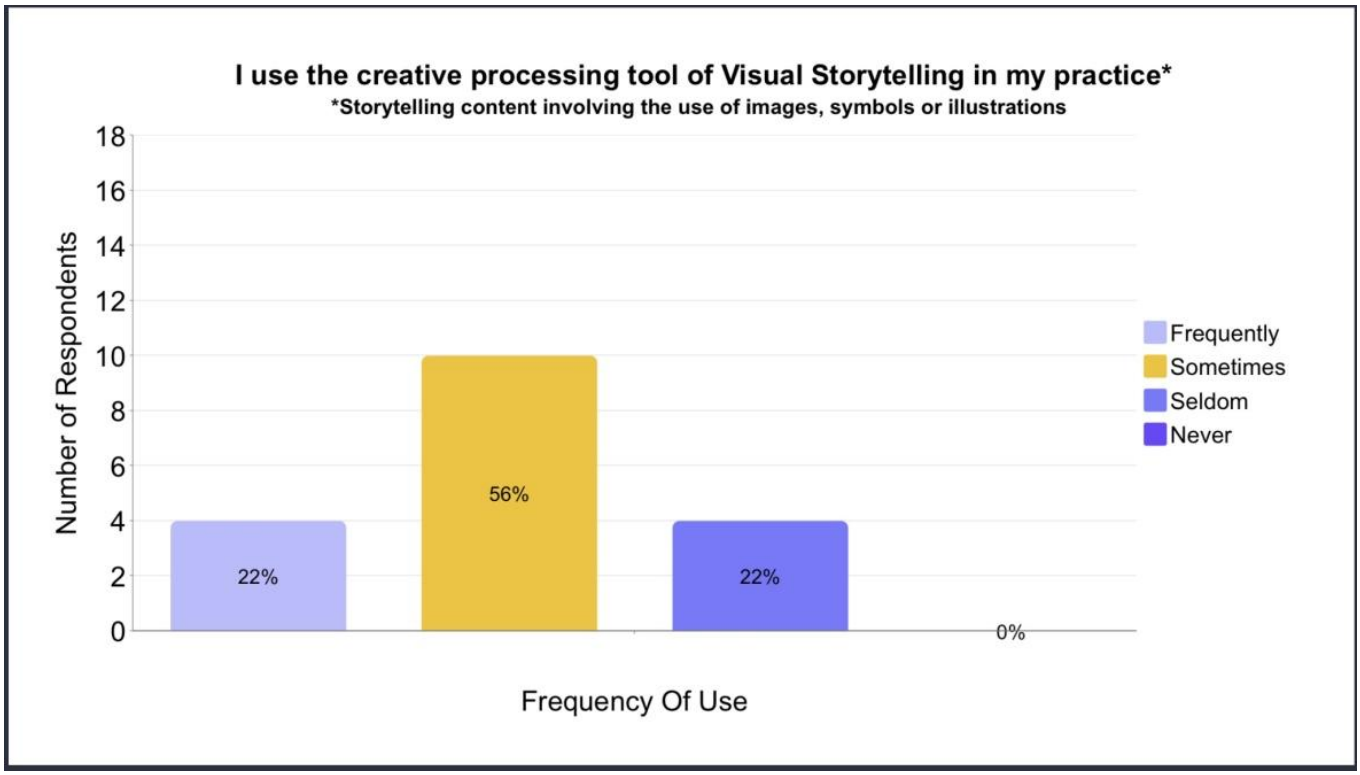

Table 3: Frequency of use of Visual Storytelling as a creative tool with clients.

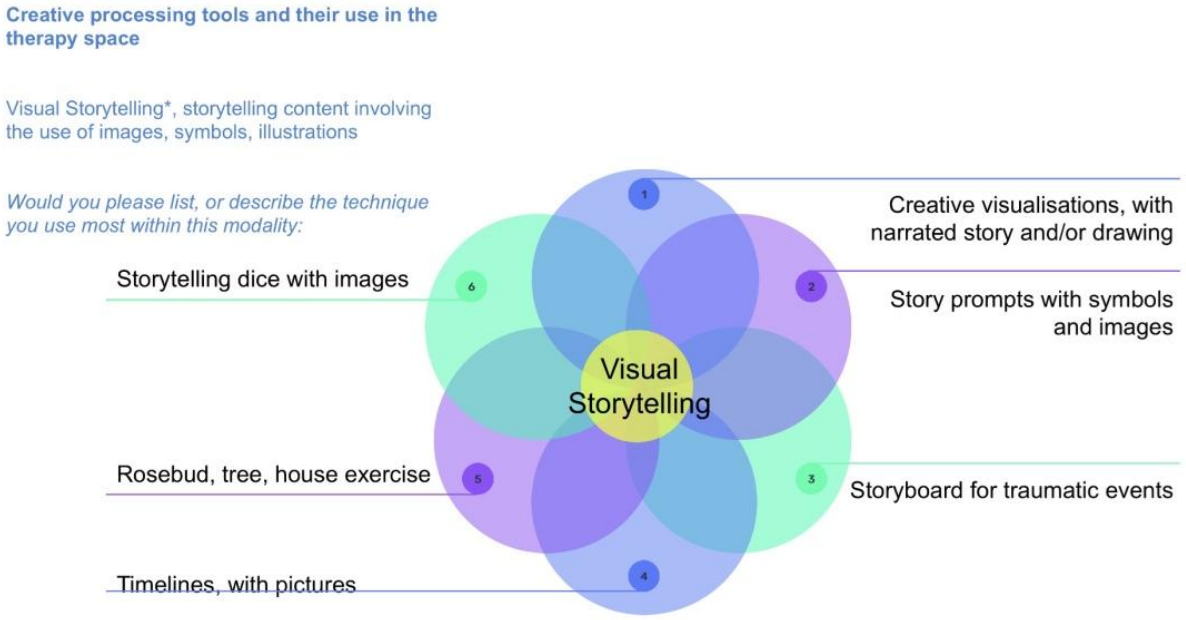

Table 3a: Breakdown of preference/use specificity responses for the use of Visual Storytelling as a creative processing tool in the therapy space.

Word-based Storytelling

Word-based storytelling is storytelling content involving verbal, oral, written, literal or metaphorical stories. It can involve stories written or told by either client, therapist or developed co-operatively, and can include therapeutic stories sourced outside of the therapy space, with focused content related to clients' presenting issues and experiences. All respondents use word-based storytelling as a processing tool within sessions, with the majority (56%) of respondents using it sometimes (see Table 4). Table 4a gives a more detailed breakdown of how this modality was used by respondents, in support of client integration.

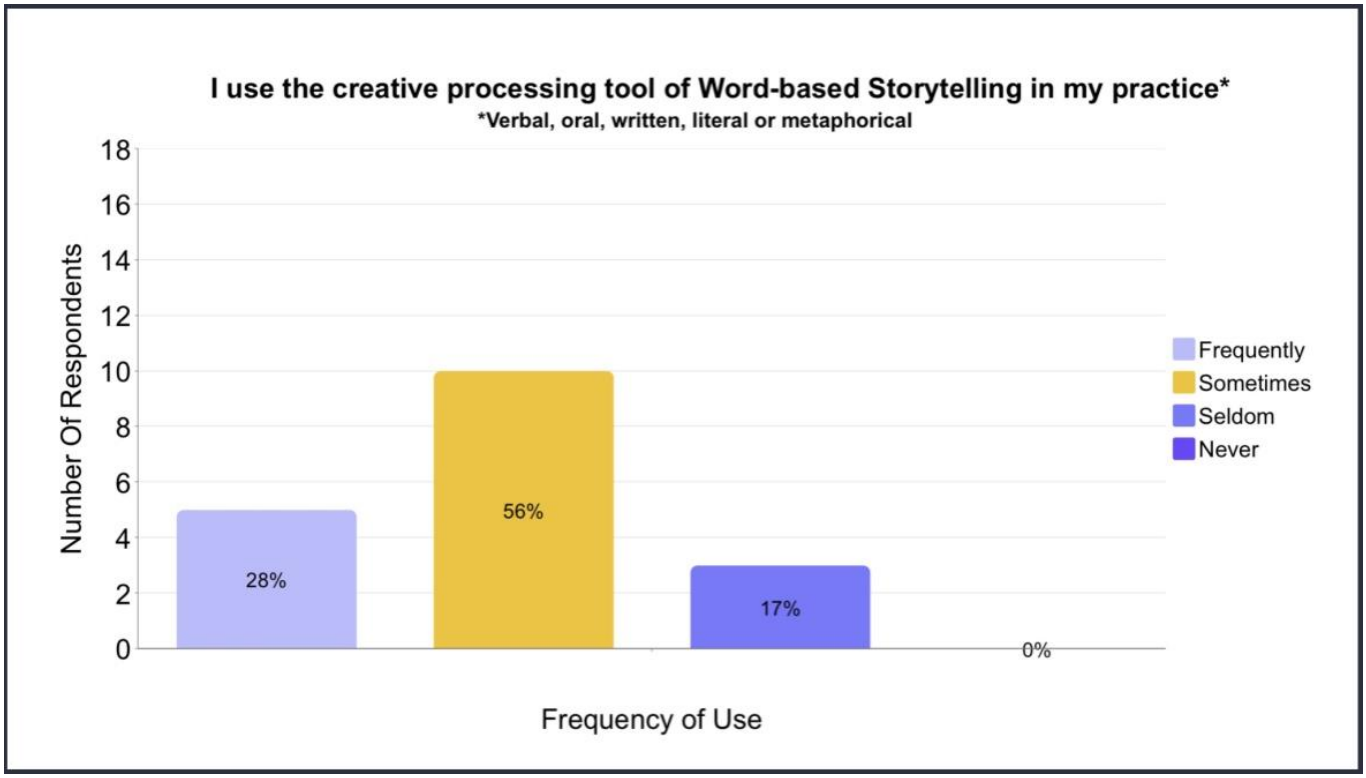

Table 4: Frequency of use of Word-based Storytelling as a creative processing tool with clients.

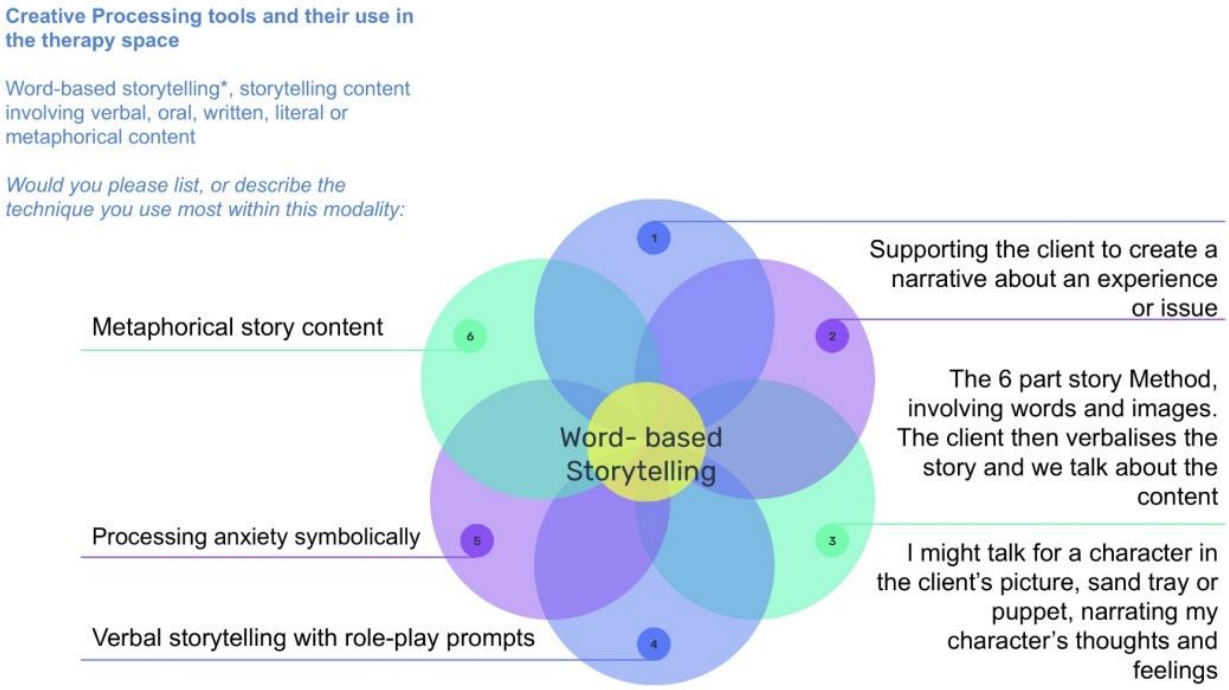

Table 4a: Breakdown of preference/use specificity responses for the use of word-based storytelling as a creative processing tool in the therapy space.

The Comic Strip

For the study, the comic strip was defined as a sequence of drawn images, usually containing dialogue in support of the story narration, but not always (McCloud, 1993). Table 6, shows the participants' frequency of use of the comic strip as a creative processing tool. Nobody reported using it frequently. The majority of respondents (38%), reported using this processing tool seldom, with the remaining respondents highlighting that they used it sometimes (31%) or never (31%).

Table 6a, shows the various ways this modality was used, and further highlights the respondents' understanding of how a comic strip was being used as a processing tool. Eleven respondents (69%) indicated using the comic strip sometimes or seldom with clients. Out of this number, six chose to elaborate further, in response to survey Question 8 inviting them to elaborate briefly on how they discovered this processing technique and why/ how they used it.

Four out of those six respondents indicated that this particular creative processing tool was introduced to them by the client, for example, "Introduced by a client who loved creating comics"; and "My client introduced me to the idea, as he was a big fan of comics" (Table 6a).

Four respondents indicated that they initiated the use of comic strip, based on a knowledge of their client's particular personal interest in this creative genre, for example, "A child I worked with was interested in Captain Underpants, so using the child's interest, we elaborated on a metaphorical creative story ... to embed and empower the chosen coping strategies he had worked out for himself" (see Table 6a).

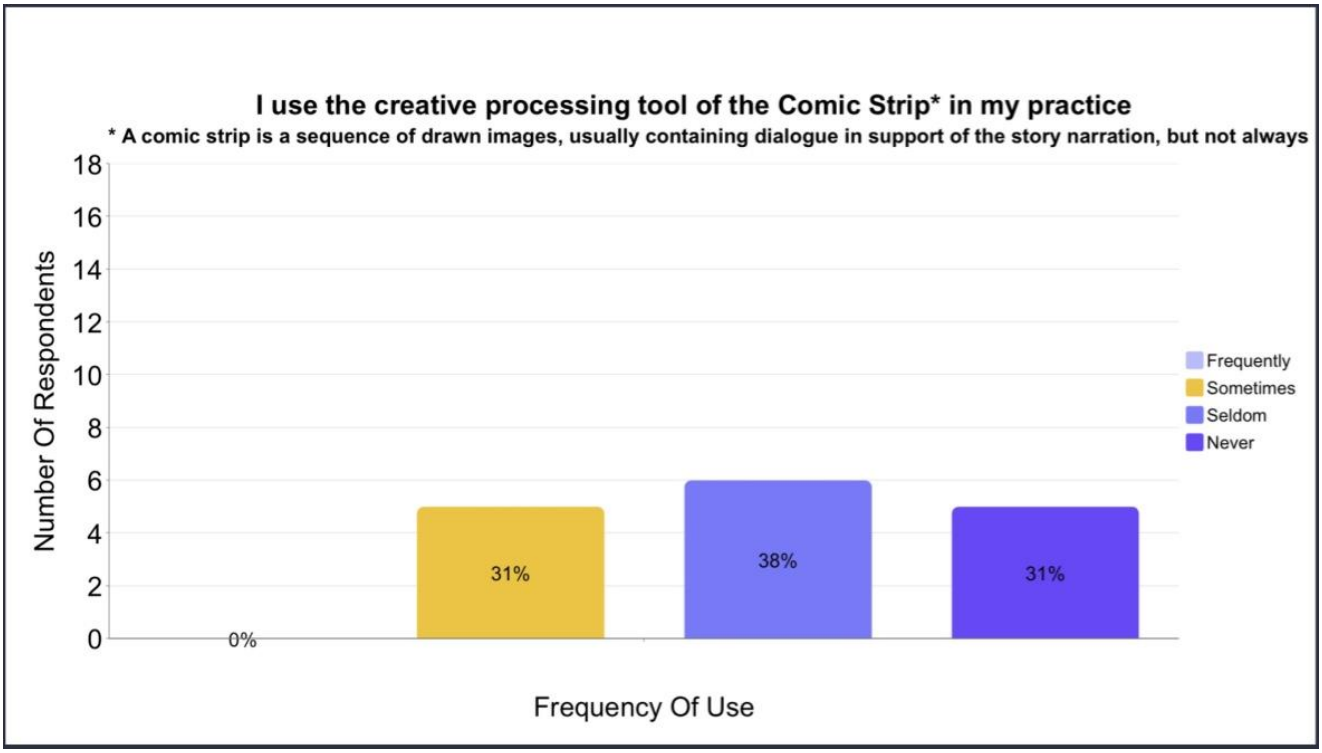

Table 6: Frequency of use of the comic-strip as a creative processing tool with clients

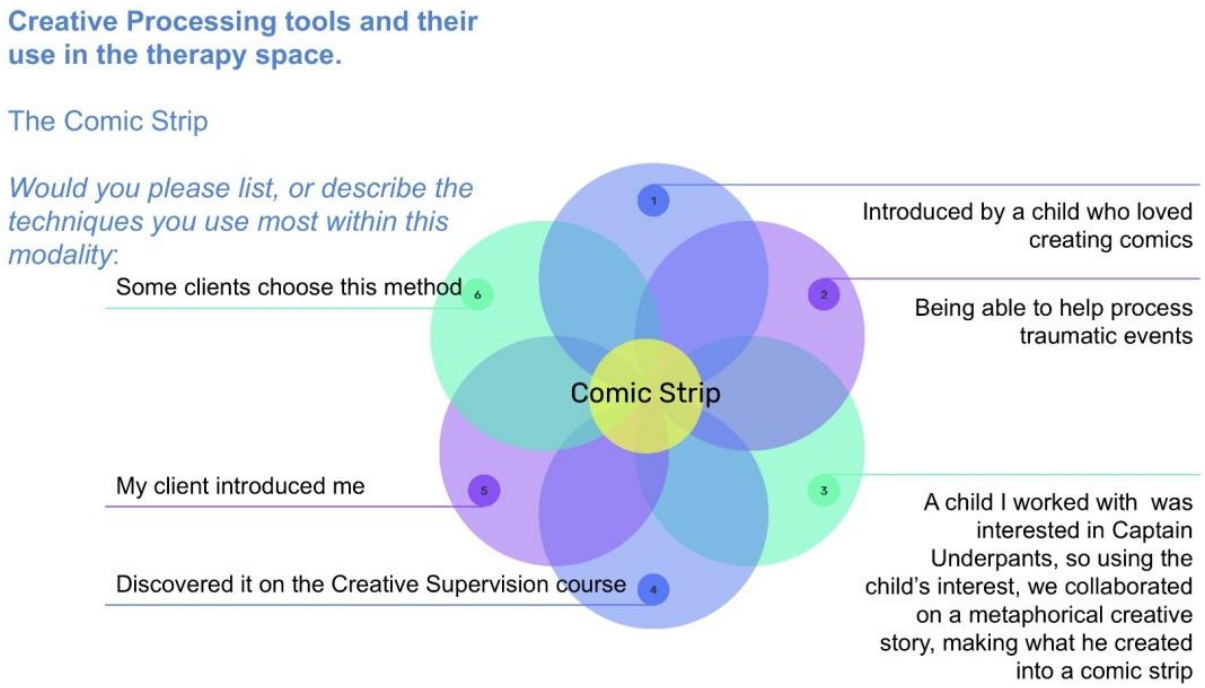

Table 6a: Breakdown of preference/use specificity responses for the use of the Comic Strip as a creative processing tool in the therapy space.

The study further examined the comparison between frequency of use of the three established creative processing tools, against the frequency of use of the comic strip. It is to be expected that the three more established creative processing tools, drawing, visual storytelling, and word-based storytelling, would be used more frequently within sessions than the comic strip format.

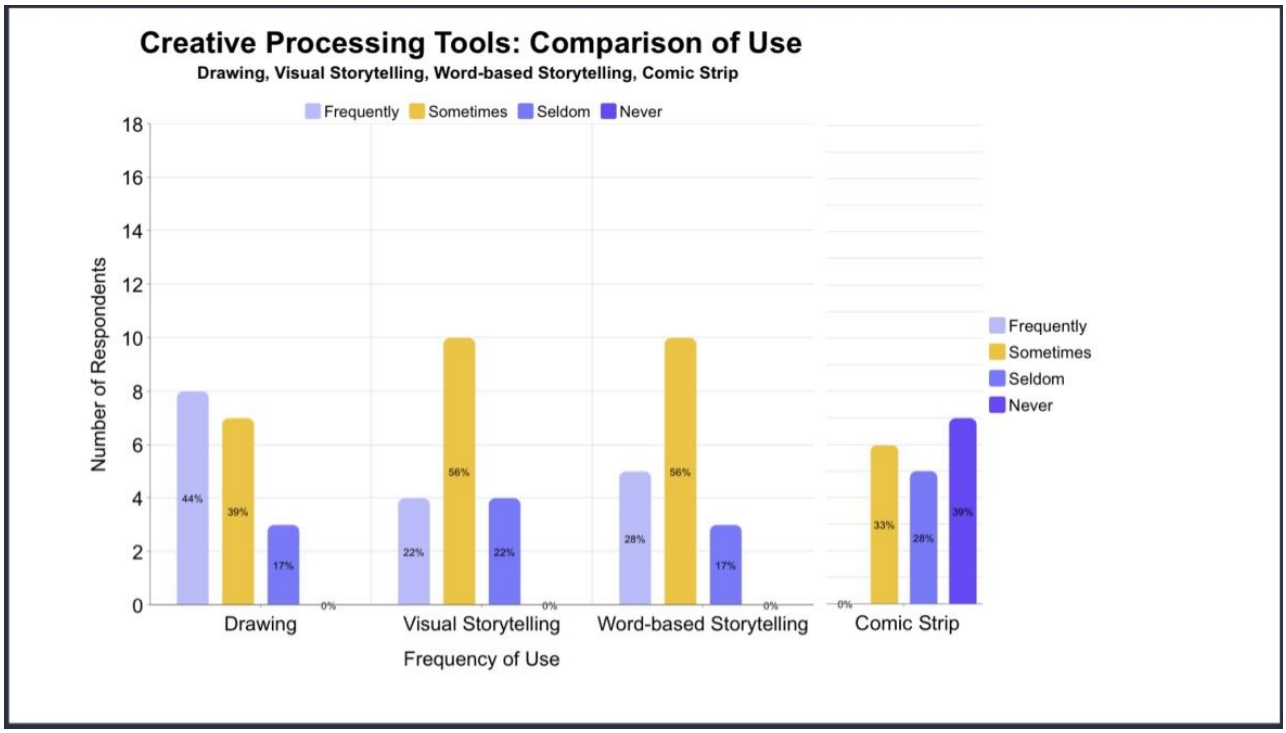

Table 7: Comparison Table: Frequency of use of the three established creative processing tools against the frequency of use of the comic strip technique

Summary of Quantitive Data Analysis

Quantitative data analysis shows that play-therapists used the creative processing tools of drawing, visual storytelling and word-based storytelling frequently, and were familiar with a wide variety of techniques and therapeutic uses of these tools (see Tables 2a, 3a, and 4a). The comic strip offered another way for elements of the three named creative processing tools to be used Reported frequency of use (as recorded by respondents) of the three main creative processing modalities and the comic strip format, should be further considered through the lens of non-directive play therapy principles and practice.

The non-directive play-therapist is trained to follow the lead of the child client in the therapy space (Wilson, 2005) and as such, use of therapeutic tools for processing will be the choice of the child, not as directed by the therapist.

Analysis of Qualitative Data

Interviews

Interviews were conducted with a sub-sample of five play-therapists. Three main themes emerged from the interviews, with eleven subthemes, (see Table 8).

Theme:	Subthemes:
Why use it: Value of the Comic Strip as a processing tool	• Named Values and benefits of engagement for the client • Sequential processing benefit for the client • Multimodality benefits • Autobiographical medium
When to use it: Therapeutic use scenarios and presentations	• Supporting self-expression/self- reflection/self-growth • Explicit memory support • Trauma processing
Ways to use it: Examples of use	• Storyboard • Sequential mapping • Try it on (different emotions, endings, directions) • Adding client into an established story

Table 8: Themes and subthemes emerging from the interviews.

All therapists offered descriptive words which they felt best encapsulated the potential benefits and values that comic strip creation could offer clients:

“Self-expression”, “self-reflection”, “creativity”, “opportunity for creative expression (struggles, hopes, desires)”, “ownership”, “a way of projection

(metaphorically)”, “process”, “what-ifs”, “thinking”, “access to the unconscious”, “sense of achievement”, “alternative way of communicating.”

The therapists with previous experience of using the comic strip format had all utilised it as a sequential processing tool.

“Being able to take things in stages, in a visual way, allows a child to have more opportunity to explore what it would be like to say something different, what it would be like to go on that route.”.

All respondents expressed a belief that access to a processing tool which can offer a multimodal function is beneficial in play therapy. Therapist descriptions of the modes of accessible communication in the comic strip medium included:

“visual progress, process, drawn events in boxes or thought bubbles, captions, capturing events in a graphic visual way, a story being told, using their voice”.

All respondents commented on the comic strip’s potential use as a means for a client to tell, re-tell or explore their own life experience.

A number of therapists gave examples of the tool having potential in supporting the client’s journey towards making the unconscious conscious:

“It really seems to get to unconscious aspects and gives the powerful archetypal hooks that really seem to strengthen them.”

One therapist used the phrase “Trying it on” when discussing her consideration about how she thought the comic strip could work for client processing:

“I like the idea of trying out multiple ideas, multiple endings. Like trying it on before committing to it”.

A therapist used her client’s ‘obsession’ with Captain Underpants to support him in making positive changes for himself. She re-drew the Captain character , adding therapeutic self-care elements, chosen by her client: “I created the sequential art, the comic strip based on the character he (client) was obsessed with ... the little boy created this dagger, I used the dagger and added it to the comic strip ... he charged it up with yoga, meditation. It charged pretty well and his problem got smaller.”

Summary of Qualitative Data Analysis

One of the main themes to emerge during the interviews was an agreement that the comic strip had therapeutic potential as a creative processing tool for use with clients, giving clients access to narrative and expressive processing techniques.

Therapists easily recognised how the comic strip utilized and layered the familiar therapeutic creative processing tools of: drawing, visual storytelling and word-based storytelling. However, there was a consensus that use was always dependent on client choice.

All interviewees were keen to access further information and/or training to better utilise this tool with clients.

Case study

The case study focused on the experiential use by De Vinchi Jr (pseudonym chosen by client) of using a comic strip as a processing tool. Case study content included an overview of client presentation, timeline of client engagement with play therapy, client interview (at the client's request), therapist's understanding.

Client Background

The case study client was male, aged ten, in his final year of primary school. The client had attended play therapy initially in 2019, aged six, for 15 sessions. The client, when aged six, had used comic strips as his preferred processing tool in the therapy space, creating large scale images, on card, using markers.

This client returned to therapy in 2023, to explore current issues he was experiencing with his father. Comic strip creation had continued to hold meaning and value for him; he now did it for fun and as a method of relaxing.

I asked if he would like to process his current issue using a comic strip. He declined. The comic strip genre now held a different resonance for him as his chosen art medium. He was proud of his drawings and his abilities to relay meaning and messages through his characters and story development. He created humorous character interactions, so was not willing to use the same medium to explore something which caused him distress and annoyance anymore. Instead, he chose to use his initial sessions to write his father a letter, highlighting his perspective and wishes.

He was keen to be part of the study and offered a theme which he wanted to explore, using the comic strip. This theme was chosen as he enjoyed talking about his past therapy experiences and how it had helped him to make sense of difficult life experiences. He was particularly interested in tracking his journey of self-acceptance, dealing with eczema. The client also requested that he be interviewed for the case study.

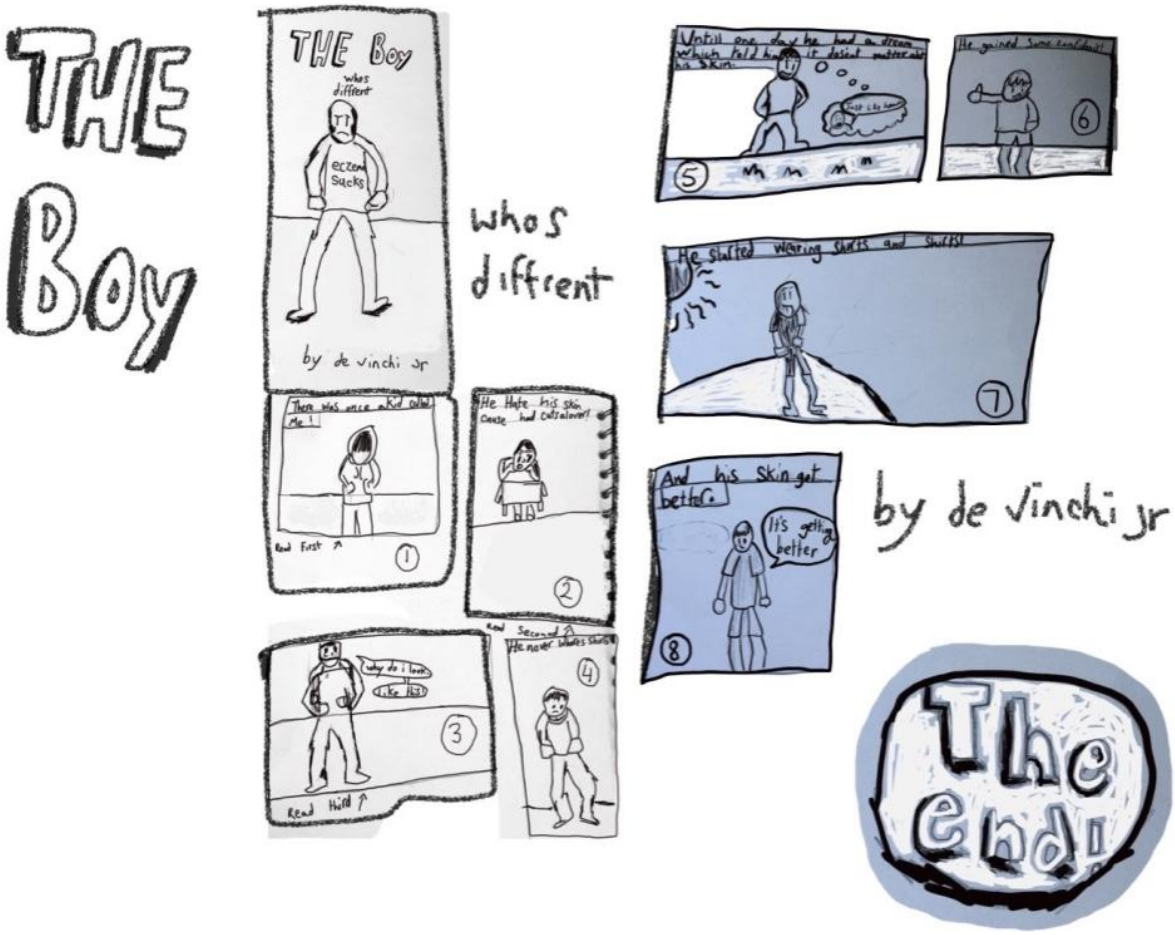

Figure 6: Eight-panel comic strip, titled “The Boy who’s different” completed by client in therapy session.

Table 10: Client comic strip panel content

Panel no.	Panel Content/Narrative/ Dialogue
Panel 1	There was once a kid called me
Panel 2	He hated his skin 'cause he had cuts all over
Panel 3	Why do I look like this!
Panel 4	He never wore shirts
Panel 5	Until one day he had a dream which told him it doesn't matter about his skin
Panel 6	He gained some confidence
Panel 7	He started wearing shirts and shorts
Panel 8	And his skin got better ("It's getting better"-speech bubble)

Table 10: Client comic strip panel content

The client's explanation of the content meaning of each panel is included below, in Figures 7 and 8.

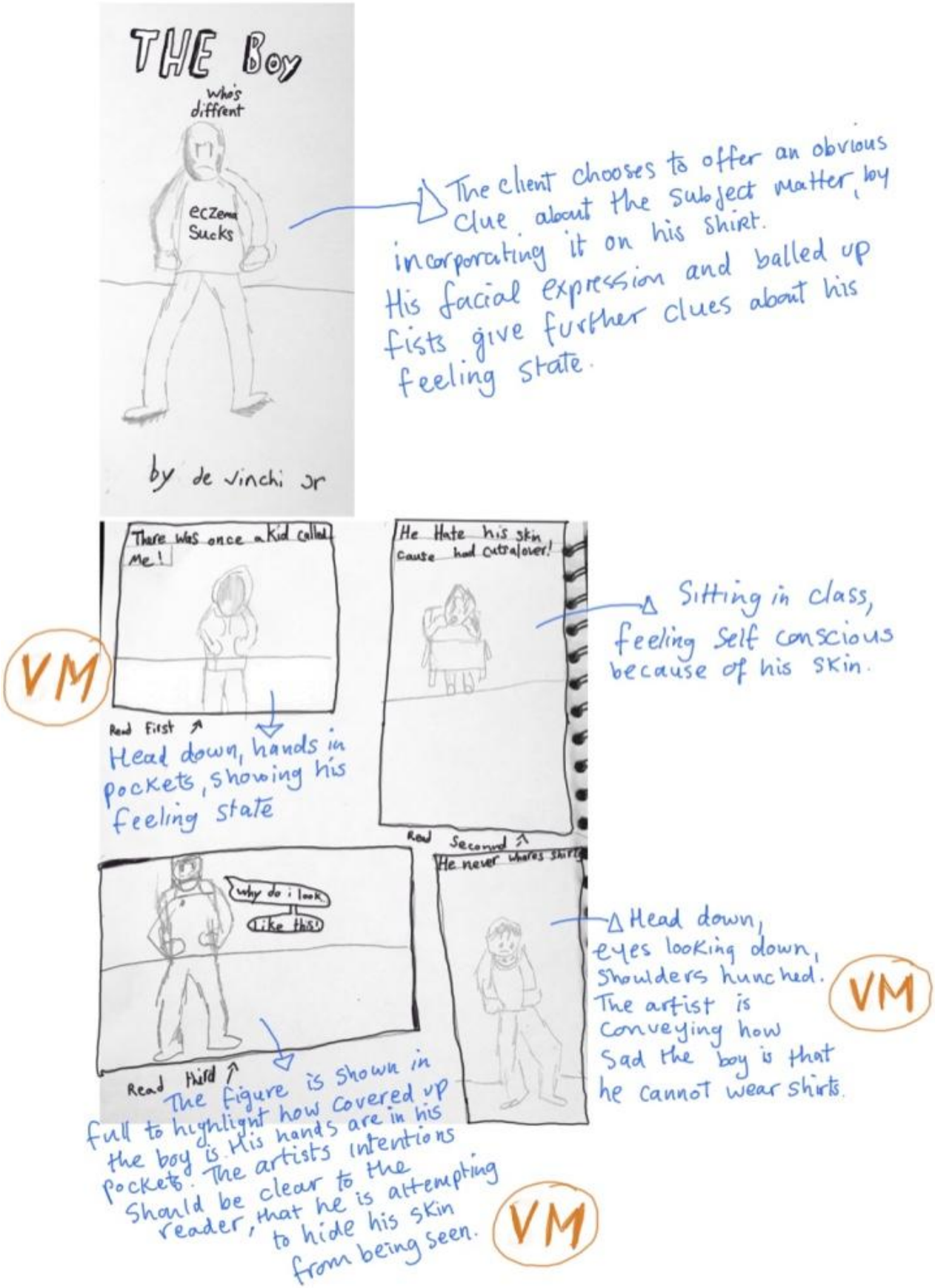

Figure 7: Client's explanation of comic content imagery, annotated by therapist. (Use of visual metaphor and emanata are highlighted by the inclusion of VM, E as they occur in the panels.)

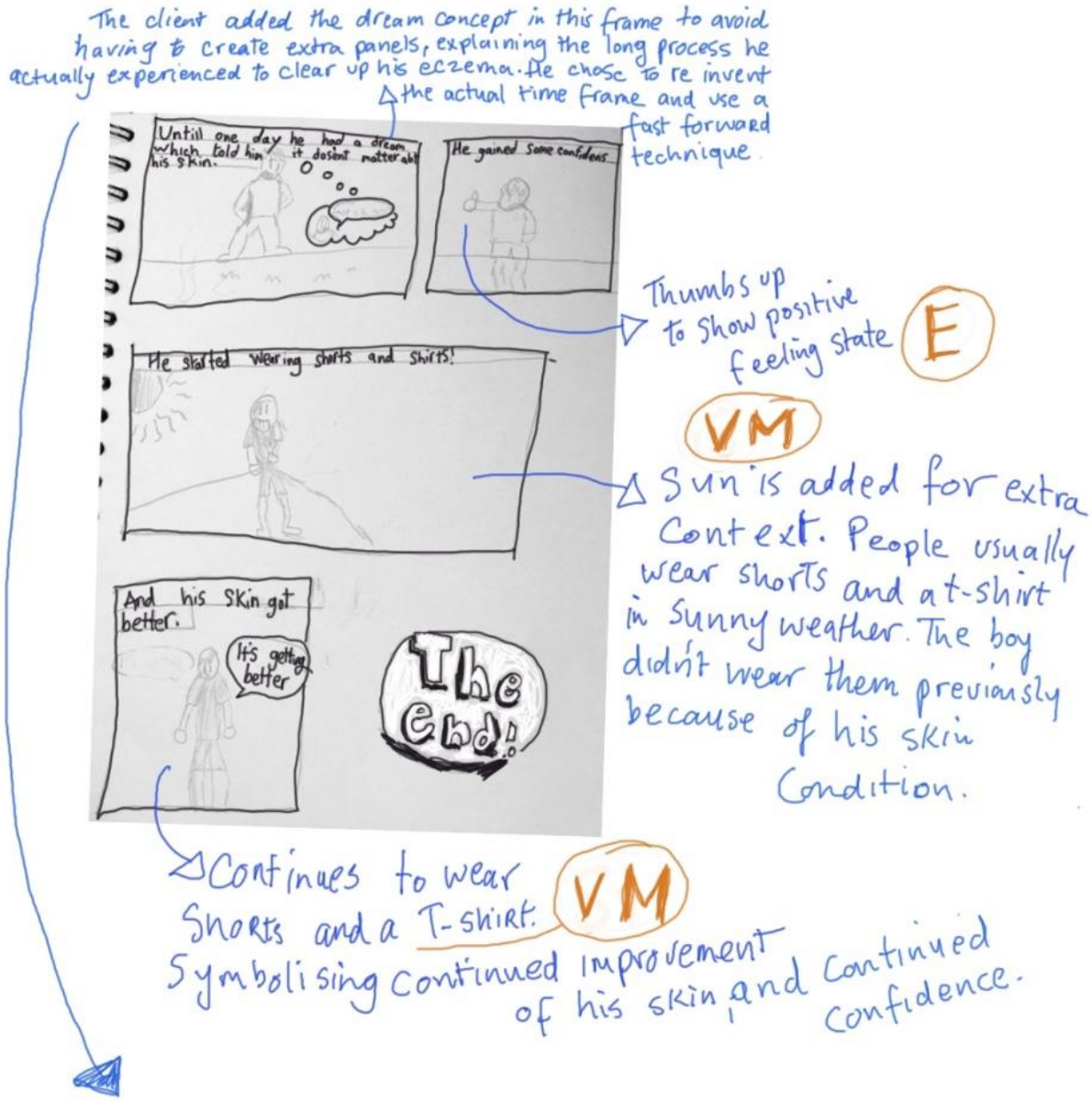

Figure 8: Client's explanation of comic content imagery, annotated by therapist. (Use of visual metaphor and emanata are highlighted by the inclusion of VM, E as they occur in the panels.)

The comic strip maps the client's journey, from self-conscious discomfort, both physical and emotional through to self-acceptance and pride in his achievements.

He positions 'the boy', the only figure featured in the comic strip, in a central position in each frame, facing the reader. 'The boy' shows various emotional states throughout the panels; annoyance, anger, sadness, dejection, shame, surprise, contentment and happiness, as he moves through the experience of dealing with eczema.

His emotional states are shown by subtle changes in facial expressions and through body posture: head down, hands in pocket, shoulders hunched. With nuanced shifts in the protagonist's posture, the client has added further feeling and meaning to his story. Eisner (1985) calls these postural changes 'expressive anatomy'.

In Panel 5, he uses one element in his story which is particular to comic strip story narration, "transporting us across significant distances of time and space" (McCloud, 1994, p.71). The comic strip creator can play with the passing of time within and between panels.

Versaci (2007), writing about memoirist comic content, points to the creator having the ability to mix past, present and future considerations in the same panel. The imagery may show the past, the speech bubble can offer a 'present' voice and the thought bubble could contain a future narrative.

The client chose to fast-forward time by introducing a bridging concept of having a dream. He doesn't give any further detailed information in the panel, the onus is on the reader to fill in the intervening moments and possible occurrences between Panels 4, 5 and 6. As the client's therapist reading this strip, I obviously had more data on the client and the client's journey related to

the subject matter. Eisner (1985) likens the reader to an interpreter, as they make sense of the content. The reader must draw from “common experience and a history of observation” (Eisner, 1985, p.20).

The case study content gives us direct access to the client’s perspective and his understanding of the therapeutic benefits of this processing tool:

When asked what inspired him to begin processing his feelings and experiences using comic strips, the client replied that he loved drawing, it made him feel a bit of relief from life. Asked how comic strips could be used in therapy, he answered that he thought they should be used for kids to put their problems out on paper, in a fun way, to take some problems off their chest. He highlighted the ability they afforded a child to change the ending.

Therapist Role

Developing a secure-base relationship with the client is the therapist’s initial priority (Lieberman & Van Horn, 2008) Attuning to De Vinchi ’s verbal and other cues in the first session, especially talking about his love of comics and wanting to draw his own characters (client notes), ensured success of a secure-base relationship (Schaefer & Kaduson, 2008).

This client was most comfortable expressing himself through the creative medium of drawing, and I was able to support his choice of using his chosen creative processing tool to work through life issues (Gussie Klorer, 2000).

The client required that I held space for him, as he made his creative explorations, and to bear witness to his creative processing journey, involving his choices and integrating insights at his own pace, as advocated by Carmichael (2006).

Discussion

This study developed from experiential use of the comic strip as a processing tool with clients within my therapy practice. I was keen to track other therapist's opinions about perceived benefits and how they would conceive of using this creative tool with clients. The results are considered in relation to therapist and client perceptions and experience, with examples from the interviews and questionnaires of their richness and variety captured in the commentary boxes, and the theory, practices, and principles of both play therapy and comic
strip/sequential art, in keeping with the study's interpretivist research paradigm (Cohen et al., 2007).

One of the main themes to emerge during the survey and interviews was an agreement that the comic strip had therapeutic potential as a creative processing tool for use with clients, giving clients access to narrative and expressive processing techniques:

One therapist spoke about the comic strip lending itself well as a visual processing tool. The client could use it to engage with an issue in stages, thus allowing them to have more opportunity to explore what it would be like to say something, to go that route, to do something different. Another therapist named the comic strip as offering a sense of narrative and further highlighted how it could lend itself to exploring and accessing archetypes, hero images and shadow aspects, probably more than other forms of creative processing.

Golomb (2011, p.80) observes, that children, motivated to make art, often present "a narrative tendency" or "an expressive tendency" in their content. The comic strip can facilitate a blending of both.

Therapists easily recognised how the comic strip utilized and layered the familiar therapeutic creative processing tools of: drawing, visual storytelling and word-based storytelling:

> A therapist highlighted that this modality offered the client access to the power inherent in words, language and metaphor. She also spoke about the drawing aspect, offering access to visual and imaginative processing.

The multimodality of the comic strip, as a processing tool was also considered by responding therapists:

> Therapist descriptions of the modes of accessible communication in the comic strip medium included: visual progress, process, drawn events in boxes or thought bubbles, captions, capturing events in a graphic visual way, a story being told, using their voice.

The comic strip creator can borrow from and blend any of these multimodal elements to present their story. Meaning can be further layered through the use of graphic symbolism and pictorial metaphor (Eisner, 2008). Both can be used as visual portrayals of emotional feeling states.

Symbols, icons and indexicals, used within the context of comic strip storytelling, can support that which Versaci (2007, p.74) names as a "metaphoric interpretation of reality", the subjective nature of the storyteller's truth. Objects, according to Eisner (2008) also possess their "own vocabulary in the visual language of comics [which can be used as] modifying adjectives or adverbs" (p.15) in place of text or lengthy written narrative.

All of the therapists interviewed, including those who had never used this creative format with clients, could perceive of various scenarios for use:

> Suggested scenarios for processing use, included: relationship focus with peers, projective conversations with parent or guardian, consciously processing a distressing dream, as a way to impact on a distressing experience, clarifying a life experience sequentially, test- driving a new idea, or seeking an alternative route(s) before the client commits to it.

(Agerbeck et al., 2016) and Chute (2011) points towards the comic strip and comics as an appropriate medium in which to document life and names the word-and-image form as suited to autobiographical life writing.

Processing of traumatic experiences was named by some therapists in the interviews as a potential use. Trauma presentations and response to trauma varies between clients, as does a client's 'literal' or 'symbolic' reconstruction processing method within the therapy space (Carey, 2006).

Jacobs & Dolmage (2012) consider the layered resources that comics can offer in the processing of trauma. They point towards the multimodal access that the comic format can offer the client to enable language, written word, and visual means of articulation.

De Vinchi Jr was able to name his appreciation of processing worries and problems, using the visual-verbal method of sequential art. His featured comic strip also points towards experiential conflict resolution, and the growth in his self-awareness, increased self- esteem and personal insight.

The client can choose not to be represented in the frames, but to watch his story unfold and reach resolution from a distance. For some children this is a safer option, when re- engaging with a traumatic experience. This could involve the child using another character to represent their story, or involve the therapist playing an active role in the creative process:

One therapist, recounting a younger client's sudden traumatic experience, spoke about her drawing a sequential story strip for the child. This proved to be an effective and safe processing experience for this younger client. The therapist already had an established therapeutic relationship with this client, so made an informed decision about what would best serve his therapeutic needs in this instance. She drew as the client spoke. This supported him to connect the dots of his experience, without the potential overwhelm of having the responsibility to present it solely by himself. The client then went back and forth, adding or changing details.

The client's experience in this instance aligns with Armstrong's (2020) consideration of the neuroscience of narrative. He makes the point that engagement with the 'twists and turns' involved in any story, compels the reader – and in this context the client could be considered as both storyteller and reader, as in the example above – to remain open to changes in perspective and understanding of the plot. This compelling engagement with the child illustrates how this "contributes to the brain's balancing act between pattern and openness to change" (Armstrong, 2020, p.1)

The purpose of processing in play therapy is to support the client to make sense of life events, resolve conflicts, explore feelings, and integrate insights, whilst building self- awareness, self-esteem and self-growth (Giordano, 2005). The purpose of the comic strip as a processing tool, is to offer an adjacent creative format for client use, giving access to narrative and expressive processing experiences. Narrative processing involves, according to White (2007), the linking of life events in sequence. This, in turn, offers "space for self-reflection and self-construction" (Angus & Greenberg, 2011, p.3). Expressive arts processing, is a process of discovery, "that comes from an emotional depth", through an art form (Rogers, 1993, p.1).

Interview data showed that there was no clear indication of demographic of client who preferred this type of processing. Question 16 (interview questions) queried whether therapists had been surprised by any aspect of using the sequential art format, related to a particular age group, gender, presentation, etc. Therapists' answers were based on personal experience of specific client use. Age ranges, genders and presentations were noticeably varied.

The following are some considerations for ways to use the comic strip as a processing tool, based on highlighted use in the survey, interviews, case study and through my experiential practice:

- Sequential presentation or mapping of a lived experience, by client or therapist, or jointly, using visual-verbal components, within frames.
- Revisiting or reimagining a scary experience, gaining mastery over the experience, using visual-verbal components.
- Trying out different paths, endings, choices, conversational narratives, within successive frames, using visual-verbal components.
- Client as a superhero or embodying characteristics of a superhero creating their own heroic characteristics, based on their interests or needs, using visual-verbal components.
- Client being added to an existing or favoured comic strip story of choice.
- The case study client had this to say about scenarios for use:

> "I think they should be used for kids to put their problems out on paper, in a fun way. It can take some problems off their chest; you can change the ending".

Barriers to use

Survey respondents and interviewees were asked to highlight potential barriers to use of this processing tool. The responses were varied. The majority of therapists flagged the non-directive practice and principles of play therapy as being the main factor in non-use of this tool.

A number of therapists named their own lack of creativity as being a possible barrier:
One therapist, whilst acknowledging that some therapists could see lack of drawing ability as a barrier, was able to re-frame her lack of artistic ability as a potential form of humour within the therapy space. If the child wanted her to represent for them through drawing, she was willing to do so and declared that she let the client know that it was okay to laugh at her attempts.

Client hesitancy was also named as a potential barrier: the client may not be a confident drawer, or the client may have no concept of comic strips. The case study client presented his view on hesitancy:

> "Some adults don't even try to draw, and kids enjoy drawing. Even kids that are bad at drawing still draw".

Having used the comic strip (sequential art) format with clients over a number of years, I have noted that it is not necessary for the client to consider themselves a confident artist to access this technique, an observation that is shared here, and could be emphasized in training with this technique to encourage its use.

A named barrier was, indeed, lack of knowledge about the ways to use the comic strip. All of the respondents were keen to access further information, with suggested guidelines for use. The therapist, following the client's lead and choices, ensures that access to preferred processing mediums is available for the client to use. This includes creative materials (Warren, 1984). The therapist must be open to new concepts, ideas and techniques (Crenshaw, 2008).

Conclusion to discussion

The discussion content presents the following conclusions for consideration:

•The comic strip has potential as a processing tool and uses accessible elements of established creative modalities; drawing, word-based storytelling and visual storytelling.

•This format of processing can be used to support a variety of presentations and scenarios of use. It can support many expressions of emotion and experiences.

•The comic strip content, created by the client, offers the therapist a visual access to the client's perspectives and emotional realities.

•Client choice is paramount in consideration of use, but therapist openness to use and awareness of this processing format should also be considered.

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NOT HOME YET

To what extent does group play therapy support Ukrainian refugee children who are newly arrived in Wales to make sense of their experiences?

Camilla Crowter

Camillacrowter@gmail.com

Abstract

The key purpose of this study - positioned within an interpretivist/ constructivist paradigm - was to explore the benefits of a group play therapy intervention for Ukrainian refugee children arriving to Wales following the Russian invasion on 24th February 2022. Five boys of primary age took part in the 8-week intervention. A mixed methods approach was used, with a range of data (parent and teacher interviews/ SDQ assessments/ HTP drawing assessments/ CRIES-8 surveys) being collected pre and post intervention with clinical notes being used to further inform findings.

Results indicated the positive impact of group play therapy in supporting Ukrainian refugee children process their experiences of war, with an overall improvement in behaviour reflected in mean total SDQ scores (parent and teacher data) and mean combined HTP scores. Thematic analysis of session content, HTP drawings, group process, and semi-structured interviews demonstrate a positive shift in children's outlook from feelings of isolation, loss, and disconnection towards a sense of safety, integration, and self-confidence. Recommendations for future training, research and practice are discussed.

Keywords: refugee, children, intervention, play therapy, Ukraine

Introduction

On 24th February 2022, Russia launched a military offensive against Ukraine, triggering a conflict that led millions to flee the country in search of safety. Almost overnight, more than 5.2 million became part of the world's 31.96 million refugee population (UNHRC, 2025). By July 2022, more than 100,000 Ukrainians – half of whom were children - had arrived to the UK through various routes and schemes.

The traumatic events of forced displacement combined with situational distress of acculturation can trigger a range of stress responses which - without intervention - can have negative long-term impact (Titzmann and Lee, 2022). However, these symptoms of trauma can be contextually normalized and should not be immediately pathologized. Many refugees succeed in harnessing their existing resource and resilience to navigate the challenges of displacement with minimal support (Schwartz, et al., 2022) whilst others may need additional help to function as before (Dokter, 1998).

Children are especially vulnerable to trauma since their brains are still developing - principally in areas responsible for cognitive function and emotional and behavioural regulation (Perry, 2017; Murray, 2019). Responses to these traumatic experiences can become defensive and survival focused presenting a threat to integrity and making relationships hard to maintain (Siegel, 2011; Van der Kolk, 2014). As a result, there is a strong argument for action and engagement in the form of early preventative work to mitigate risk and facilitate recovery (Bhugra and Becker, 2005; Silove et al., 2017; Schwartz, et al., 2022). The present paper aims to address this need by examining the effectiveness of group play therapy with Ukrainian refugees.

Context for the Study

Play therapy's power to transcend language has long been advocated. Virginia

Axline (1969) believed that play provides a natural way for a child to communicate, externalising their thoughts and feelings by sharing their world through metaphor. Additionally, through play and creative arts, trauma and loss can be explored through a reparative, body-based process (Van der Kolk, 2014; Seymour, 2016; Bareka et al., 2019; Malchiodi, 2020). Discoveries in neuroscience and developmental psychopathology have provided greater

understanding of how adverse experiences can leave 'traces' or memories,

increasing vulnerability and subsequently impacting behaviour, relationships and even biology and immune systems (Siegel, 2011; Van der Kolk, 2014; Roysircar et al., 2019). The use of 'preverbal language' in the therapy space enables implicit memories to be outworked and processed using the senses, the therapist's empathic responses further strengthening self-awareness and developing new neural pathways (Dieterich-Hartwell and Koch, 2017; Meyer DeMott, 2017; Bareka et al., 2019, p. 8; Heynen et al., 2022).

Siegel (2011) claims that the early connections children make with their caregivers help shape neural pathways in the brain which become foundational to their concepts of self - the navigational point from which they interact with the world around them. Through this social dimension, identity is forged, providing a sense of internal coherence connecting past and present (Erikson, 1993; Mosselson, 2006; Wilcke, 2006). As a result, refugee children are impacted greatly by forced displacement since their self-concept is not yet secure (Baker

and Jones, 2007). Cognitive frameworks which 'make the world manageable and are the basis for expectations' (Gottschald and Sierau, 2020, p. 189) become

uncertain, so perceptions must flex to adapt and survive in a new culture. A loss or denial of identity – now recognised as an innately fluid concept (Liebkind et al., 2016; Marsh, 2017) - can result, as children strive to gain acceptance in a new context (Dion, 2022).

Through enabling access to therapeutic interventions for this population, trauma recovery can be facilitated and a shift from dislocation and disorientation to safety and wholeness can occur (Bhugra and Becker, 2005; Van der Kolk, 2014; Dion, 2022).

Key adaptations such as the selection of toys reflective of children's backgrounds, can ensure cultural inclusivity whilst maintaining play therapy's core principles (Killian et al., 2017; Taheri et al., 2021; Ray, et al., 2022). Consequently, group play therapy offers an approach highly suited to supporting the needs of refugee children since it facilitates communication, cohesion, and a sense of belonging and safety, enabling children to grow in self-awareness, self-acceptance, and self-confidence as they process change, manage psychological distress and harness their inner resources (Marsh, 2017; Simmons, 2020; Wood, et al., 2020; Dion, 2022).

Focus of the Research

Although the field of trauma research has expanded significantly in recent years leading to a greater understanding of its impact on refugees and their experience, there remains a sparsity of studies evidencing the effectiveness of therapeutic interventions with refugee children. Available studies evidence play therapy as 'a promising intervention, particularly when targeting symptoms of PTSD in samples of young children' (Cowling and Anderson, 2023, p. 10).

Children's limited knowledge of host language and early stage of linguistic development mean they may more successfully project and express themselves symbolically (Kim et al., 2021) making play therapy a 'developmentally appropriate and culturally responsive' approach (Schottelkorb et al., 2012, p. 59).

Findings demonstrate the potential for art and creative expression provide 'a transactional space' in which elements from original and host cultures can co-exist and become integrated (Dieterich-Hartwell and Koch, 2017; Meyer DeMott, 2017, p. 511), creative therapies acting as a bridge - from past to present, from one culture to another – as children move between fragmented worlds and start to build connection (Heynen et al., 2022).

Play and creative arts allow trauma and loss to be explored on a body-based level (Bareka et al., 2019), the use of 'preverbal language' in the therapy space enabling implicit memories to be outworked and processed using the senses.

Evidence shows creative arts workshops have led to an increased sense of social connectedness and belonging for child participants (Heynen et al., 2022) as well as an improvement in hyperactivity and emotional symptoms (Baker and Jones, 2007).

Furthermore, creative therapies can act as a bridge - from past to present, from one culture to another – as children move between fragmented worlds and start to build connection (Rousseau et al., 2005; Dieterich-Hartwell and Koch, 2017; Heynen et al., 2022).

In conclusion, play therapy therefore offers this population a developmentally and culturally relevant approach. However, further studies with different groups within this demographic, considering factors such as nationality, country, age, trauma type and duration of exposure, are urgently needed (Genç, 2022).

Research Methodology

The researcher was positioned within an interpretivist/ constructivist paradigm, seeking to understand the subjective world of human experience through deep engagement with selected participants in the therapeutic process. This exploratory study followed a single case mixed methods design, and set out to evaluate the effectiveness of group play therapy when used with Ukrainian refugee children. The role of naturalist observer was assumed, the researcher directly involved in the group play therapy sessions. A convergent approach was adopted, with data being collected pre, during and post intervention before being separately analysed, then merged and compared to draw meaningful conclusions.

Intervention Design

The group play therapy intervention was delivered across the Spring/ Summer term over an 8-week period on a weekly basis in a primary school setting in Wales. Sessions lasted 45 minutes and were conducted and facilitated by two trained Play therapists (PTUK/ BAPT). Each session followed a similar format, and contained a warm-up activity, a main activity, and an end ritual. Activities offered were semi-structured and designed to facilitate a wide range of behaviours (see Table 1):

1	Introducing the group and establishing a group agreement
2	**Creating a nature sensory box (Nature-based art)** *Focus: developing attunement to others and to the environment; providing experiences of connection*
3	**Family sculpture (Clay)** *Focus: building bridges between the past and present*
4	**Create a shared world (Sand tray)** *Focus: to build connections with others*
5	**Mask making (Masks)** *Focus: to reflect on identity – both public and private*
6	**Painting to music (Music/ Art)** *Focus: to engage with a range of different emotions*
7	**Puppets pets (Puppets)** *Focus: to reflect on the past and reclaim memory*
8	**Memories activity (Story telling)** *Focus: to look inward and reflect on state of self in relation to experiences as a refugee; to hold on to friendships from home; to allow others to understand what these relationships mean to the child; to acknowledge the importance of new friendships* **Celebration**

TABLE 1
MAIN SESSION ACTIVITIES AND KEY FOCUS

Child participants were recruited through the school, on the advice of the Headteacher acting as 'gatekeeper'. The sample was selected according to specific criteria. Children needed to be i) in Year 5 or 6 ii) refugees from Ukraine, iii) currently attending the participating school and iv) living in Wales for over 6 months. From the sample identified, a total of 5 children – all male - took part in the research. Parents were sent an information letter detailing the purpose of the study, the procedures planned, the use and storage of data and the general session structure, as well as a consent form. Children's assent was also secured using an interpreter to ensure good understanding of the approach and purpose of the intervention offered. The study was underpinned by the Ethical Framework of Play Therapy UK (PTUK, 2022) and approved by Leeds Beckett University (LBU).

Data Collection Methods and Measures

Qualitative data relating to individual experiences of therapy was gathered and integrated from a range of sources using a variety of methods, including: semi-structured interviews with parents and teachers, clinical observations, House-Tree-Person (HTP) assessments (Buck, 1948), and clinical notes made by the researcher and facilitating play therapist.

This was further informed by quantitative data gathered pre and post intervention, including: the Strengths and Difficulties Questionnaire (SDQ, Goodman, 1994), Children's Revised Impact of Impact Scale (CRIES-8) surveys, and projective House-Tree-Person (HTP) drawing assessments. A member of staff for the Local Authority's minority ethnic service acted as an interpreter for all interviews and followed guidelines provided by the researcher. Where appropriate, assessments and measures were translated into Ukrainian using https://doctranslator.com/translate-pdf-to-ukrainian/.

Data Analysis and Results

- **HTP drawings**

HTP drawings were analysed at both a quantitative and qualitative level, with both descriptive and statistical analyses being carried out. Quantitative scores were based on Roysircar et al.'s method (2017) which objectively scores drawings created, identifying two types of impact - resilience (positive impact) and vulnerability (negative impact).

Results reflected an increase in the total score for children's resilience across the course of the intervention from 48 to 56, suggesting an improvement in children's ability to cope with the stressors they

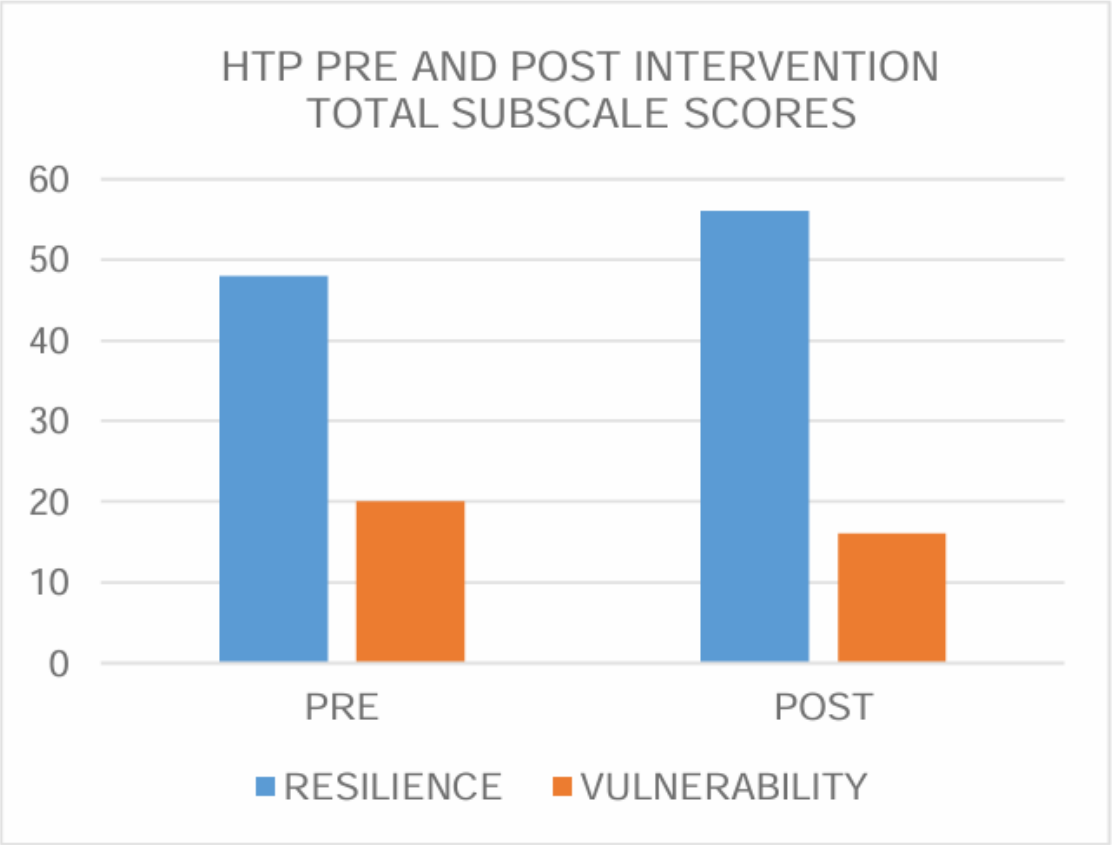
were experiencing. The total score for vulnerability decreased across the course of the intervention, falling from 20 to 16, suggesting a reduction in children's feelings of helplessness in the face of adversity (see Table 2):

TABLE 2 HTP SCORES DESCRIPTIVE ANALYSIS

HTP SCORES	PRE TOTAL	RANGE	MEAN	STANDARD DEVIATION	POST TOTAL	RANGE	MEAN	STANDARD DEVIATION
TOTAL	68	7	13.6	2.58	73	5	14.6	1.85
RESILIENCE	48	8	9.6	2.87	57	6	11.4	1.96
VULNERABILITY	20	5	4	1.67	16	5	3.2	2.32

These outcomes are graphically represented in Figure 1:

FIGURE 1 HTP PRE AND POST INTERVENTION TOTAL SUBSCALE SCORES



Subjective qualitative analysis of HTP drawings was carried out by two researchers who considered the dimensions of objects, the level of detail added, the location of objects, the strokes and lines and the attitude of the test-taker as key criteria when engaging with the drawing content.

This analysis was further informed by children's responses to Part 2 of the HTP assessment. Emergent themes suggested most participants experienced an overall positive shift from feelings of isolation, uncertainty, and emotional flooding at the start of the intervention to feelings of strength, connection, security, and community by the end (see Table 3):

TABLE 3 KEY THEMES FROM QUALITATIVE ANALYSIS OF HTP ASSESSMENT (PRE AND POST INTERVENTION)

CODE	PRE	POST
C01	stability, isolation, hostility	connection, community, strong, loss, open, external front
C02	security, uncertainty, small, protected, unsteady	strong, solid, trouble, difficulty, rooted, growth, grounded, disconnect
C03	order, healthy, central, fun, connection, status	community, established, growth, loss, aggressive, status
C04	unconnected, isolated, disconnection, attacking, defending	isolated, hidden, connection, growth, blank
C05	overwhelm, nurture, helpless, instability, limited vision, free, flighty	growth, security, change, solidity, movement, grounded

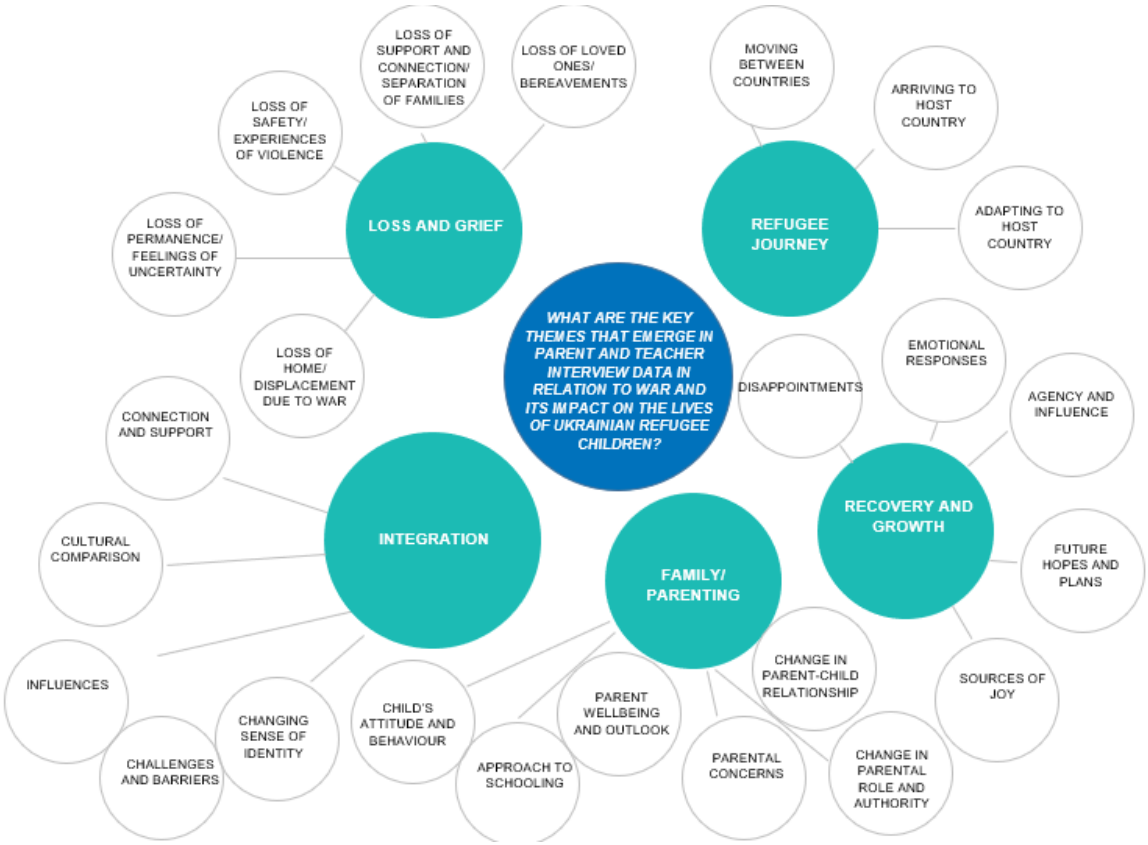
- **Semi-structured interviews**

Content from the semi-structured interviews (SSIs) with parents and teachers covering topics including family background, context for migration, child's relationships, behaviour, health, and development, friendships, strengths and hopes, was organised, analysed, and coded following Braun and Clarke's six-phase reflexive thematic analysis model (2012) to reach an awareness of how both parents and teachers perceived the shifts in children's wellbeing, mood, and behaviour as a result of the intervention. Five overarching themes were identified as a result:

- Loss and Grief
- The Refugee Journey
- Recovery and Growth; Integration
- Family/ Parenting
- Integration

These findings were visually represented in the form of a thematic map (see Figure 2):

FIGURE 2 THEMATIC MAP DEMONSTRATING KEY THEMES OF SEMI-STRUCTURED INTERVIEWS



- **Clinical notes**

Ryan and Edge's (2012) theme classifications, based on Erikson's psychological

stages, were used to analyse clinical notes, drawing out four prominent themes and related sub-themes on a group and individual level based on the play

behaviours demonstrated as well as the emotional content expressed in each session. Two of these were negative concepts and two were positive:

• Mistrust – death, destruction, loss, chaos, avoidance, lack of permanence (negative)

• Shame and Doubt – weakness, helplessness, limited vision (negative)

• Trust – safety and protection; nurture and care (positive)

• Identity – sense of belonging; hopefulness (positive)

Themes expressed at the start (Session 1-3) and end (Session 7-8) of the intervention were compared (see Table 4), revealing a slight shift in children's process to include a greater number of positive concepts:

TABLE 4 COMPARISON OF KEY THEMES IDENTIFIED IN GROUP PROCESS WITHIN SESSIONS 1-3 AND SESSIONS 7-8

	ERIKSON'S PSYCHOSOCIAL STAGES				
STAGE	Infancy 0-1yr	Early childhood 1-3yrs	Play age 3-6yrs	School age 7-11yrs	Adolescence 12-18yrs
BASIC CONFLICT	TRUST VS MISTRUST	AUTONOMY VS SHAME/DOUBT	INITIATIVE VS GUILT	INDUSTRY VS INFERIORITY	IDENTITY VS CONFUSION
SESSIONS 1-3	TRUST -safety and protection -attunement MISTRUST -avoidance -distancing or rejection of relationship	SHAME AND DOUBT -high approval-seeking -aggression -limit-testing	GUILT -over-concern for safety -non-compliance with social rules	INFERIORITY -alienation of peers	
SESSIONS 7-8	MISTRUST -avoidance -emotional detachment -distancing or rejection of relationship -death/ destruction/loss	AUTONOMY/ INDEPENDENCE -increased independence -age-appropriate risk-taking SHAME AND DOUBT -self-doubt -frustration		INDUSTRY/ COMPETENCE -friendship	IDENTITY -identification with a group

- **Strengths and Difficulties Questionnaire**

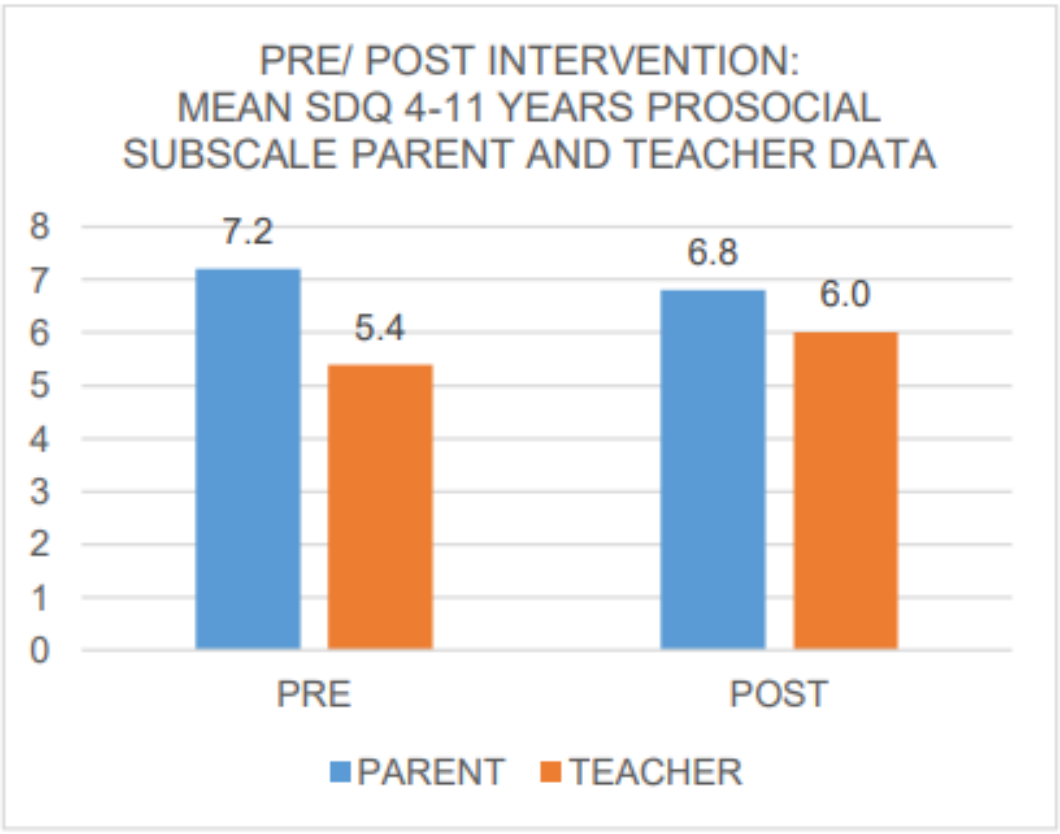
The SDQ is a well-evidenced, brief emotional and behavioural screening questionnaire designed for use with parents and teachers of 4–16-year-olds. The SDQ has been the most used measure in studies with similar client groups and with a similar therapy approach (Sullivan and Simonson, 2016; Bareka et al., 2019). Data generated for each participant for each of the five subscales (emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior) gathered before and after the intervention was added to graphs and tables, before being analysed to identify trends and changes.

The SDQ tool has a three-factor structure: 'internalising', (consisting of the peer and emotional sub-scales) and 'externalising', (consisting of the conduct and hyperactivity sub-scales), with an additional pro-social factor. Statements are rated on a 3-point Likert scale (not true, somewhat true, and certainly true) (Hall, et al., 2019). The resulting Total Difficulties Score is generated from the sum of the 4 subscales (emotional symptoms, conduct problems, hyperactivity, and peer issues) and decreases if problems improve. The 64 prosocial subscale is marked separately, and the score increases if it improves.

Results from both parent and teacher data were tabled, graphed, and analysed to identify any change following the intervention. Both teacher and parent data showed mean scores in all subscales fell within the normal range (< 80th percentile) before the intervention, with prosocial scores being borderline (90-90th percentile). Following the intervention, analysis of teacher data showed mean scores across all categories had decreased whilst remaining within the original range, with a slight increase in the prosocial score. Parent data showed a reduction in scores across all areas except hyperactivity, where there was a slight increase whilst remaining within the normal range. In contrast to teacher data, the prosocial score slightly decreased in parent data whilst remaining within the normal range, reflecting a negative trend.

The pre and post intervention total difficulties mean scores of combined parent and teacher data shows a reduction in overall scores suggesting an improvement in children's behaviour (see Figure 3, Graph A):

FIGURE 3 GRAPH A – PRE/ POST INTERVENTION: MEAN SDQ 4-11 YEARS PROSOCIAL SUBSCALE PARENT AND TEACHER DATA



- **Children's Revised Impact of Events Scale**

The Children's Revised Impact of Events Scale (CRIES-8) - a reliable and valid standardised measure composed of 8 questions which aligns with the DSM criteria for PTSD symptoms (Deeba, et al., 2014) – was used to determine both the levels of exposure to war trauma and the subjective reactions experienced by affected children within a specific period (Ehntholt and Yule, 2006). In accordance with instructions, children self-completed this questionnaire, so careful attention was given to how the tool was introduced and explained.

Data gathered was tabled, graphed, and analysed to identify changes within each subscale.

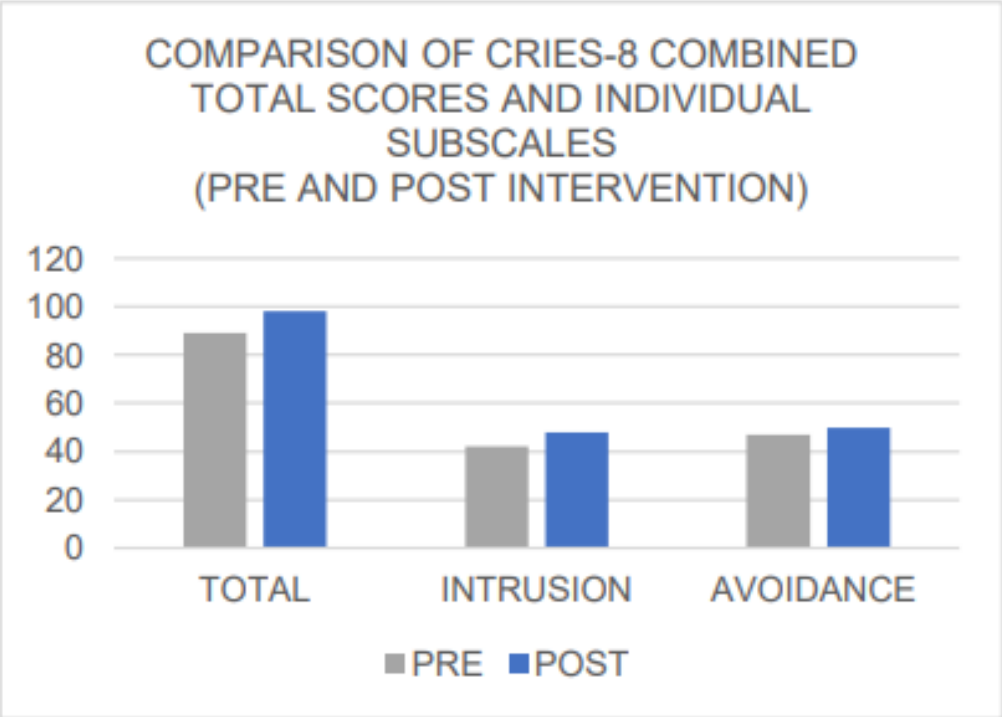
Results demonstrate an increase in the total mean from 17.8 to 19.6 across theintervention, with an increase of 1.2 on the intrusion subscale and an increase of 0.6 on the avoidance subscale indicating some children continued to experiencehigher frequencies of PTSD symptoms and were still mentally affected by the war in Ukraine and related events (see Table 5):

TABLE 5 CRIES-8 SCORE DESCRIPTIVE ANALYSIS

CRIES-8 SCORES	**PRE TOTAL**	**PRE RANGE**	**PRE MEAN**	**STANDARD DEVIATION**	**POST TOTAL**	**POST RANGE**	**POST MEAN**	**STANDARD DEVIATION**
TOTAL	89	16	17.8	5.71	98	21	19.6	7.71
INTRUSION	42	13	8.4	4.32	48	10	9.6	3.83
AVOIDANCE	47	11	9.4	3.93	50	17	10	5.83

Results were also graphed to represent data visually (see Figure 4):

FIGURE 4 GRAPH B – COMPARISON OF CRIES-8 COMBINED TOTAL SCORES AND INDIVIDUAL SUBSCALES (PRE AND POST INTERVENTION)



In conclusion, qualitative and quantitative data from this intervention demonstrate the positive impact and overall effectiveness of group play therapy with Ukrainian refugee children.

Discussion

This research aimed to explore the effectiveness of group play therapy in supporting Ukrainian refugee children to process their experiences of war and is the first known study of its kind. Subsequently, the results gained are of significant value in strengthening the existing evidence base since they demonstrate clearly the positive impact of group play therapy with this population.

- **Shelter and Safety**

Firstly, findings highlight the significance of the therapist's role in holding a transitional space for clients to know shelter and safety once more following their experiences of war and displacement – a primary focus when dealing with trauma (Schwartz, et al., 2022; Van der Kolk, 2022).

Children in the study were able to 'come and be seen', moving from places of isolation and disempowerment, to working both within themselves and with others to make sense of their experiences (Souter-Anderson, 2019, p. 27). As the group progressed, it was evident that shared language was not needed; instead, a process of therapeutic attunement was at work (Kossak, 2009; Dion, 2011).

- **Relearning the Self**

Secondly, outcomes demonstrate the positive impact of group play therapy on refugee children's sense of self. The fragmentation of their personal narratives had prompted a crisis of identity as foundational views of self, others and the world unravelled (Van der Kolk, 2020). Group therapy gave children an opportunity to return – both emotionally and developmentally – asking questions such as: "Who am I?", "What do I want?", "What is important to me?", "What are my values?", and "How can I be myself in my many worlds/cultures?" (Dion, 2022).

Through sensory, rhythmic, and movement-based activities, emotional energy was unleashed, facilitating regressive embodiment (Jennings, 2011). Post-intervention teacher interview data and SDQ results confirmed this concept of a strengthened self, staff noting positive shifts towards integration in children's attitudes and behaviour as a result of the intervention.

- **Community and Belonging**

Thirdly, findings indicate the role of group play therapy in developing a sense of belonging. Themes identified in qualitative HTP data analysis show children were able to move from feelings of isolation and disconnection at the start of the intervention towards themes of connection and community as they engaged with the unifying possibilities of their collective trauma in a group context (Acquaye, et al., 2020).

- **A Suspended State**

Additionally, this study provided opportunities to reflect on the nature of parallel process in the caregiver-child relationship. It became evident that while maintaining a focus on the child, there must also be a curiosity around the parent's own experiences of loss and an awareness of related trauma responses. In this study, the refugee experience - although individual in nature – was generally characterised by a sense of uncertainty. Parents found themselves in a suspended state, existing in the everyday whilst holding a deep longing either to return or move on.

Children's well-being must then be seen not only as a response to the traumatic events taking place around them, but also to the impact of these very events on their parents (Miller, et al., 2005). In most cases, the relational dynamic between parent and child had been disrupted, or greatly altered, with parents turning inward as a crisis response. This preoccupation with survival meant they had limited capacity to be curious about their children (Dion, 2022).

- **Cultural Aspects**

Finally, research findings reinforce the significance of cultural and linguistic barriers faced when working with refugees. Reflecting on cultural attitudes towards therapeutic intervention is a useful exercise as it can provide insights as to how support will be received.

In this instance, it was key to recognise that in Ukraine, strength and resilience are valued, so during hardship, many would quietly endure, carrying on through adversity without complaint. Seeking psychological support could indicate weakness so the concept of seeking therapy remains a progressive one which has only recently gained acceptance due to the war.

Cultural attitudes towards the therapist were also considered. Inherent to the refugee experience is a loss of power and influence. Consequently, parents can experience a range of responses including a sense of inferiority, dependence, gratefulness, mistrust, or resentment on meeting the therapist who represents the bigger system (Marlowe, 2018).

The researcher noted an emotional shift in how parents presented at the start and end of the interventions with initial and varying themes of hope, determination and disillusionment moving towards more negative themes of survival, despair, and anger.

In the current research, linguistic barriers were significant but not insurmountable. An interpreter was used during pre and post assessments to facilitate communication with parents and children. They acted as a bridge, offering an insight to the cultural and social context of Ukraine whilst building trust in the therapist and the process.

Implications of Research

These results build on existing evidence demonstrating the effectiveness of using the creative arts and play therapy with refugee children. By examining the impact of using group play therapy with Ukrainian children seeking refuge in Wales, the study further strengthens the research base highlighting this approach as both culturally and developmentally appropriate (Genç, 2022). Through therapeutic relationship, children were shown to regain a sense of safety and work through their traumatic experiences. By engaging in sensory-based approaches and non-verbal self-expression (Kwon and Lee, 2018), children were able to communicate embodied experiences and reach a secure self-concept (Van der Kolk, 2014; Malchiodi, 2020). The data gathered in this study shows group play therapy to be effective even as a short-term intervention of 8 weeks.

Limitations and Challenges

Several limitations and challenges of the study were identified. Firstly, the size of the sample meant limited conclusions may be drawn from the results. Secondly, all participants originated from Ukraine and left the country due to the Russian invasion and consequent fears for safety. As there is no diversity in participants' country of origin, results can only be applied to this population and meaning outcomes across contexts must be tentative. In the same way, since all participants of the group were male, some gender bias may be evident in results.

Additionally, the group took place in a school setting which, for some pupils, may have impacted their engagement with the therapeutic process. Not all children attended the group every week meaning some participants had a greater amount of therapy overall. The reality of researcher bias must be acknowledged as having an impact on the study, since interpretations or observations made are from a specific point of cultural understanding (Djelantik et al., 2022).

In conclusion, although some variables are constant, (i.e. ethnicity, gender, age of the participants), there are many additional aspects which cannot be controlled or even fully known, such as the dispositional traits of the children taking part, their openness to the therapeutic work and the degree of distress they had faced before starting the intervention.

Recommendations

- **For Policy and Practice**

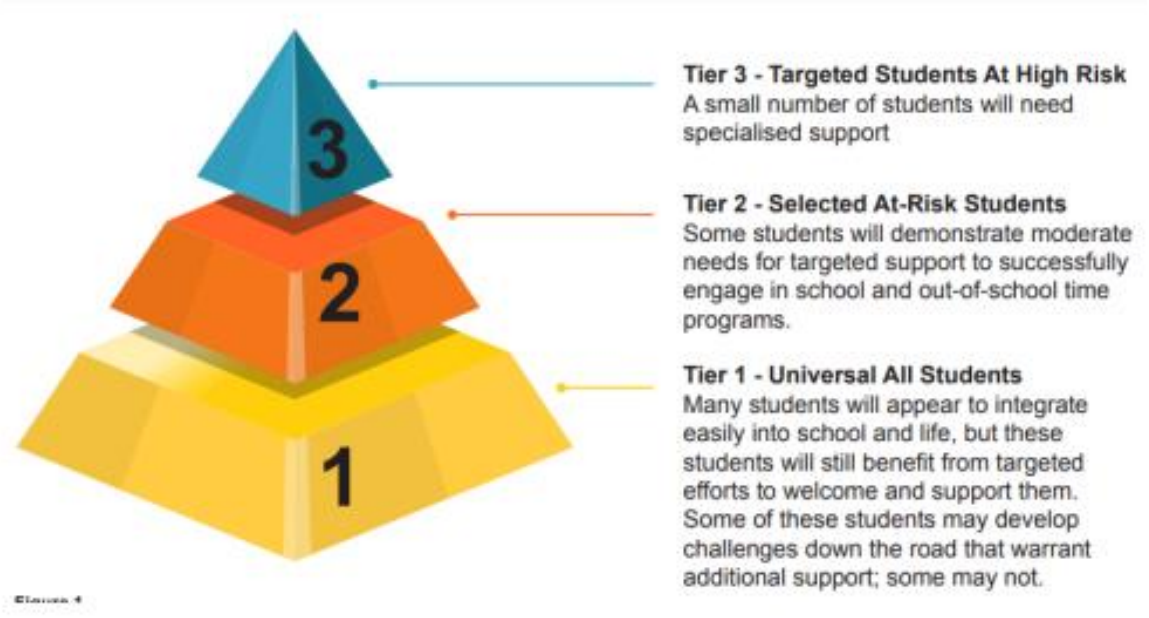
The process of relocating following war, violence or persecution is further complicated by the impact that these events can have on the emotional worlds of children (UKTC, 2023). Sometimes these events are traumatic, often shaping the way children view themselves and the world around them. This research highlights the importance of rebuilding a sense of safety, identity, and connection for refugee children and underlines the key role of schools and other educational landscapes in facilitating this.

Exploring ways to offer protective environments which enable children to recover from trauma is a priority. Establishing a sense of safety through relationships, language, curriculum, routine, and the physical environment is a crucial stage in effective trauma recovery (UKTC, 2023). This looks like learning children's names and how to pronounce them, offering teacher check-ins, learning some well-used phrases to show a desire to connect, ensuring predictable routines, providing sheltered corners within the classroom which children can access in moments of overwhelm.

Promoting belonging through enhancing inclusive practice and reducing barriers to access and participation is also key. Recognising cultural differences as an element to celebrate rather than as a problem to be overcome will shift the narrative of refugee children and empower them within their new context. Parmigiani, et al. (2023) claim the role of individual teachers must be emphasised in facilitating connection, healing disrupted healthy attachments and building positive, trusting relationships with children whose individual difference is valued

Staff training that leads to trauma-informed practice, with a focus on feelings and needs rather than on compliance is advised. By prioritising wellbeing ahead of learning, children 'will eventually be better placed to engage in their education' and make academic progress (UKTC, 2023, p.14). A tiered response is recommended (IRC, 2022) which details robust systems of support which can be accessed for pupils experiencing a range of need (see Figure 5):

FIGURE 5 WELCOMING STUDENTS AFFECTED BY FORCED MIGRATION: A TIERED RESPONSE (From: IRC., 2022)



(From: IRC., 2022)

Many schools now recognise that the role of a school no longer ends with academic education alone and see the value of investing in systems which support families in a huge variety of ways. Family support or liaison roles have been proven successful in strengthening home-school links. Expanding this support to refugee and asylum-seeker families is recommended as a means of promoting greater connection between school and parents as they seek to navigate a new culture. Overcoming linguistic barriers is key. Facilitating sessions for parents using an interpreter to share information and offer a space to answer questions will enable improved access and lead to an increased sense of agency for families still working within a trauma response of survival (IRC, 2022).

Offering courses which will develop key skills and strengthen parental confidence to navigate British culture such as language classes and 'stay and play' activities as well as using a peer-based model where possible, matching new parents to those who have been in the school longer for advice and support are among recommendations for practice (Parmigiani, et al., 2023).

- **For Training**

Schwartz, et al. (2022) note that not all children require specialist mental health services following exposure to war However, the sudden arrival of refugees from Ukraine into Wales has highlighted the need for a greater understanding of trauma among educators as well as a commitment to adapt pedagogy to be trauma-informed and responsive to the needs of this population (IRC, 2022; Parmigiani, et al., 2023). Play therapists also lack expertise in meeting the specific needs of this vulnerable group following their initial training so continued professional learning in this area is recommended.

- **For Research**

Ongoing studies using group play therapy among mixed populations of refugee children are needed, considering factors such as nationality, age, and length of time in host country, so that evidence base can be strengthened further. Ongoing advocacy is required to ensure that all schools recognise their role in providing timely and appropriate mental health interventions. The interconnectedness of the parent-child refugee experience suggests there is value in exploring a holistic systems-level approach to intervention to maximise the impact on children's mental health through the use of parallel interventions or systemic approaches (Kaufman, et al., 2022).

CONCLUSION

The refugee crisis remains a topic of intense debate on the world stage. The number of forcibly displaced in the world is growing. Children remain the most vulnerable population within this group and are at risk of developing mental health disorders unless urgent action is taken and timely, appropriate and effective psychosocial interventions are prioritised (ACAMH, 2023; Costanza, et al., 2022; Kaufman, et al., 2022). This study aimed to explore the role of using group play therapy to support Ukrainian refugee children newly arrived in Wales to make sense of their experiences.

The findings of the research are positive and highlight several key aspects. Firstly, the importance of group play therapy in providing safety through therapeutic relationship and the predictability of structure and routines. Due to this containment and steady witness, children felt secure enough to move away from feelings of psychological inferiority, mistrust and shame towards renewed confidence and self-belief.

Secondly, the role of the group in offering children a space to process their experiences and reach coherence in their narrative, moving from feelings of isolation and disconnection to encounter a new sense of community and belonging.

Thirdly, the power of offering children creative activities which enabled deep exploration of body-based memories and feelings and facilitated a shift from fear and anxiety towards greater self-awareness. In summary, this research demonstrates the positive role of group therapy for enabling successful integration of their experiences for refugee children and the suitability of the approach for this population.

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Den Play: From womb to tomb

An exploration of the metaphorical and therapeutic processes involved in den play

Katherine Jackson MA
katherine@vitalsparktheatre.org

Abstract

I was motivated to conduct an exploration of the metaphorical and therapeutic processes of den play. This motivation came from childhood memories and subsequent life experiences of this type of play.
An initial literature review concluded that there was little existing theory in the field of play therapy which related specifically to dens.

The study was therefore designed with a mixed method approach. The qualitative element was constructivist grounded theory with an interpretivist philosophical positioning. The research participants were play therapists. The sample size was 97 in the case of the quantitative element and 9 therapists were then engaged in semi-structured interviews.

Grounded theory analysis resulted in a substantive theory on therapeutic use of dens in play therapy. The quantitative results showed triangulation in some areas. The theory provides a definition for dens and a proposition regarding their value in play therapy. A key element of the theory is the suggestion that therapists undertake experiential training on the use of dens as a therapeutic tool in play therapy.

This extends to the use of dens as a tool for self-reflection and exploration of the therapist's inner processes.
The contribution of the study is to consider a new creative medium which allows us to consider both therapist needs and client needs.
Future research in the field is recommended which may test aspects of the theory.

Introduction

I was inspired to conduct research in this field due to clients in my own practice who have seemed drawn to den play, wider observations of children at play and memories from my own childhood. Despite being a widely acknowledged form of play, there is little existing research relating to the processes involved. By conducting a research study which aims to develop further theory on this topic it is hoped that the play therapy community will gain a richer understanding of its potential as a therapeutic tool.

The topic of den play fits within the integrative, holistic model of play therapy. A range of tools are used within a play therapist's kit. Within this model of working, PTUK therapists follow Axline's Principles (1972) while combining theories from existing research in Psychology and creative arts therapies. The connection between dens as a metaphor for identity is supported by the ideas of Carl Jung (1963) who saw them as an opportunity to shape oneself. In his memoir Memories, Dreams, Reflections, Jung talks about his childhood hidden spaces and secret places. Even at a young age they drew him to consider his place within the world. Much later, in adulthood, he built a tower… perhaps the ultimate psychological den. Jung explicitly describes these adult den building experiences as a representation of his ego-personality and draws metaphorical parallels with both birth and death: from womb to tomb.

It seems to me that in childhood and beyond there is something to be gained therapeutically through the metaphorical processes of den making and this could not only be a vital tool within play therapy practice for our clients but also as an act of self-care for the therapists themselves. I would argue for this reason that my research cannot be fully inductive as the frameworks that I'm working within will no doubt influence the interpretation of data to some degree whether consciously or unconsciously.

This piece of research aims to explore the processes which children experience when engaged in den play. One objective being to better understand the reasons

why children are drawn to engage in this type of play; another being, whether further understanding of these processes could add to their therapeutic benefit for clients in play therapy.
In order to answer my research question (To what extent do the metaphorical processes of den play have a therapeutic value for clients in play therapy?) I have generated and analysed data which explores what the metaphorical processes are and how these connect to the processes within play therapy.

Literature Review

There are differing views on whether a literature review should be conducted when the study will follow a Grounded Theory methodology. The literature review in this study was conducted prior to the commencement of the research. The purpose of this was to orient myself to the area of study. On finding that the existing research specifically relating to dens in play therapy was limited I looked for wider links to theory. Reflecting on this allowed me to ascertain where my assumptions were already forming which stimulated an awareness of this later in the study. Urquart (2007) is one of many writers on Grounded Theory who believes there is a value to a limited initial review of literature. She also believes that it need not prejudice the researcher but ignites theoretical sensitivity from early on in the study. A return to existing theory during data analysis helps to position the study within the theoretical framework of play therapy.

Methodology

The qualitative element of this study uses constructivist Grounded Theory (Charmaz, 1995) to develop a substantive theory which is grounded in the data collected for the study. It was therefore vital to consider my research philosophy. As my research question states my research is value-bound. The phenomenon of den play is primarily being considered within the context of play therapy. My research philosophy is Interpretivism as the reality of the den play processes cannot be understood independently of the therapists and clients who engage in

them. It was my aim as researcher to interpret and make meaning from these practices. This philosophical position meant that my reflexive skills would be essential to recognising my impact on the study.
I concluded that the most appropriate methodological framework for the qualitative element of my study would be grounded theory because it allowed the study to be an initial piece of research to lay a foundation of theory for future work.

The Methods used for gathering data were questionnaires and semi-structured interviews. The questions on the questionnaire were closed in nature in order to be able to make direct comparisons. The mixed methods nature of the design collected data that could be analysed both quantitively and qualitatively.

The research participants for this study are play therapists registered with PTUK. This allowed me to work with research participants who understood the concept of the inner child. They also had experience of working with clients in play therapy to draw on. Suitable sample size for grounded theory studies has been much debated. When working with interviews, there is no set number stated for when saturation will occur. In one hundred grounded theory studies which used interviews, the average sample size was 25 and the range was 5 to 114 (Thomson, 2011). A small sample size may limit the validity of the research. However, the quality of analysis and coding is also important. The aim was for the collection of quality data which enabled the extraction of meaningful results.

Results and Analysis

The questionnaire was completed by 97 play therapists though not all of them answered all questions. I believe that this was primarily because 32 of the participants answered “no” to having experienced clients making dens in play therapy and therefore were unable to answer some of the subsequent questions. 100% of the therapists who completed the question regarding personal memories of engaging in den play as a child said that they did have memories of this type

of play. 63 participants (67%) said that they had experienced clients making dens in play therapy.

Participants were also asked about whether they provide den making materials within their play therapy kit. This was interesting as it allowed me to compare the provision of materials with the instances of observing clients making dens. There was a 79% correlation between the provision or absence of den materials and the client's engagement with den making. This suggests that if therapists included more opportunities for den making within their kit then we would see more clients engaging with this type of play. More data is needed regarding the reasons that play therapists may choose to include these types of materials or not. 12% of participants said that they had seen clients making dens even though they do not offer den making materials which suggests this is a type of play which some clients will be drawn to instinctively.

In terms of safeguarding, it seems that there are more concerns from therapists who have experienced clients making dens in play therapy than those who haven't. Could this be because those who have not experienced clients engaging in this type of play have not considered the types of issues which may arise? This encouraged me to look at this area in more detail when collecting qualitative data. The results from the quantitative data stimulated several further questions and I hoped that the qualitative data may allow for more nuanced responses.

The construction of my questionnaire and the later reflection on this was a clear indication that I was already making an impact on the study with my preconceived ideas. An example of this was the selection of "construction, time inside and emergence" as the processes involved in den play. The separation and oversimplification of these processes means that there is little value to the data collected here. However, when comparing the number data of the therapists considering their own value placement to their perception of the client's process we can be curious about the possible reasoning. Without experiential training in

this area might therapists reasonably make assumptions about the value of the different elements which relate to their own experiences rather than having a deeper understanding of how the elements of den play may relate to the client's own process? The higher value placed on construction for the therapist reflecting on their own experiences may also relate to the fact that some therapists aren't providing that opportunity and are instead offering a premade "den" opportunity such as a pop-up tent.

This type of comparison can also be made regarding therapeutic themes identified in their own experiences and in their practice. Whilst there is a clear definition between the environments of free play and within a therapeutic setting it is interesting to note the similarities and differences here. The themes of safety and containment are clearly dominant, and it could be argued that they could have both come under the theme of a felt sense of safety. When considered as a single theme they account for over half of the responses in both cases. There is clearly a strong association between den play and the creation of a "safe space".

The main difference lies in the responses regarding the theme of control. This could be because children in play therapy have been referred due to specific difficulties and hoped-for outcomes have been identified. Therefore, the nature of the principles of play therapy to allow the child to lead and empower them to bring about positive change may illicit more controlling behaviours. Another consideration may be that we do not see control as a positive trait and therefore the therapist may have unconscious bias in not relating that theme to their own needs.

Nine play therapists were interviewed for the study and the data contained information about their own memories of experiences of den play, their definition of den play and experiences within their clinical practice. I was extremely aware during the interview process that I may be influencing the data with my line of questioning. Following the first interview I reflected on the transcription and evaluated the language I had used. By using the language of my therapy practice

such as “I’m just wondering…” and “Have I got that right?” it seemed that I had allowed for further elaboration without leading the participant.
Patterns and themes were starting to emerge throughout the process of open coding. I was concurrently memoing throughout, with the intention of keeping my codes close to the data. For example, there seemed to be such a frequent mention of safety that I wrote a memo which said, “am I getting bored of seeing “safe” and “safety” so I’m trying to make it about something else?”. I was concerned that if I didn’t stay alert to my own processes I would subconsciously start to miss mentions of safety altogether.

This was perhaps an overreaction to my awareness of potential bias in the study. It was the emergence of a pattern around darkness which drew me to realise that much of the data also alluded to fear and danger. I had memoed that it seemed strange to me that darkness is often associated with childhood fears and yet in the data there was a pattern of desire for a lack of light. This widened my lens to the need for exposure to limited threat or danger which builds resilience to fear. This also seemed relevant to a sense of living in a different time where there are less opportunities to take risks.

“Developing grounded confidence is driven by a commitment to learning and improving. Its near enemy is knowing and proving.” (Brown, 2021, P. 260) During open coding some connections began to emerge between categories. Birks and Mills (2015) explain that ‘Axial coding’ (Strauss & Corbin, 1990) is a form of intermediate coding which acknowledges the inevitability of identifying relationships at this stage of the analysis. Again, memoing was essential during this process. The memos mainly asked questions about definitions in order to better understand where the connections may be. For example, the word “comfort” has an assumed meaning but as Kolcaba and Kolcaba (1991) discover in their analysis of the concept of comfort there is a “conceptual richness which makes plain the unexpected complexity of comfort as a reality in human experience.” (P.1310)

The ten axial codes identified are discussed below with examples of codes which were included. Due to the iterative nature of the study, I was returning at this stage to existing theory for theoretical integration. I will use storyline to share my findings.

Code 1 - Reference to needs

Codes in this category related specifically to meeting needs, unmet needs, and identification of individual needs. This sometimes related to the therapist and sometimes to the client they were working with and their referral reasons. Reference to needs was particularly prevalent during attempts to define a den. One participant said, "Oh gosh… a den… I think it's a very personal space that's meaningful to me that offers a sense of safety, security, memory, friendship, and achievement as well because of the joy and excitement of making it." Without intending to the participant has referred to almost all elements of an existing theory of need. It's difficult to talk about needs without referring to Maslow (1943, 1954) and his hierarchy of needs. His initial theory that each category of need must be met before individuals can attend to the needs which are higher up the hierarchy has since been expanded upon. For example, love and belonging which are in the middle of Maslow's hierarchy and were not initially thought to be essential to human survival. Recent research shows that as we are a social species, the need for relationships is vital in order for humans to be healthy (Brown, 2021). Regardless of the debate about ordering of needs, Maslow's categories provided a theoretical framework for grouping half of the axial codes identified.

Code 2 - Survival needs

There were 53 codes in the data which related to physiological needs. These included rest, food, water, shelter, air, and warmth. This was the lowest quantity

of codes within the separate need categories which is perhaps surprising since a den can often be seen as a shelter. I wonder whether something is going on here which relates to our current societal values. Tricia Hersey (2022) attributes our lack of time spent resting to capitalism and links it to a lack of self-worth. She links rest with opportunity for creativity thus connecting physiological and high order needs. Perhaps the instances of survival codes were low because we take for granted that these needs are met but we must not neglect them. One participant reflected this when she said, "I do want to just kind of have time in a nice, quiet, dark, space and just be able to cut off from people when I need to and just regenerate. And it's a little bit (I suppose) harder with the expectation that as adults we're coping human beings and we don't need these things when actually we really do now." It's interesting to me that she used the words want and need here and it seems that the line between the two has become blurred and we are made to feel self-indulgent if we are meeting our own needs.

The deconstruction element of den play was elusive in the data. Research participants noted gaps in their memory when it came to deconstruction. I wonder if this is related to basic needs and the hope that our shelter will be consistent. Just as Mcarthy (2012) refers to a need to help things to fall apart in play therapy sometimes the den is deliberately destroyed. I have witnessed this within my own practice and the important elements seemed to be timing and control.

Code 3 - Safety needs

Within this category I have included codes which refer to containment and security as well as specifically to safety. I have also included references to comfort and protection. The opposites of safety such as fear, danger, threat, and insecurity have also been included as they are all seen as part of the perception of safety in the human experience. A familiar theme within play therapy, we recognise the work of psychologists such as Winnicott, Bowlby and Bion who developed theory on security, attachment, and containment. More recently

Stephen Porges (2017) noted the transformative power of the feeling of safety. He put it front and centre when he said, “safety IS the treatment.” In other modern play therapy theory, Paris Goodyear-Brown (2023) talks about the play therapist as the “safe boss” and the need to carefully dose the amount of exposure to “the scary stuff” (P.9). However, monitoring the child’s positioning within their window of tolerance becomes impossible if a therapist is outside of their own. Within the data there were times when the research participants seemed unclear about their own boundaries around den play. One therapist said, “that moment of hesitation of…you know, should I be going into this space, this really personal space that she’s created?” Another said, “I can imagine in a school if anyone had of seen a report saying that this child was in a dark space with an adult stroking her face… you know, there would’ve been some people thinking… (that don’t know about play therapy, that don’t understand that therapeutic aspect) and particularly if I had been a male practitioner it would’ve been like “ooh”.” As I coded this part of the transcript I noticed my own body tensing and a triggering of the stress response. I had memoed previously that the frequency of the word “safe” in the data was making me feel anxious. While not wanting to get in the way of the data I had to acknowledge my feelings. As therapists we act as external regulators for our clients, and we can only do that if we remain regulated ourselves. Lisa Dion (2023) talks about the importance of a reflective state in play therapy. Therapists must stay attuned to themselves and their own processes whilst also attuning to the client, she describes this as keeping “one foot in and one foot out.” Due to a lack of theory or training in the area of den play we as therapists are likely to feel a level of uncertainty which could be unhelpful in remaining present and able to attune in the moment. Codes which alluded to therapist safety were related to two aspects. The boundary of being able to see the child at all times is broken when a child is inside, and the therapist is outside. Most felt this was necessary to the child’s process and were satisfied that the client’s safety could still be ensured provided they were aware of what may be

inside the den with the child. One therapist had used translucent fabric to ensure that she could see the child at all times. She was confident that the same needs were being met. The other area of concern around therapist safety was the proximity of the space inside the den if a client invited them in. Therapists working in schools were more unsure about the perception of this than those in private practice.

Code 4 - Connection needs

Codes which referred to love, belonging, connection, friendship, trust, and acceptance all came under the axial code of connection needs. These needs are known to be especially strong in childhood and can sometimes override safety needs. There were 182 codes in the data relating to connection. This was the highest frequency among the axial codes related to needs. Even before the covid-19 pandemic there was an emerging sense of loss of connection. Hari (2018) set out nine types of disconnection that he argues are causing depression and anxiety. These included disconnection from other people, the natural world and childhood trauma. Societal trends such as this are reflected in the lives of our children as they develop neurons which mirror the experiences of those around them. Brené Brown's work on belonging (2017) explains that a sense of belonging is rooted in a connection to our self. Play therapy provides a safe environment for children to explore their sense of self without judgement. The therapeutic relationship also offers the opportunity for trust and connection. One research participant reflected to their client "You built this den by yourself and you're really happy with how it looks." The client replied, "no, I didn't do it by myself… I help from you!" This made the client feel able to collaborate positively and gave him a sense of not being alone.

In more than one of the client processes shared, there was a connection which did not happen by being in close proximity inside the den. Whilst the client was inside the den they would communicate using sound or rhythm which the therapist

would echo back from outside the den. Mirroring and matching are something that we learn in our training. However, the added element of the den blocking the visual sense seemed to intensify the connection through sound. This may signify a communication which overcomes challenges.

Code 5 - High order needs

Here I collated codes which relate to creativity, self-worth, accomplishment, respect, and esteem. In Maslow's hierarchy, these were the needs that when fulfilled would allow for peak experiences which are transitory moments of euphoria, joy, and wonder. The opportunities for creativity and accomplishment do not sit purely within the construction element of den play. The potential of imagination to transform the space is endless and there were many examples of this in the data. "We'd never have got the opportunity to go to the moon, but we thought we could!" This research participant's excitement was palpable many years on from the experience she was recounting. "Our imagination was massive! Absolutely massive!" The power of play therapy is rooted in the opportunity for creative expression. One therapist said that it was a large cardboard box which was used as a den in her practice, and it became a boat and a car. Imagination seemed frequently to transform the den into a mode of transport which was perhaps a metaphor for the client's moving processes and therapeutic journey. Several therapists made links between their own den play experiences and the children's literature which was their creative food. The transformative element of den play which emerged from the data is well captured by the 1970s TV show Mr Benn. The title character, created by David Mckee, enters a den like space in each episode, (a changing room in a costume shop) which transforms into a magical world. As noted in my literature review prior to data collection it has already been acknowledged that there has been a shift in this regard. Perhaps there is a need for a modern reimagining of a den in children's literature or perhaps we need to stay connected to the stories of the past. "Myths deal with creation and

destruction and rebirth and the struggle that each of these entails, as do children's play therapy themes." (Mcarthy, 2012 p.126) The data shows a high frequency of role play connected to dens. This type of enacted storytelling was present in many forms though they often included a level of threat. From the reenactment of a volatile homelife, robbery, and other unnamed dangers. Clients would often play with instructing the therapist to be the threat, facing the threat together or being the threat themselves. The combination of the den as protection and using imagination to play with fear was a common theme.

Code 6 – Control

Codes including choice, permission, freedom, rules, and empowerment were all included as well as direct reference to control. I also included references to hide-and-seek and the client playing with being seen and unseen. Control itself is not a need but you may require it to help you meet a need. Predictability and control are sometimes categorised within safety in Maslow's hierarchy. My reason for giving it a separate axial code were that there were 157 open codes which fitted within the title of control, so it seemed worth exploring in isolation. Controlling behaviours could arise as a result of an unmet need. When identifying play themes in her 2021 book *Advanced Play Therapy*, Dee C. Ray suggests that the internal statement of a child who is demonstrating themes of power or control may be "I must be in control of my environment to feel safe." Or "I must have power over you or others to feel worthy." (P.115) These internal statements suggest unmet needs from two different categories (safety and self-worth). One of the key principles of Play Therapy is that the child leads. The empowerment that comes from that autonomy is not to be underestimated. There are many opportunities within den play to assert control. Clients can lead or instruct the construction process. Clients have an opportunity to control whether (and which parts of them) are seen or unseen. Clients can give permission (or not) for the therapist to enter the den. There are opportunities for control when it comes to what to take inside,

controlling the sensory input such as light and sound and transforming the space through adaptations or imagination. In Gabor Maté's 2022 book *The Myth of Normal* he outlines how our modern society is putting stress on our physiological systems. One of the things that puts greatest strain on our stress systems within the brain is lack of control. If the adults within our society are experiencing uncertainty it is likely that they will look for things which they can control. If this is at the expense of children having the ability to make choices about how they spend time then the opportunity for this within the playroom will become all the more important.

Power struggles over control can be seen in family dynamics and in educational settings. More than one of the research participants reported children going under tables in a school setting which they believed to be an attempt to meet a need. "Oh! he's under the table again and we made him get out." A therapist was told by the school. "Why?!" she exclaimed to me in horror. "Why would you make him get out… he's like a tortoise with his shell on his back. Why do you want to make him get out. It's all about the power isn't it? The power of the school over the power of the child." This is a difficult balance for schools who are under immense pressure to meet growing mental health needs within what is supposed to be a learning environment. However, there were examples in the data of schools offering den play opportunities. The focus, of course, must be on allowing the child the opportunity of choice to create a space that fits their needs in that moment.

Code 7 – Transitory

The word transitory suggests an impermanence which could relate to the den itself or to our moment-to-moment experience of life. Codes related to time, context and moving processes. There is a link here between the den processes, the client's experience moment-to-moment and also that of the therapist. Therefore, a cross over occurs with connection needs because the level of attunement in the therapeutic relationship is also transitory. The instances of codes relating to a sense of "a different time" in relation to the therapist's own childhood experiences was prevalent.

Although this links to other themes which recognise the harmful elements of modern society, nostalgia may be unhelpful. The combination of happiness, sadness, yearning, and loss put us in the centre of the story of memories which may be untrustworthy (Brown, 2021). What we require for therapeutic attunement is an ability to be present in the moment, as Eckhart Tolle (2000) explains, time is a concept that we have created, and the only reality is the present moment. The transitory nature of life is one of life's only certainties. From darkness into the light, we are born, and each moment moves into the next. The movement element of transience links to the embodiment code when we look at the possibility of the body and mind to express the physical experiences of the cycles of life. The symbols of these cycles which can be seen in the den processes such a nest, an egg, the womb, a chrysalis can be seen as metaphors for the transient processes of life and death. This idea of holding the client and believing in their capacity for change is central to play therapy. We must never assume to know what the client needs as it will change from moment to moment. However, if we can establish a regular practice of curiosity about our own needs we will have a greater ability to be present in our practice.

Code 8 – Embodiment

Codes which have been connected here are those in which it is difficult to disconnect the mind from the body. The physical nature of den play or a bodily expression of feelings have been included. Also, codes which refer to the womb metaphor, birth, or transformation. In my preliminary literature review I referred to the work of Sue Jennings (1999) when considering den play as an embodiment piece in a child's play therapy process. The physical nature of moving in, out and around a space which has been created for a child can be challenging for the therapist. It does, however, offer an opportunity for the child to communicate physically, "this is what it's like for me".

An example of this in the data was a child who darted into the den and wanted the therapist to post things through the window. It was known that there was a possibility of sexual abuse. The therapist was supported in supervision regarding the possible symbolism in the thrusting action. The den provided a protective physical barrier but also a window into the child's experience.

The patterns within the collective codes here were that several children were described as having a chaotic movement quality. They did not seem in control of their bodies and the time inside the dens would initially be fleeting. Often this progressed over time to longer periods of stillness followed by an invitation to the therapist to join them inside the den. Emergent movement quality varied from a slow unfolding to a rapid and playful reveal. Much more is now understood about the mind brain body connection. The way that trauma impacts our physiology and how reconnecting to our bodies can be part of a path to recovery (Van der Kolk, 2019). The permissiveness of the therapist along with the physical aspects of den play allows the child to explore this. Peter A. Levine (2017) encourages us to listen to what our bodies are trying to communicate to us. He believes that there is an innate ability within our bodies to heal through movement. This faith in nature is not supported by modern, Western culture. Sweat lodges are an important cultural tradition used in ceremony by the Indigenous peoples of the Americas. Described as a womb-like experience in the belly of Mother Earth which gives an opportunity to return to our origins and let things go before continuing on life's journey (Maté, 2022). These ceremonies are led by Indigenous Elders to ensure the safety of this inherited tradition. Therapists in this study described engaging instinctively in "womb work" and reported that children who had been adopted seemed especially drawn to it. "They were flipping around and moving… it's amazing how that kind of happens naturally and then we kind of do the rebirthing thing afterwards." There is a tentative

leaning into our instincts when it comes to the symbolism of birth and rebirth. Death, however, is another matter. Pinkola Estés feels that in Western culture we are afraid of death and that this gets in the way of the natural cycles of renewal. She states the importance of knowing when something must die. In East Indian and Mayan cultures "Lady Death enfolds the already dying, easing their pain, giving them comfort." (Pinkola Estés, 1992, P.133) Could we allow this to relate to our role as therapist in den play to allow the den to become a tomb for that which must be left behind? Lady Death is also said to become midwife for a safe transition into new life as well as a story keeper for grief. This fits Goodyear-Brown's model of therapist as safe boss, nurturer, and story keeper.

Code 9 – Materials

There were many codes that related to the materials used for den making. It was considered to be an important axial code in the context of the hoped-for outcomes of the study. It is an area that needs consideration in regard to the contribution which the study may make to the field of play therapy. References were often to found materials which offered the combination of a firm structure with a soft covering. Furniture was often moved or repurposed in conjunction with fabric of some kind. There was some uncertainty over the definition of a den which meant that therapists were unsure whether to include experiences of clients using an existing small space such as a tent or table. Definitions offered were very open. It was clear that dens were many things to many people. One described it as "whatever your imagination wants it to be" and later added that a sense of ownership or belonging was also important.

Other areas of the play therapy tool-kit are all supported by existing play therapy theory so it is not surprising that den materials are not included. The data noted this absence, with one participant stating, "they (dens) should be an integral part of the toolkit." Materials provided by therapists for den play included pegs, string, blankets, cushions, mats, and sheets. Premade structures included circus tents,

black sensory cube tents and a cardboard box. Found materials included an upside-down rocking chair, washing airers, tables, chairs and a long- tailed rainbow fan. It is considered helpful in therapeutic spaces to offer a range of opportunities for big and small spaces so that children can choose how to use the space according to their perception of safety (Goodyear-Brown, 2019).

Code 10 – Therapist

Codes which included references to supervision, safeguarding and training were included. Although there was some cross over with the category of safety (especially relating to the therapist's safe practice) it seemed important to consider this in order to maximise the potential contribution of the study. As I myself am a practicing therapist I was very aware of myself within the study at this point. I recognised the feelings of concern for balancing the ethical principles of beneficence and self-respect. This effectively requires the balancing of the client's needs with your own and it often requires a sound knowledge of theory. As the instinct of therapists is that den play has high value for the client's well-being they will need theory to lean on when feeling that their own safety needs may be compromised. Returning to the codes in this category I have found that very few of them are actually about safeguarding. This made me realise that my own anxieties around this area were getting in the way of the data and potentially the study itself. These therapist codes were more commonly relating to the importance of the therapist in the therapeutic processes involving dens. As many of my participants shared, childhood den building can be a solitary activity. They recalled feelings of comfort, empowerment and the value of a time and space away from adults. So why bring dens into play therapy at all? The therapist is the witness and the container. In the dance of attunement they keep in step with the child while acting as an external regulator. These elements have been discussed previously but the important thing about this code is more than that. If the therapist has not experientially explored their own past experiences, feelings, and associations to dens then it is possible that they will find it more challenging to hold dual attention to the processes in the room. If we collectively think we know that dens are about safety, will we be open to rethinking this idea?

Core Category and Theoretical Saturation

Having explored the axial codes and theoretical underpinning of the ideas involved I began diagramming to explore how the axial codes connected. At this stage I was feeling a strong sense of imposter syndrome. The pendulum had been swinging throughout the study between conviction and doubt. All of the axial codes seemed so anchored in existing theory that I started to wonder whether I had anything new to say at all. Adam Grant's 2021 book *Think Again* helped enormously here because he shared that imposter syndrome can sometimes be helpful in staying curious and not assuming that we have the answers or even that there is an answer to be had. It reminded me that if people didn't offer theories because they were afraid of somebody proving it wrong then we would never learn new things. We should embrace being proved wrong as the new gift of knowledge that it brings. My philosophical position is interpretivism. "Interpretive theory calls for the imaginative understanding of the studied phenomenon." (Charmaz, 2006) My imaginative understanding of dens and their therapeutic potential is that they are a space within a space. The definition is the key to my theory because it is what was missing from the jigsaw. The core category is definition. The axial codes fit within that definition. I believe that theoretical saturation of the data I collected and analysed is summarised in the following:

Dance of attunement

Everything is transitory

Needs are not fixed

Spaces can be transformative

The diagram that led to this model explains how dens can be seen as a tool for considering both client and therapist needs. The continued instinct of children to do this is a lesson to adults. In her 2022 study of pandemic-fatigue and therapist self-care, Catherine Hennessy found that 40% of the therapists studied were not prioritising self-care. She did note the ability of therapists to access varied forms of self-care, probably due to their creativity. It often seems as though self-care is seen as way of continuing to do more than is reasonable. Maté (2022) recommends regular compassionate self-enquiry in order to remain healthily connected to our minds and bodies. We may feel that we do not have time, but there are rich rewards for those who take time to recognise their needs.

In a sense my analysis of the qualitative data renders my quantitative data superfluous. I believe that due to the transitory nature of our human experience, the same people may answer those questions differently at a different time. However, the number data that suggests we all have a predisposition to den play is supported by my findings in the interviews and the key here is opportunity. It seems in both sets of results that the provision of materials is secondary to the therapist's ability to remain open to the processes and true to the key principles of play therapy.

Discussion and Recommendations

It was proposed in the theory that den play is instinctive. If this is the case then play therapists will continue to see clients engaging with the processes involved whether they provide materials specific to it or not. Therefore, the contribution of this study is to provide play therapists with a reference for consideration when that happens. There is certainly the potential of wider application of the theory. Further research possibilities in this area are multiple. In order to measure the effectiveness of dens as a wellbeing tool for therapists I suggest Arts based research. This could include a regular practice of taking time to reflect on our needs and the creation of a space which we feel meets those needs. The implications of this study for clinical practice are that the value of a professional development course based on the theory has been identified. A definition of what constitutes a den has been offered and the theory proposes that the engagement in this type of play is instinct driven.

The therapeutic relationship is central to the theory in relation to play therapy. The value of self-reflection on maximising the quality of attunement is noted. The need for an alertness to transitory processes is also stated.
As a result of this study, it is hoped that therapists will have a reference for when clients are drawn to this type of play and an openness to engagement with the processes involved.

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Outcomes and Updates in Developing a Second Edition Clinical Evidence Base for Play Therapy

Sophia O'Neill & Dr Stephanie Lambert

Abstract

This paper presents the rationale behind the development of a second edition clinical evidence base (CEB) for the Integrative Holistic Model (IHM) of Play Therapy. The work builds on that published in 2017 by Thomas & Lambert. The requirements for the new system are described and how data analysis and collaboration with member practitioners (of Play Therapy UK and Play Therapy International) led to extensions and additions to record keeping.

The paper rigorously analyses the data concerning the overall effectiveness of IHM play therapy using robust statistical testing. In addition to aggregate outcomes, the analysis includes multiple sub-group evaluations based on client scores to create a full picture of the positive impact of the intervention with children. Notably, the study examines the efficacy of IHM play therapy for children across differing risk bands, revealing solid evidence—derived from parent and referrer reports—of significant improvements in Goodman's (1997) Strengths and Difficulties Questionnaire (SDQ) scores for most children receiving IHM play therapy as an intervention. These findings underscore the therapeutic value of IHM play therapy across diverse clinical profiles and, crucially, it's consistency over time. Conclusions and implications for future practice are integrated throughout the paper.

Acknowledgements

It is with great gratitude that we acknowledge the commitment and effort made by all PTUK & PTI members in recording their clinical outcomes to the CEB created for this task. We thank them too for the work behind these records, providing early, effective and expert mental health support for children, young people and their families, around the world. It is our goal that papers such as this will continue to elevate and explain the work, helping to reach more children in need, with evidence-based approaches.
All practice data analysed in this paper pertains to play therapy under the Integrative Holistic Model (IHM).

Introduction

This paper follows three previous papers written by Jeff Thomas and Stephanie Lambert (Thomas, 2016; Thomas & Lambert, 2017; Thomas & Lambert, 2018). These discussed the creation of and results from a Clinical Evidence Base (CEB), where data from real world practice could be collected and examined.

'*Towards a Clinical Evidence Base'* (Thomas, 2016) was the first evaluation of the Integrative Holistic Model of Play Therapy. Employing the Goodman Strength and Difficulties Questionnaire (SDQ), the paper reports that "overall, children improved significantly following an intervention based upon the standard Integrative Holistic Model of Play Therapy."

'*Outcomes of Developing a Clinical Evidence Base for Play Therapy'* (Thomas & Lambert, 2017) examined over 21,000 clinical cases. Parent and referrer SDQ data was analysed. Referrers reported positive change in 72.9% of cases, and parents in 74.2%. This was shown to be statistically reliable. In the approach to writing this fourth paper, a superficial look at current data revealed that from 47,100 complete cases since 2019, referrers report positive change in 74% of cases, rising to 85.4% for those children with the highest needs at the time of referral. Parents report positive change in 73.1% of cases, rising to 80.3% for those children with the highest needs at the time of referral. The consistency of efficacy was initially encouraging but awaited due scientific scrutiny.

The third paper '*Expanding the Play Therapy Toolkit: The Inclusion of Evidence-Informed Other Activities'* (Lambert & Thomas, 2018) examined the activities undertaken by the children during therapy sessions. Understanding how and which therapeutic media are employed by children is relevant to best practice and dissemination of knowledge across the profession. By examining the most frequent types of play that fell into different/new categories from those traditionally included, they argued for their inclusion in the choices available for member record keeping. These inclusions were made, and led to an approach of evidence-based flexibility to CEB design.

In 2019, PTUK/PTI moved record keeping to a new, 2nd edition CEB model (herein CEB-F). This was due to technical difficulties with the first database, related to it being the first attempt at such an ambitious design. Learning from the first experience, and listening to feedback from service users, resulted in both a more capable and user-friendly model being created the second time. Following the transition to the new database, this paper aims to replicate the measures undertaken by Thomas & Lambert in 2017 using practice data recorded since 2019.

The chief method for measurement remains the Goodman SDQ, as it is not only a well-respected and widely employed standardised measure but provides clearer openings to compare datasets outside of our organisation, leading to contributions and collaborations to the benefit of the field of child and young person mental health. This 2025 evaluation of effectiveness of the IHM of Play Therapy will be administered with the same statistical testing and rigour as the 2017 paper.

In 2017, the analysis was conducted from 46,367 SDQ records, the total from the start of collection in the early 2000s. This paper is to be taken from the dataset collected since 2019 (until December 2024). At the time of extraction, 43,500 records are suitable for statistical analysis. Approximately 7,000 reports are from children themselves, 20,000 from parents and 16,000 from Referrers. Future research plans include triangulating our understanding of the IHM through analysis of the children's own perspectives.

As stated by Thomas and Lambert (2024, p12), “An important point to consider in designing data capture for a CEB is that unlike a one-off study, a continuous flow of data is needed.” The CEB-F currently provides a multi-faceted and continually updating picture of client work. Client demographics, presenting conditions, number of sessions, severity of need at referral, clinical outcomes and therapeutic media use can all be isolated. These variables can then be viewed in bespoke combinations to help understand the work in different ways. Practitioners can view only their own submissions to the database, and full GDPR regulations and policies are in place to protect sensitive client information. The CEB-F continues to evolve in response to practice needs, legislative instruction and practitioner feedback.

Sophia O’Neill, as PTUK Research Writer (and lead author of this paper), compiles regular reports from the CEB-F for member practitioners, other organisations, funders and government officials. These reports use aggregated and anonymised data, employ descriptive statistics and are widely available. The rationale for this paper is to examine the practice data compiled since 2019 under greater statistical scrutiny. It is important to make clear that the data inputted is from real world practice, not trials or tests.

The information comes direct from usual and normal practice in play therapy rooms around the globe. Therefore, any conclusions made arise from situations where the variables present are those usual to real-world practice, instead of in controlled combinations. It is reasonable to suggest higher confidence that the effects of data born from usual practice would be more likely reproduced in usual practice, at large.

The SDQ was chosen as a main measurement tool in both CEBs. The SDQ is a swift to administer behavioural screening questionnaire, for 3–16-year-olds. Studies have shown that the SDQ is sensitive to treatment effects and remains widely used by organisations and for national surveys of UK child mental health (Place2Be, 2025; NHS digital, 2022; Dept of Health & Dept. of Education, 2022; Anna Freud Mentally Healthy Schools, 2024).

It performs with acceptable reliability and validity, performing at least on par with the CBCL and Rutter questionnaires (Goodman, 1997; Goodman et al., 1998; Goodman & Scott, 1999; Goodman, 1999).

Questions are answered by adults who know the child well: Referrers providing professional perspectives from the fields of education, care or health (such as Teachers, SENCOs and Social Workers); and Parents providing their perspective from the home environment. Often the child will also complete the questionnaire themselves; the opportunity to do so is offered to them at the time of referral and is entirely their choice.

The CEB-F links the pre and post therapy SDQ sub-facets and Total Difficulty scores with the presenting issue of the child in each instance. The taxonomy of presenting issues was created for the original version of the CEB from DSM-IV criteria with just a few additions. The CEB-F extended this to include requested or necessary conditions, as the model evolves in response to clinical practice in real time. The CEB-F also has the facility to note down client medical conditions, as this may underlie a referral or bring important co-morbidity information to the work. Providing a 'further information' field provides space for additional essential annotation, and a place from which analysis can justify any decision to add items to either referral or medical menus.

Psychotherapy and scientific measurement

It is crucial that the CEB-F captures trustworthy and statistically reliable data to support the qualitative measures also in place. Although arguments about the rigor of science behind psychotherapies has been common in the past, we argue that the IHM of PT is rooted in accepted scientific traditions and remains so in its approach to practice, and the reporting of it.

IHM practice is underpinned by theoretical knowledge and professional experience, with very real pulls on practical, relational and cognitive skills. IHM Play Therapists are necessarily agile in their thinking. Capturing this fluent and complex intervention takes rigour and diligence.

Data Collection, Protection & Ownership

The CEB-F was created after the new requirements of the General Data Protection Regulation in 2018. The collection and submission of practice data is completed by member practitioners for their own record keeping purposes and for future clinical report writing and practice evaluations.

This makes each member Data Controller and responsible for safeguarding and ensuring that all their processes comply with GDPR regulations (for example being Information Commissioners Office [ICO] registered). All member practitioners enter into a Data Processing Agreement with PTUK on this basis. All trainee practitioners are trained in the use of the CEB-F as part of their taught experience on the post-graduate master's course, or other post-qualification courses.

Online resources and staff support serve to boost member confidence and employment of the tool. PTUK is annually assessed by their accrediting body, The Professional Standards Authority. PTUK acts as the Data Processor and legal owner of the database itself. Named Data Processing staff have restricted access to non-identifiable client data which is used for clinical governance compliance. Regular reports for members provide helpful material for promotion of their practices, the intervention at large, and for wider research and dissemination purposes. These cover a range of subjects, are expressed with inferential statistics and are presented widely to interested parties. Our hope is that the benefits on both the micro and macro scale of using the CEB-F motivate practitioners to record their clinical outcomes accurately, and with due care and diligence, as part of best practice.

Data Storage and Scope for the organisation

All data is securely stored within the European Economic Area (EEA) using data centres from a specialist organisation (herein DataCorp), which comply with relevant data protection regulations. Data in transit is encrypted in accordance with DataCorp's security protocols. Data is backed up regularly and stored securely on internal systems. Data collection encompasses users globally, including but not limited to the United Kingdom, European Union, United States, Asia, and Australia.

Analysis of Results

Membership inputting participation is 100%, as client profile, SDQ outcomes and therapeutic media usage estimates are requested as part of PTUK/PTI annual professional revalidation requirements. At the time of writing (January 2025) 3,293 registrants have entered clinical data into the CEB-F since it was launched in November 2019.

Client Profiles

Geography

In 2017, data was submitted from 49 countries; by 2025, this number had decreased to 43. While this reduction may reflect genuine shifts in practice locations, inconsistencies in data entry may play a part, as a significant number of entries list 'unknown' in this field. Despite this, the dataset continues to reflect a broad international reach, and the work remains global in scope.

Gender

The table presents a comparative overview of gender representation in datasets from 2017 and 2025. In both years, the majority of participants identified as either female or male. However, notable shifts are evident over time (see Table 1).

Table 1: Gender distributions from 2017 (original CEB) and 2025 (CEB-F) records. In accordance with GDPR, results are redacted where sample size falls below 200 cases.

	2017		2025	
	%	n	%	n
Female	39.36	24949	42.7	26490
Male	60.63	38428	57	35348
Other	0.01		N/A	N/A
Transgender	N/A	N/A	0.2	
All genders	N/A	N/A	0.1	
Totals	100	63,381	100	61, 987

In 2017, females made up 39.36% of the sample (n = 24,949) and males 60.63% (n = 38,428), with only 0.01% identifying as "Other." By 2025, female representation rose to 42.7% (n = 26,490), while male representation declined to 57% (n = 35,348), indicating a slight move toward gender parity. The 2025 dataset also introduced more inclusive categories—"Transgender" (0.2%) and "All genders" (0.1%)—replacing the singular "Other"

label used in 2017. This reflects evolving understandings of gender and improved inclusivity in data collection.
Sample sizes were comparable (n = 63,381 in 2017; n = 61,987 in 2025), supporting year-on-year comparison. However, inconsistent categorisation limits longitudinal analysis of non-binary identities. Future studies should adopt consistent, inclusive gender classifications to enhance comparability.

Age at referral

The majority of play therapy clients are aged between 4-12 years, as this is the age bracket clinicians are trained to practice with. However, practitioners with additional post-qualification trainings and/or previous qualifications are licensed to work with younger or older clients. In 2017 the percentage of children referred who were aged between 4-12 years was 93% (n= 59,230).

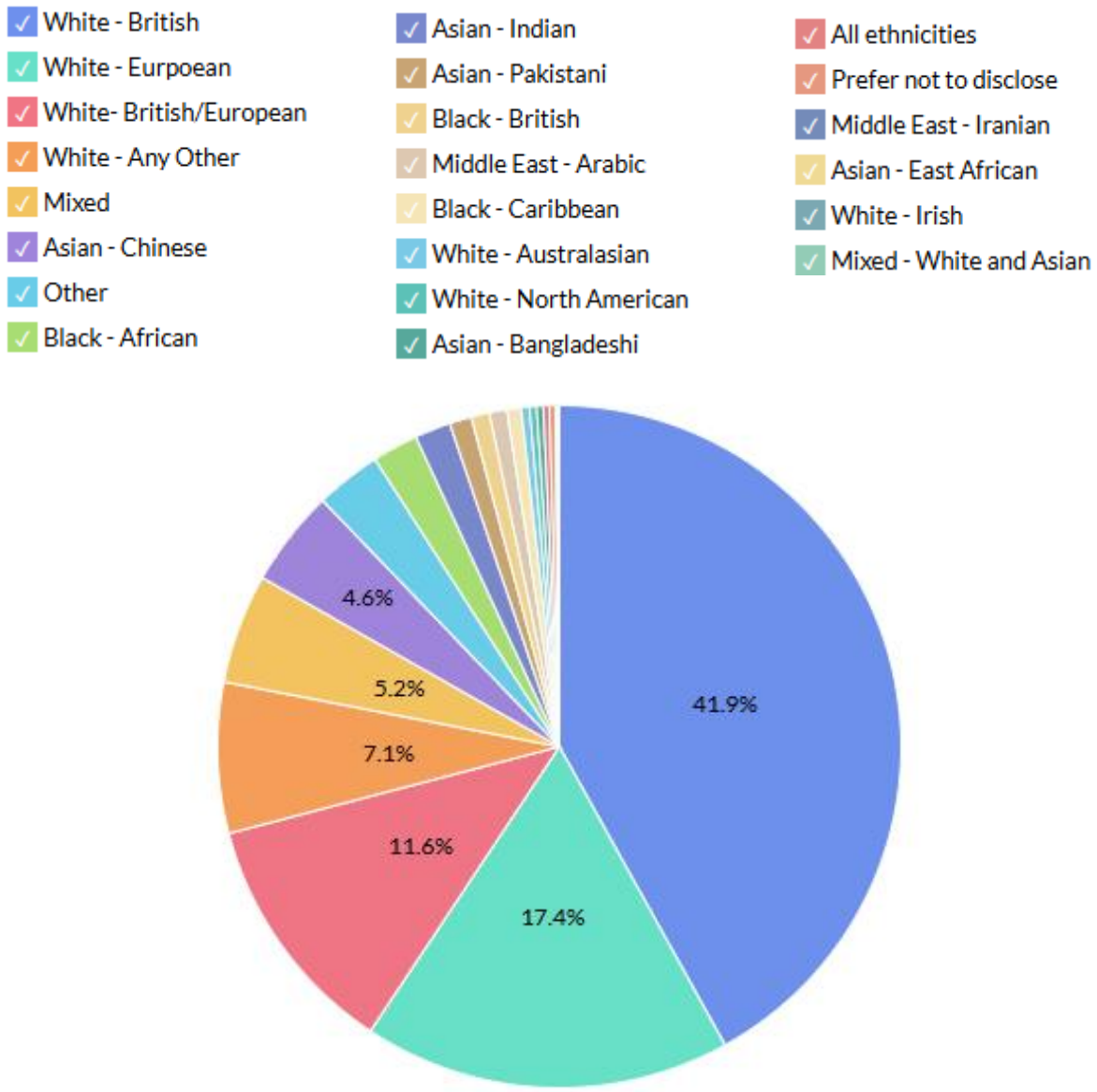
In 2025, 4-12 years make up 96.2% of all referrals (n= 38,338)[1]. 13-18 years account for 2.4%,1-3 years for 0.7% and 19-35 years 0.04%. Future research could observe for change in the wider age ranges, as interest in further training grows in post-qualifications such as Filial Coaching, Creative Arts & Play Therapy Counselling of Children and Young People, and Play & Creative Arts Counselling with Adults.

Ethnicity

Ethnicity was not reported in the 2017 paper. The CEB-F incorporates the full list of ethnic groups as defined by the UK government (GOV.UK, 2021). This list aligns with the classifications used in the national Census and is intended to support consistent and inclusive data collection practices across services.
Figure 1 visualises the data that the CEB-F has on ethnicity.

[1]This figure is lower accounting for missing data entries and anomalies that are clearly errors.

Figure 1: Pie Chart - Ethnicity



Presenting Conditions

The number of categories for presenting conditions has increased from 64 in the original CEB to 70 in the current CEB-F, reflecting the growing complexity and diversity of presenting issues. To illustrate this development while maintaining comparability with the 2017 findings, the top ten presenting conditions are reported in Table 3. A full list of all categories is provided in Appendix 1, which includes 23,988 cited referral conditions.

Table 3: Top Ten Referral conditions

	Frequency	**Percent**
Anxiety disorder – generalised	2092	16.4%
Lacking Confidence/Low Self-Esteem	1954	15.3%
Behaviour – Anger	1753	13.7%
Social relationships difficulties	1310	10.3%
Autistic Spectrum Disorder (ASD)	1161	9.1%
Anxiety – Separation	1097	8.6%
Other – unclassified	959	7.5%
Domestic violence experience of	839	6.6%
Loss - Bereavement Close Relatives	799	6.3%
Adjustment Issue - With anxiety	791	6.2%
Total	**12755**	**100.0%**

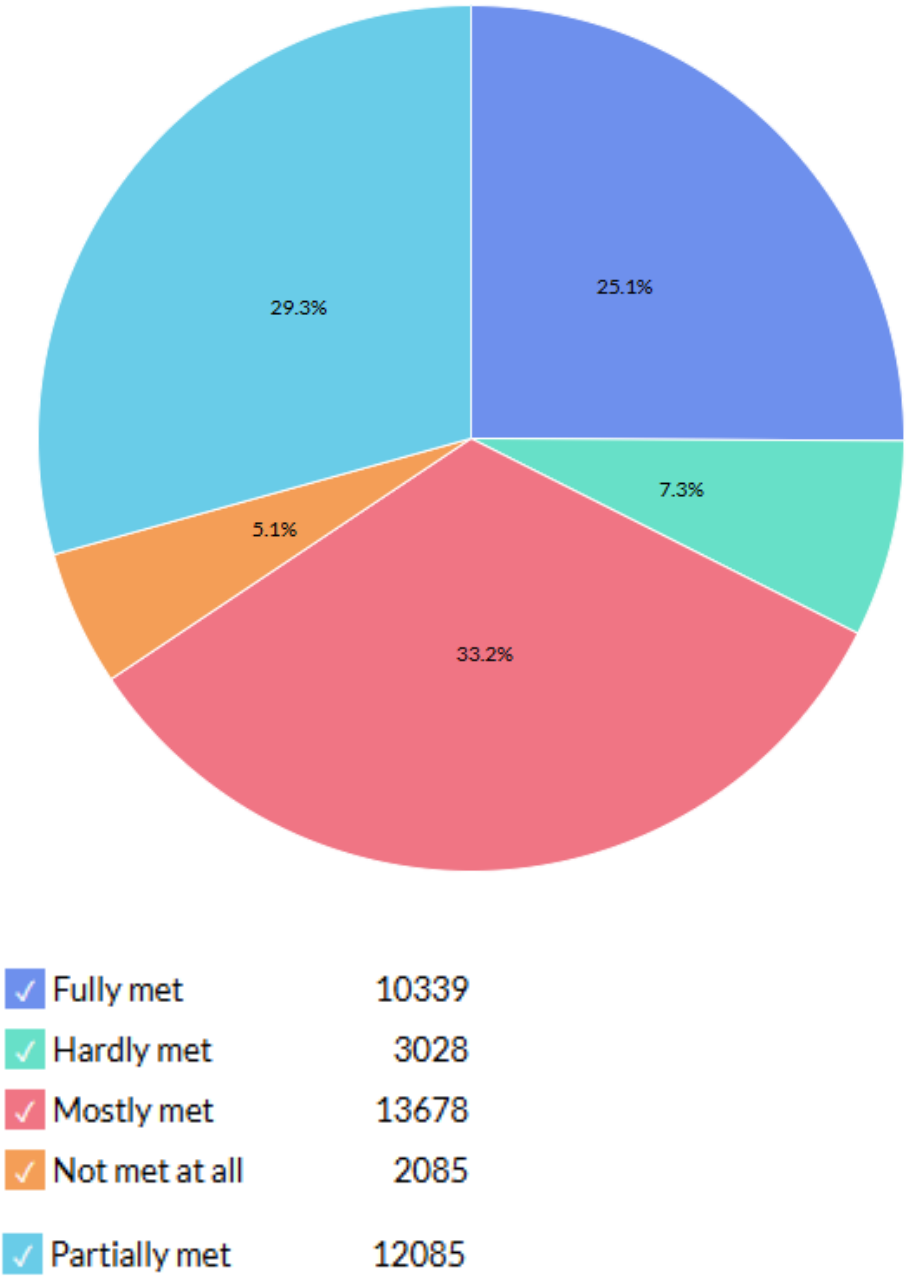
Mean number of sessions

This remains at 16 across all referrals (2017= 15.85, 2025=15.91). In 2025 we now have data for mean number of sessions for children with SDQ 20+ at time of referral. This mean is 18 sessions.

Qualitative Data

Before therapy starts, Hopes and Expectations for the intervention are made by parents/referrers. These are then revisited at the end of the work and the extent to which they were met is recorded. 58% report goals as 'fully' or 'mostly' met, 5% 'not met at all', demonstrating that beyond the SDQ data the intervention was perceived as successful. Further, detailed analysis is warranted.

Figure 2: Hopes & Expectations pie-chart



Clinical Outcomes

Method

The data compromises 36,570 reports of SDQ scores for children engaged in IHM play therapy. All SDQ scores were analysed to assess the impact of the intervention. Scores given by both referrers and parents were analysed separately. For the purpose of analysis, the authors only included referrers that were able to assess classroom behaviour in the children; these were SENCOs, teachers and teaching assistants (n=16,301). For parents only the mothers and fathers scores were used for analysis (n=20,269).

SDQ scores were divided into four categories (see Ford, Goodman & Meltzer, 2003) as shown in Table 4. These categories represent the general population children as 'close to average' (80%), 'slightly raised' (10%), 'high' (5%), and 'very high' (5%) for total difficulties (and respectively for pro-social as 'slightly lowered', 'low' and 'very low').

Table 4: Categorising SDQ scores for 4-17 year olds. Total difficulties and pro-social scores (adapted from Goodman, 1997)

4-band Categorisation	Total Difficulties		Pro-social	
	Referrer	*Parent*	*Referrer*	*Parent*
Close to Average	0-11	0-13	6-10	8-10
Slightly Raised (/Slightly Lowered)	12-15	14-16	5	7
High (/Low)	16-18	17-19	4	6
Very High (/Very Low)	19-40	20-40	0-3	0-5

The analysis was completed using statistical analysis software (IBM SPSS Statistics), with data extracted directly from the CEB-F in a format suitable for analysis. Firstly, the analysis focused on basic descriptive outputs to present a broad overview of how IHM play therapy may be an effective intervention. This also provided information on the distribution of the data and served as preliminary activity to determine the normality of the data for parametric tests.The next stage of analysis involved several paired sample t-tests to assess the significant impact of IHM play therapy as an intervention, and whether changes in scores are more likely to be as a result of therapy rather than occurring by chance.

Analysis

SDQ Total Difficulties Scores, descriptive statistics

Table 5: Descriptive statistics for change in referrer and parent SDQ pre & post total difficulties scores

	N	Minimum	Maximum	Mean		Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Statistic	Std. Error	Statistic	Std. Error
Referrer Total Difficulties Change	16301	-26	29	4.24	.049	6.221	.072	.019	.400	.038
Parent Total Difficulties Change	20269	-21	33	3.83	.039	5.607	.299	.017	.640	.034

The mean score for change in total pre and post difficulties scores is similar for both referrer and parent, suggesting that the measure holds validity across different groups. Parents have scored their children marginally lower than referrers as indicated by the mean.

The data for both groups, in change scores but also in the general post and pre-intervention SDQ total scores, reflect acceptable figures for skewness and kurtosis. Both variables have positive skewness values, indicating distributions with right tails. The Referrer Total Difficulties Change is almost symmetrical with a skewness of 0.072, while the Parent Total Difficulties Change has a mild positive skew (0.299) which may be expected in parents reporting behaviour more favourably than referrers.

The kurtosis values indicate that both distributions have heavier tails and sharper peaks than a normal distribution. The Referrer Total Difficulties Change has a kurtosis of 0.400, suggesting it is close to normal. In contrast, the Parent Total Difficulties Change has a higher kurtosis of 0.640, indicating more extreme values or outliers (which one may expect in parents reporting behaviours). The Kolmogorov-Smirnov test indicated deviations from normality for both Referrer Total Difficulties Change (Statistic = 0.046, $p < 0.001$) and Parent Total Difficulties Change (Statistic = 0.065, $p < 0.001$).

These results suggest that neither distribution follows a normal distribution. This is quite common in larger samples (Pallant, 2010) and therefore assessing normality via histograms and inspection of normal probability plots may be more insightful. Here the observed value for a score is plotted against an expected value from normal distribution, the plots for observed and expected values should not deviate far from one another. Given the results of this analysis the distribution of the scores for the SDQ total scores (for pre and post intervention) and change scale is considered reasonably normal and therefore suitable for more powerful parametric tests.

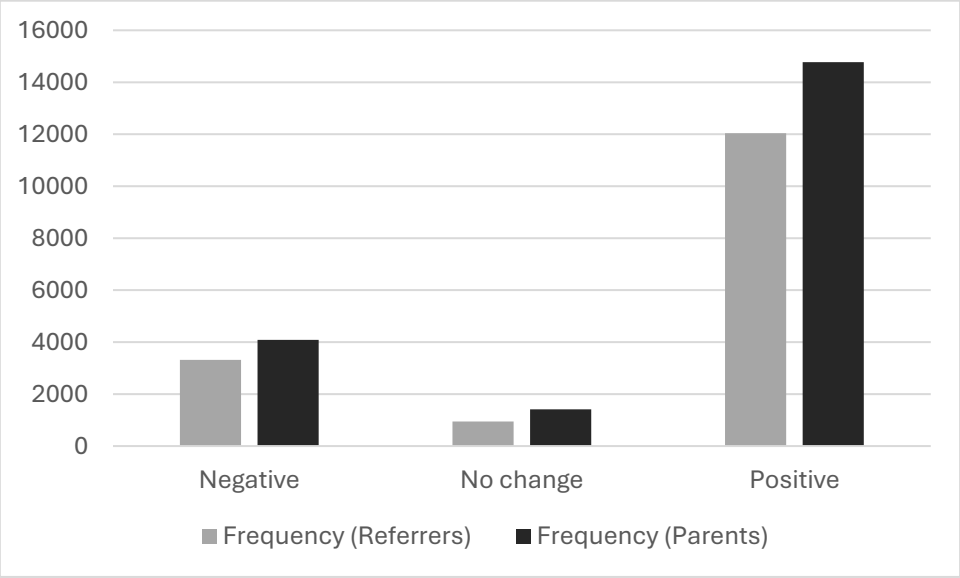
Descriptive data was also examined by change band. The change band categorises the SDQ total difficulties change score into those who showed a positive, negative or non-response to IHM play therapy as an intervention. These scores were considered by referrer or parent scores which are presented in Table 6.

Table 6: SDQ total Difficulties by change band: All data

		Referrer Percent	Parent Percent
Valid	Negative	20.3	20.2
	No change	5.8	7.0
	Positive	73.9	72.9

As initially suggested by the mean scores around change addressed earlier in this section, it is evident that the percentages around change band do not differ greatly between referrer and parent showing that the SDQ is reliable across two different groups involved in a child's intervention. Figure 1 visualises this data.

Figure 3: SDQ total difficulties score for referrer and parent by change band - All data



This basic assessment of the data may suggest that IHM play therapy has a positive impact on a child's SDQ score, the significance of this will be established in further analysis using t-tests.

Paired sample t-tests

Several t-test analyses were conducted to assess the impact of IHM play therapy in children moving between different categorisations of risk (Goodman, 1997).

Children remaining in slightly raised, high and very high risk categories

A paired samples t-test was used to analyse the significance of IHM play therapy as an intervention in children that were considered as slightly raised,

high and very high risk categories in both their pre and post SDQ total difficulties score (scores below 12 given by referrer and 14 by parent). This included an available sample of 7533 and 8483 children with scores from referrer and parent respectively.

Table 7: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Total Difficulties - Post Referrer Total Difficulties	2.130	5.317	0.061	2.010	2.251	34.779	7532	0.000	0.000
Pre Parent Total Difficulties - Post Parent Total Difficulties	2.016	4.657	0.051	1.917	2.115	39.883	8482	0.000	0.000

Table 8: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Total Difficulties	19.807	7533	4.904	0.057
Post Referrer Total Difficulties	17.677	7533	4.518	0.052
Pre Parent Total Difficulties	22.052	8483	4.812	0.052
Post Parent Total Difficulties	20.036	8483	4.742	0.051

For scores given by referrer, there was a statistically significant decrease in total difficulties scores from pre (M=19.807, SD = 4.904) to post (M=17.677, SD = 4.518), t (7532) = 34.779, p<.0005 (two-tailed). The mean decrease in the scores was 2.130 with a 95% confidence interval ranging from 2.010 to 2.251. The eta squared statistic (0.14) indicated a large effect size. For scores given by parents, there was a statistically significant decrease in total difficulties scores from pre (M=22.052, SD = 4.812) to post (M=20.036, SD = 4.742), t (8482) = 39.883, p<.0005 (two-tailed). The mean decrease in the scores was 2.016 with a 95% confidence interval ranging from 1.917to 2.115. The eta squared statistic (0.16) indicated a large effect size**.**

Children remaining within the close to average risk band pre and post intervention

A paired samples t-test was used to analyse the significance of IHM play therapy as an intervention in children that were considered as 'close to average' in the new 4-band categorisation in both their pre and post SDQ total difficulties score (scores below 11 given by referrer and 13 by parent). This included an available sample of 2929 and 5424 children with scores from referrer and parent respectively.

Table 9: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Total Difficulties - Post	2.428	3.580	0.066	2.298	2.558	36.704	2928	0.000	0.000
Referrer Total Difficulties									
Pre Parent Total Difficulties - Post Parent Total Difficulties	2.414	3.455	0.047	2.322	2.506	51.465	5423	0.000	0.000

Table 10: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Total Difficulties	8.069	2929	3.005	0.056
Post Referrer Total Difficulties	5.640	2929	3.057	0.056
Pre Parent Total Difficulties	9.495	5424	2.909	0.040
Post Parent Total Difficulties	7.080	5424	3.308	0.045

For scores given by referrer, there was a statistically significant decrease in total difficulties scores from pre (M=8.069, SD = 3.005) to post (M=5.640, SD = 3.057), t (2928) = 36.704, p<.0005 (two-tailed). The mean decrease in the scores was 2.428 with a 95% confidence interval ranging from 2.298 to 2.558. The eta squared statistic (0.32) indicated a large effect size.

There was also a statistically significant decrease in total difficulties scores from pre (M=9.495, SD = 2.909) to post (M=7.080, SD = 3.308), t (5423) = 51.465, p<.0005 (two-tailed) for scores given by parents. The mean decrease in the scores was 2.414 with a 95% confidence interval ranging from 2.322 to 2.506. The eta squared statistic (0.33) indicated a large effect size.

Children moving from a risk band to no risk after intervention

This group of analysis represents those children that were considered slightly raised, high and very high risk pre-therapy and that had a post therapy score categorised as close to average.

A paired samples t-test was used to analyse the significance of IHM play therapy as an intervention for children who were considered slightly raised, high or very high risk at pre-SDQ scores and then close to average post; data from referrer and parent SDQs were analysed separately.

Table 11: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Total Difficulties - Post Referrer Total Difficulties	9.460	4.756	0.066	9.331	9.588	144.097	5248	0.000	0.000
Pre Parent Total Difficulties - Post Parent Total Difficulties	9.124	4.610	0.061	9.004	9.245	148.667	5641	0.000	0.000

Table 12: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Total Difficulties	16.833	5249	4.302	0.059
Post Referrer Total Difficulties	7.374	5249	2.784	0.038
Pre Parent Total Difficulties	18.375	5642	3.785	0.050
Post Parent Total Difficulties	9.250	5642	2.980	0.040

For scores given by referrer, there was a statistically significant decrease in total difficulties scores from pre (M=16.833, SD = 4.302) to post (M=7.374, SD = 2.784), t (5248) = 144.097, p<.0005 (two-tailed). The mean decrease in the scores was 9.460 with a 95% confidence interval ranging from 9.331 to 9.588. The eta squared statistic (0.80) indicated a large effect size.

There was also a statistically significant decrease in total difficulties scores from pre (M=18.375, SD = 3.785) to post (M=9.250, SD = 2.980), t (5641) = 148.667, p<.0005 (two-tailed) for scores given by parents. The mean decrease in the scores was 9.124 with a 95% confidence interval ranging from 9.004 to 9.245. The eta squared statistic (0.80) indicated a large effect size.

Children moving from slightly raised, high and very high risk band to any band after intervention

Another paired-samples t-test was conducted to evaluate the impact of the intervention on SDQ total difficulties scores as reported by referrers and parents representing children with slightly raised, high or very high risk SDQ scores pre and post intervention moving to any band after intervention, and where scores have been reported for both pre and post intervention.

There was a statistically significant decrease in total difficulties scores from pre (M=18.586, SD = 4.890) to post (M=13.446, SD = 6.396), t (12781) = 93.12, p<.001 (two-tailed) for scores reported by referrers for low or high risk (scores of over 12). The mean decrease in the scores was 5.14 with a 95% confidence interval ranging from 5.032 to 5.248. The eta squared statistic (0.4) indicated a large effect size. Whilst the t-test results prove that the difference between interventions was unlikely to occur by chance, the effect size expresses the magnitude of the intervention's impact (guidelines proposed by Cohen, 1988, pp.284-7).

Table 13: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Total Difficulties - Post Referrer Total Difficulties	5.14	6.241	0.055	5.032	5.248	93.12	12781	<.001	<.001
Pre Parent Total Difficulties - Post Parent Total Difficulties	4.856	5.799	0.049	4.76	4.951	99.51	14124	<.001	<.001

Table 14: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Total Difficulties	18.586	12782	4.890	0.0433
Post Referrer Total Difficulties	13.446	12782	6.396	0.0566
Pre Parent Total Difficulties	20.583	14125	4.782	0.0402
Post Parent Total Difficulties	15.728	14125	6.705	0.0564

There was a statistically significant decrease in total difficulties scores from pre (M=20.583, SD = 4.782) to post (M=15.728, SD = 6.705), t (14124) = 99.51, p<.001 (two-tailed) for scores reported by parents for low or high risk (scores of over 14). The mean decrease in the scores was 4.856 with a 95% confidence interval ranging from 4.76 to 4.951. The eta squared statistic (0.4) indicated a large effect size.

SDQ Pro-Social Scores

Descriptive statistics

Table 15: Descriptive Statistics: Descriptive statistics for change in referrer and parent SDQ pro-social scores between pre and post intervention

	N	Minimum	Maximum	Mean		Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Statistic	Std. Error	Statistic	Std. Error
Referrer Pro-social Change	16301	-9	10	1.02	.019	2.422	.113	.019	.464	.038
Parent Pro-social Change	20269	-9	10	.55	.013	1.785	.251	.017	1.496	.034

As in Thomas and Lambert (2017) the mean change in pro-social scores between pre- and post-play therapy differs between referrers and parents. Referrers tend to report greater improvements, with more variability in their scores compared to parents. This may reflect the differing contexts in which they observe the children, such as the more socially dynamic classroom environment versus the home.

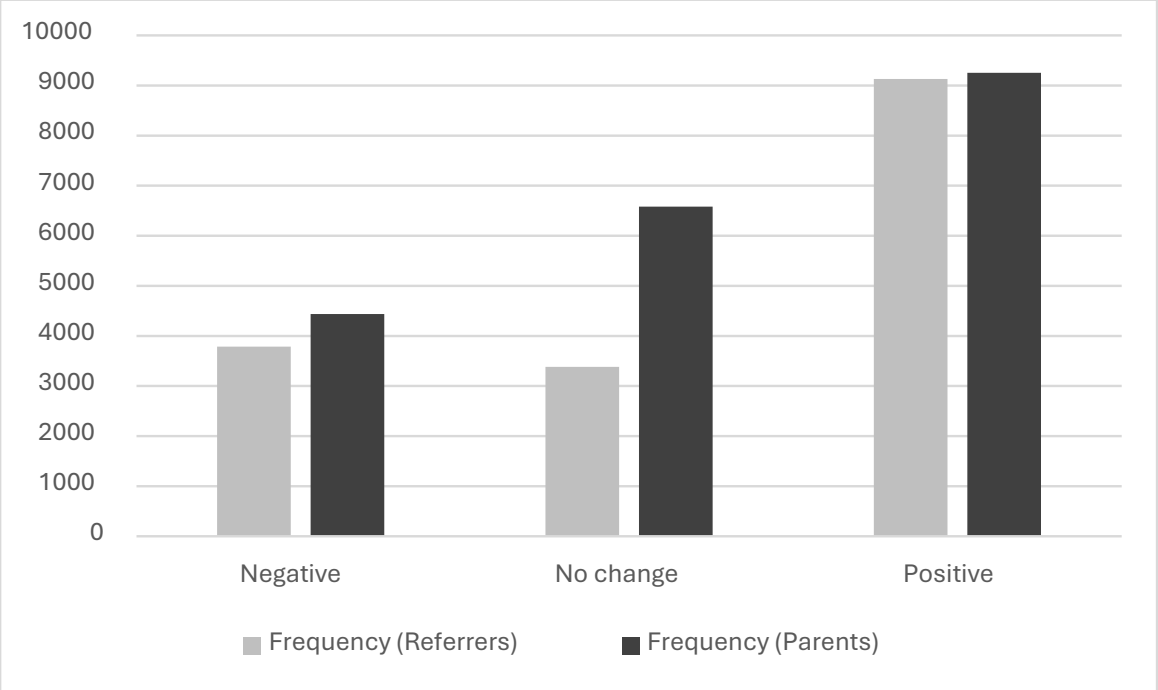
Both referrer and parent scores have low skewness values (0.113 and 0.251, respectively), indicating that the distributions are fairly symmetrical. The referrer scores have a kurtosis value of 0.464, suggesting a flatter distribution. The parent scores have a higher kurtosis value of 1.496, indicating a distribution that is somewhat more peaked but still flatter than a normal distribution.

Table 16: SDQ Pro-social scores by change band: All data

		Referrer Percent	Parent Percent
Valid	Negative	18.22	26.36
	No change	16.26	39.10
	Positive	43.91	54.99

Descriptive data concerning pro-social scores was examined by change band to demonstrate which children showed either a positive, negative or non-response to IHM play therapy as an intervention (see Table 16 and Figure 4).

Figure 4: SDQ Pro-social score for referrer and parent by change band - All data



Again, repetition is seen in comparison with Thomas and Lambert (2017) in terms of number of cases and children that moved risk bands. The percentage of positive change is slightly lower for pro-social scores than for total difficulties scores. Nonetheless, IHM play therapy appears largely effective. The smaller observed change in pro-social scores may be attributed to:

1. Questionnaire design – Pro-social items are framed positively (e.g., 'considerate', 'helpful'), potentially introducing a positive response bias, as suggested by the skewness, and limiting observable change.

2. Therapeutic focus – Play therapy may be more effective in addressing difficulties than enhancing pro-social behaviours. It is also reasonable to suggest that pro-social behaviours may continue to develop after the therapeutic intervention has ceased. Further research on this is warranted.

3. Reporter perception – Referrers and parents may interpret changes in pro-social behaviour differently from those related to emotional, conduct, hyperactivity, or peer issues. These different parties also know the children differently, in different contexts and from differing relational dynamics.

Further research is required to draw definitive conclusions. However, current data suggest that play therapy contributes significantly to positive changes in pro-social behaviour. This will be further examined through paired sample t-tests.

Paired samples t-tests

These tests produced negative t statistics. A negative t-value simply indicates a reversal in the direction of the effect which has no impact on the significance of the difference between groups. This differs from the SDQ total difficulties score

because in this case we are looking for a reduction in figures, whereas with pro-social data we are looking for an increase in score.

Children remaining in low and high risk categories

For pro-social scores provided by referrers, there was a statistically significant increase from pre (M=2.965, SD = 1.623) to post (M=3.607, SD=1.416), t (4088) = -22.692, p<.0005 (two-tailed) prosocial scores. The mean change in the scores was -0.642 with a 95% confidence interval ranging from -0.698to -0.587. The eta squared statistic 0.11 indicated a moderate effect size.

There was a statistically significant increase in pro-social scores from pre (M=4.864, SD=1.690) to post (M=5.322, SD = 1.520), t (6007) = -21.593, p<.0005 (two-tailed) for scores reported by parents. The mean change in the scores was -0.458 with a 95% confidence interval ranging from -0.499to -0.416. The eta squared statistic 0.07 indicated a moderate effect size.

Table 17: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Pro-social - Post Referrer Pro-social	-0.642	1.810	0.028	-0.698	-0.587	-22.692	4088	0.000	0.000
Pre Parent Pro-social - Post Parent Pro-social	-0.458	1.643	0.021	-0.499	-0.416	-21.593	6007	0.000	0.000

Table 18: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Pro-social	2.965	4089	1.623	0.025
Post Referrer Pro-social	3.607	4089	1.416	0.022
Pre Parent Pro-social	4.864	6008	1.690	0.022
Post Parent Pro-social	5.322	6008	1.520	0.020

Children remaining within the no risk band pre and post intervention

For pro-social scores provided by referrers, there was a statistically significant increase from pre (M=8.027, SD = 1.445) to post (M=8.524, SD=1.371), t (7306) = -26.890, p<.0005 (two-tailed) prosocial scores. The mean change in the scores was -0.497with a 95% confidence interval ranging from -0.533 to -0.461. The eta squared statistic 0.09 indicated a moderate effect size.

There was a statistically significant increase in pro-social scores from pre (M=9.153, SD=0.806) to post (M=9.365, SD = 0.760), t (9311) = -23.298, p<.0005 (two-tailed) for scores reported by parents. The mean change in the scores was -0.213 with a 95% confidence interval ranging from --0.230 to -0.195. The eta squared statistic 0.06 indicated a moderate effect size.

Table 19: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Pro-social - Post Referrer Pro-social	-0.497	1.581	0.018	-0.533	-0.461	-26.890	7306	0.000	0.000
Pre Parent Pro-social - Post Parent Pro-social	-0.213	0.880	0.009	-0.230	-0.195	-23.298	9311	0.000	0.000

Table 20: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Pro-social	8.027	7307	1.445	0.017
Post Referrer Pro-social	8.524	7307	1.371	0.016
Pre Parent Pro-social	9.153	9312	0.806	0.008
Post Parent Pro-social	9.365	9312	0.760	0.008

Children moving from a risk band to no risk after intervention

There were 3671 cases reported by referrer and 3480 by parents where children's pro-social score had moved from a high or low risk band to no risk post intervention.

For pro-social scores provided by referrers, there was a statistically significant increase from pre (M=3.735, SD = 1.366) to post (M=7.506, SD=1.346), t (3670) = -126.509, p<.0005 (two-tailed) prosocial scores. The mean change in the scores was -3.771 with a 95% confidence interval ranging from -3.830to -3.713. The eta squared statistic 0.81 indicated a large effect size.

There was a statistically significant increase in pro-social scores from pre (M=5.962, SD=1.238) to post (M=8.793, SD = 0.781), t (3479) = -118.325, p<.0005 (two-tailed) for scores reported by parents. The mean change in the scores was -2.831 with a 95% confidence interval ranging from 2.878 to -2.784. The eta squared statistic 0.80 indicated a large effect size.

Table 21: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Pro-social - Post Referrer Pro-social	-3.771	1.806	0.030	-3.830	-3.713	-126.509	3670	0.000	0.000
Pre Parent Pro-social - Post Parent Pro-social	-2.831	1.411	0.024	-2.878	-2.784	-118.325	3479	0.000	0.000

Table 22: Paired Samples Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Pro-social	3.735	3671	1.366	0.023
Post Referrer Pro-social	7.506	3671	1.346	0.022
Pre Parent Pro-social	5.962	3480	1.238	0.021
Post Parent Pro-social	8.793	3480	0.781	0.013

Children moving from a low or high risk band to any band after intervention

There was a statistically significant increase in pro-social scores from pre (M=3.329, SD=1.555) to post (M=5.452, SD = 2.388), t (7759) = -78.245, p<.0005 (two-tailed) for scores reported by referrers. The mean change in the scores was 2.123 with a 95% confidence interval ranging from -2.176 to -2.069. The eta squared statistic 0.44 indicated a large effect size.

For pro-social scores provided by parents, there was a statistically significant increase from pre (M=5.267, SD = 1.628) to post (M=6.595, SD=2.118), t (9487) = -66.825, p<.0005 (two-tailed) prosocial scores.

-The mean change in the scores was -1.328 with a 95% confidence interval ranging from -1.367 to -1.289. The eta squared statistic 0.32 indicated a large effect size.

Table 23: Paired Samples Test

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre Referrer Pro-social - Post Referrer Pro-social	-2.123	2.390	0.027	-2.176	-2.069	-78.245	7759	0.000	0.000
Pre Parent Pro-social - Post Parent Pro-social	-1.328	1.936	0.020	-1.367	-1.289	-66.825	9487	0.000	0.000

Table 24: *Paired Samples Statistics*

	Mean	N	Std. Deviation	Std. Error Mean
Pre Referrer Pro-social	3.329	7760	1.555	0.018
Post Referrer Pro-social	5.452	7760	2.388	0.027
Pre Parent Pro-social	5.267	9488	1.628	0.017
Post Parent Pro-social	6.595	9488	2.118	0.022

Discussion

The current analysis builds upon and extends the foundational work of Thomas and Lambert (2017), offering a more recent and expansive dataset. Both studies utilise the Strengths and Difficulties Questionnaire (SDQ) to evaluate the effectiveness of IHM play therapy, with a focus on total difficulties and pro-social domains.

Both report statistically significant improvements post-intervention, although several key developments and distinctions emerge in the 2025 data.

Both datasets demonstrate that IHM play therapy is associated with significant reductions in total difficulties scores and increases in pro-social behaviours. In 2017, the mean change in total difficulties was -3.86 (referrers) and -4.02 (parents), while in 2025, the mean changes were +4.24 and +3.83 respectively (noting the direction of scoring differs). Despite differences in scoring conventions, both studies report large effect sizes, particularly for children moving from high-risk to low-risk categories ($eta^2 \approx 0.8$ in both datasets). This consistency reinforces the reliability and clinical relevance of IHM play therapy outcomes across time and increased complexity of reported demographics.

Both studies report smaller, though still significant, improvements in pro-social scores. In 2017, mean changes were 0.916 (referrers) and 0.530 (parents); in 2025, these were 1.02 and 0.55 respectively. The consistency in effect size (moderate, $eta^2 \approx 0.07–0.11$) suggests that whilst IHM play therapy positively influences pro-social behaviour, the magnitude of change is less pronounced than for difficulties. This may reflect limitations in the SDQ's pro-social scale (e.g., ceiling effects, positive framing) or the therapy's primary focus on reducing distress rather than enhancing strengths (with the possibility that the latter will follow the former in due course, perhaps after the last assessment is taken).

The 2025 analysis demonstrates improved methodological rigour: Use of 4-band SDQ categorisation (vs. 3-band in 2017); clearer delineation of sample groups (e.g., SENCOs vs. parents); and more detailed reporting of normality tests and effect sizes. These refinements enhance the interpretability and robustness of the findings, aligning with best practices in clinical outcome research.

While the 2017 study highlighted the development of a Clinical Evidence Base (CEB) and the challenges of data collection, the 2025 dataset (from CEB-F) reflects a more mature infrastructure. The inclusion of broader: gender, ethnicity, referral conditions, medical conditions and session activities categories, plus the scale of data collection suggest improved inclusivity and technological capacity. However, both studies acknowledge limitations in demographic consistency and the need for better integration of therapist variables.

The 2025 findings not only replicate but extend the conclusions of Thomas and Lambert (2017), offering stronger evidence for the effectiveness of the IHM play therapy across diverse populations and risk profiles. The consistency in outcomes over time, combined with methodological enhancements, supports the continued development of a robust clinical evidence base. Future research should prioritise longitudinal tracking, integration of therapist-level data, and refinement of measurement tools—particularly for pro-social outcomes.

Limitations and Further research

Limitations will always be found when working with data uploaded from large numbers of participants who have varying amounts of data to input and who do so across different criteria. In this paper we have been concerned with client SDQ data pre and post therapy, as well as some basic demographic details. Regular spot checks and annual revalidation processes of the database are carried out by PTUK, alongside member training and support, however, errors and anomalies were discovered at the point of analysis and removed/'cleaned'.

The CEB-F includes fields to record parent/referrer objectives and goals for the therapy, alongside their reports of whether these were met. The gathering of this information was designed to go some way to offer alternative methods to capture change and provide a more robust measure, as there are understandably instances where the SDQ may not accurately reflect the interventions outcomes. This paper's focus is on the results from the SDQ measure as understood after rigorous statistical testing with other aspects of measurement and perspectives of change and engagement with the IHM, as recorded in the CEB-F, planned in following reports.

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Appendices

Appendix 1: Full Referral Condition data (in accordance with GDPR, results are redacted where sample size falls below 200 cases).

Referral Condition			
	Frequency	**Percent**	**Percent of entered data**
Condition not entered by therapist	13109	35.3	N/A
Anxiety disorder - generalised	2092	5.6	8.7
Lacking Confidence/Low Self-Esteem	1954	5.3	8.1
Behaviour - Anger	1753	4.7	7.3
Social relationships difficulties	1310	3.5	5.5
Autistic Spectrum Disorder (ASD)	1161	3.1	4.8
Anxiety - Separation	1097	3.0	4.6
Other - unclassified	959	2.6	4.0
Domestic violence experience of	839	2.3	3.5
Loss - Bereavement Close Relatives	799	2.2	3.3
Adjustment Issue - With anxiety	791	2.1	3.3
Behaviour - Impulsiveness	773	2.1	3.2
Family relationship difficulties	721	1.9	3.0
Behaviour - Temper tantrums	641	1.7	2.7
Confidence - lack of	627	1.7	2.6
Aggression	567	1.5	2.4
Adjustment Issue - With mixed disturbance of emotion	491	1.3	2.0

Behaviour - Inappropriate	465	1.3	1.9
Attachment Issues	441	1.2	1.8
Anxiety disorder - specific cause	381	1.0	1.6
Self-esteem - lack of	364	1.0	1.5
ADHD - Difficulties in sustaining attention	333	0.9	1.4
Family - Parent-child relational problems	281	0.8	1.2
Adjustment Issue – General	275	0.7	1.1
Relational problem - general	263	0.7	1.1
ADHD - Disruptive Behaviour Disorder	259	0.7	1.1
Adjustment Issue - With mixed anxiety and depressed mood	253	0.7	1.1
Abuse - Emotional	237	0.6	1.0
Behaviour - Oppositional Defiant	235	0.6	1.0
Family - Sibling relational problem	227	0.6	0.9
Adjustment	221	0.6	0.9
ADHD - Combined subtype	220	0.6	0.9
Personality - Withdrawn Personality	216	0.6	0.9
Adjustment Issue - With disturbance of conduct	211	0.6	0.9
Abuse - Sexual			
ADHD - Hyperactivity			
Neglect			
Trauma - PTSD - Posttraumatic stress disorder			
Personality - Shyness			
Learning Under achievement - academic			
Abuse - Physical			

ADHD - Reduced concentration and attention			
Self-esteem - reduced			
Loss - other			
Self-harming			
School - Poor School Attendance			
ADHD - Predominantly hyperactive-impulsive			
Personality - Loss of interest and enjoyment			
Attachment - Reactive Attachment Disorder			
Asperger's Disorder			
Social - Anti social behaviour			
Developmental language disorders (DLD)			
Attachment disorganised			
Learning - Dyslexia/Reading disorder			
School - risk of exclusion			
Depression - Childhood depression			
Depression - Mild Depressive disorders			
Lying			
Nightmares			
ADHD - Persistent over activity			
Eating Disorder - Other			
Internet games and other addictions			
Personality - Guilt and unworthiness			
Diminished activity			
Excluded from school			

Encopresis			
Social phobia			
Screen time addiction			
Under performance - physical			
ADHD - Predominantly inattentive subtype			
Enuresis			
School - Unauthorised Absences			
Eating - Binge-Eating Disorder			
Total	**37097**	**100.0**	**100.0**

An Exploration of the Effectiveness of Play Therapy with Adolescents Diagnosed with Autism and Intellectual Disabilities.

Gemma Hookins
Gemhookins@hotmail.com
Accredited Play Therapist M.A.

Abstract

This article reflects on a research project which explored the effectiveness of integrative holistic play therapy with adolescents diagnosed with autism and intellectual disabilities. The integrative holistic play therapy approach is not common among this student population, especially amongst adolescents with autism, who are usually referred for more directive therapies such as Applied Behaviour Analysis (ABA), Cognitive Behavioural Therapy (CBT), Occupational Therapy. Furthermore, discrete trial training has been identified as a more naturalistic method to teach play as a functional treatment for autism (Stahmer et al 2003).
Although, it is important to note, these therapies are not treating the social and emotional aspects of the children and adolescents with Autism, as their focus is on the behaviour, teaching play, and social skills. Whereas play therapy is designed to help with emotions, fears, anxieties, self-regulation, self-confidence, and developmental needs (Grant, 2017). There are many models of play therapy, however, this study focusses on an exploration of the effectiveness of integrative holistic play therapy, a non-directive and child centered approach.
That was explored through weekly individual sessions over a period of 10 months of the academic year, where the participants engaged in approximately 20 play therapy sessions each. It took place at a centre for special needs in Dubai, UAE, where the participants were between the ages of 13 to 17 years old.

A mixed methodological approach, where both qualitative and quantitative measures were adopted, and these included collecting scores from the Goodman's (1997) Strengths and difficulties questionnaire

(SDQ), with comments from the parents and teachers' pre-therapy, throughout the duration and post therapy. Overall, the results showed a reduction of anxieties, with improvements in self-regulation and communication skills, however, the outcome showed mixed results.

Introduction

The aim of the study was to highlight the importance of integrated holistic play therapy as a therapeutic intervention with adolescents diagnosed with autism and intellectual disabilities. My wish was to enable these young people to integrate into society and subsequently understand their emotions, reduce anxiety, self-regulation and improve communication skills. Thornley (2017) stressed that if the emotional needs have not been met, it will greatly impact on the child's quality of life. There is a lack of awareness in the UAE about the use of play therapy as a therapeutic intervention with only a few organisations utilising this service. However, recently His Royal Highness Sheikh Mohammed bin Rashid Al Maktoum, the vice President, Prime Minster of the United Arab Emirates and ruler of Dubai, unveiled a new countrywide initiative recognising the importance and provisions for the special needs population whom he has called the 'Determined Ones'. This strategy is intended to improve the lives and well-being of individuals with special needs within the UAE. Article 3. of the Federal law No: (29) of 2006 (government.ae) states that the person has the right to access rehabilitation services including social development programs.

The current national statistics on the prevalence of ASD in the UAE, is estimated to effect 1 in 146 births in Dubai for 2014, according to the Dubai Autism Centre (Al Abbady et al, 2017, p. (1)). Therefore, my rationale for choosing this area of research is in the hope that the findings will demonstrate to my colleagues and the wider community of the United Arab Emirates, the effectiveness of play therapy.

It is hoped that, as a result, the UAE will implement play therapy within the schools, special needs centres and hospital settings. It is also hoped they will formulate policies and procedures and insurance coverage for the wellbeing of this population and alter practices for the future of the UAE's 'determined ones.'

Autism Spectrum Disorder

According to the Centre for Disease and Control Prevention 2020 (CDC) Autism and Developmental Disabilities Monitoring (ADDM) Network, one in thirty-six children have been diagnosed with autism spectrum disorder (ASD). Statistics show an increase in numbers between 2000 and 2020, from 1 in 150 to 1 in 36 children diagnosed with autism. It is not certain why there has been a rise in numbers, however, it could be due to increased awareness by parents, training of doctors/clinicians in diagnostic measures or early ASD identification. With the increase in numbers, it feels important that an alternative means of dealing with this disorder be considered. Autism is a lifelong neurodevelopmental disability that causes social communication and behavioural problems.

Autism in Adolescents

Adolescents with low functioning autism find it difficult to understand other people's emotions and social cues. Some have repetitive behaviour and routines, obsessions with particular objects or themes and are self-absorbed and ritualistic (DSM-5). Adolescents with autism struggle with their emotions and changing body image particularly when going through puberty. These muddled feelings can become overwhelming and consequently leave the adolescent feeling confused, aggressive and socially inept plus they often lack conversational skills, are unable to understand the emotions of others and often avoid eye-contact. They are, therefore, unable to understand or respond appropriately to the facial expressions of others.

Autism and Play

Play is a crucial part of a child's development; it is the way they learn about themselves, others, and new experiences. However, children with autism usually have social and communication problems, which also impacts on their ability to play symbolically. They have a lack of imagination and creativity and show unusual features in their play. Autistic children tend to play out scenes from cartoons and repeat words and songs from computer games. There are many alternatives to improve play skills for autistic children and adolescents, from structured to naturalistic techniques deriving from applied behaviour analysis (ABA) (Stahmer et al 2003).

Play Therapy

It is natural that children are drawn to toys and use play to learn and explore. Play therapy is a holistic approach, where using play as means of helping in a non-intrusive way the physical, spiritual, emotional, and cognitive aspects of the whole child (West, 1992). It helps children overcome internalised issues within a safe trusting therapeutic environment. This is facilitated by a therapist who shows understanding and accepts the child as they are, giving them the freedom to lead the play. The therapist does not hurry the therapeutic process, their presence is to support and facilitate the session at the child's own pace. The therapist is non-judgmental and non-interpretive, only setting boundaries to protect the child and the therapist. Integrative holistic play therapy provides the opportunity to solve internalised conflicts and improve self-regulation; Axline (1964) explained that since play is his or her natural medium for self-expression, the child is given the opportunity to play out his or her accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, and confusion. For individuals who have a lack of speech, play therapy can be utilised by giving them the opportunity to express themselves with play tools and still be understood.

Integrative Holistic Play Therapy

Carl Rogers (1942), developed the Client-Centred approach to therapy, later called Person-Centred approach. This approach relies on building a trusting therapeutic relationship with the therapist, and letting the child lead the play. The play therapist's role is as important as the play therapy itself, 'the presence of an accepting understanding, friendly therapist in the playroom gives him a sense of security' (Axline, 1974). Non-directive play therapy was developed by Virginia Axline, (1969-1974) utilising the theoretical foundations of Rogers (1951) Person-Centred approach. This method of therapy also implements Axline's eight basic principles of non-directive, child centred, play therapy which include, accepting and respecting the child as is and building a trusting, friendly relationship with the child, "The non-directive aspect gives the individual the opportunity to be themselves in a safe and non-judgemental environment. 'Non-directive therapy grants the individual the permissiveness to be himself: it accepts that self completely, without evaluation or pressure to change" (Axline, 1974, p.15). Furthermore, the non-directive method gives the individual the opportunity to self-heal, by using toys to communicate a problem, and work through it in a safe setting. Axline (1964), herself brought attention to the importance of play therapy with her book 'Dibs in search of self' which is a sound introduction to the use of non-directive play therapy to solve internalised psychological issues. The integrative holistic play therapy approach has many benefits, incorporating all aspects of the play therapy dimensions model (PTDM), where the play therapist chooses the model that best fits the client. The PTDM consist of four quadrants, conscious, unconscious, directive, non-directive, giving the therapist flexibility in the approach according to Yasenik and Gardner (2012).

Literature Review

There have been recent studies to show that play therapy can be used effectively as a therapeutic intervention for positive outcome behaviours in autistic children.

As stated in AutPlay – play therapy with autistic children and adolescents, "Play Therapy approaches hold many benefits for children and adolescents with autism spectrum disorder especially in treating social and emotional issues they typically struggle with" (Grant, 2014, p.20). He further mentions that current research suggests that children with autism have improved in coping with change, pretend play, and social regulation after the implementation of play therapy sessions. A research paper journal of play based interventions named '*Behavioural approaches promoting play'* Stahmer et al, (2003), mentioned the different therapeutic approaches deriving from applied behaviour analysis (ABA). This research paper gives information on discrete trial training, pivotal response training and reciprocal imitation training amongst others, giving an explanation on how each of the approaches work, including the benefits. Furthermore, Stahmer et al, (2003) describes how these methods are used to increase the play skills and language of individuals with autism. He goes on to explain that these approaches can be used by parents and peers to help teach children with autism to learn new skills. The research paper by Mahoney (2012) entitled 'Is Play Therapy an effective intervention for children with Autism Spectrum Disorder (ASD)' explained that play therapy is very effective for a wide range of conditions and pointed out that after a series of play therapy sessions that the children improved with eye contact and shared play. She concluded that there still needs to be more research in this area. A research paper by DeGiovanni (2011), entitled, 'The use of non-directive play therapy with children who have autism' mentions that play therapy is particularly effective for children with autism as they lack the adequate social and communication skills and engage in repetitive play. DeGiovanni also emphasises Axline's (1974) 8 basic principles in pointing out that these are the basis for all therapeutic relationships. DeGiovanni argues that a child can carry out behaviours that are not allowed outside the playroom and concludes that play helps children move beyond autism self-absorption into shared interaction, therefore, helping them to explore their feelings and relationships and allows the child to share their world with the therapist. In his research article Astramovich et al (2015) suggested that young people who have an intellectual disability often develop emotional and behavioural problems. He said that undesirable learnt behaviours in childhood will, if left untreated, continue into adulthood.

Research carried out by Kim, Lombardino, Rothman & Vinson (1989) was based on symbolic play intervention versus non-intervention for children with learning disabilities. They worked with two groups of children. One group received sessions of symbolic play and the other received no intervention. The conclusion of the study showed that the children who received the symbolic play intervention demonstrated qualitative as well as quantitative changes in their symbolic play profile, consequently showing positive changes in their play. Kim, et al, (1989) describe how the child's mental age compares to their cchronological age regarding their 'symbolic play performance'. This is something that needs further research, considering the gap between the chronological age and the actual developmental age of the adolescents that are in this study. They concluded that there is limited data available in this area. Moreover, they pointed out that there is less research on play therapy intervention with adolescents who have intellectual disabilities.

Methodology

Research design; multiple case study.

The method chosen was a mixed method, multiple case study design, using qualitative and quantitative exploratory measures. The method of triangulation suited this research study because 'Multiple case studies can be used to either augur contrasting results for expected reasons or either augur similar results in the studies' as the study needed to assess all areas of the experiment to get a more detailed accuracy and best conclusive results (Yin, 2003). The use of quantitative methods was important to the study to collect data on the participants throughout the therapeutic intervention. This study used the Goodman's (1997) strengths and difficulties questionnaire (SDQ) score method, a measurement tool used by many play therapists to measure the effectiveness of the intervention. The SDQ questionnaires were used pre-play therapy to attain a starting measurement of total difficulties. During the play therapy, collecting SDQ scores after each of the mid-term breaks was used to gather more information of any fluctuations in the scores, and to answer the research questions. Furthermore, collecting post- play therapy SDQ scores helps give a clearer picture of how the play therapy effected the participant.

The third part of the mixed methodology was to use the clinical data in the form of sessional notes as it was decided that the mixed-method, multiple case study was the most appropriate. Baxter and Jack, (2008) insisted, “An all-embracing fact is that the evidence created from a multiple case study is measured strong and reliable”.

There was a total of five participants, four of them boys with a diagnosis of autism, and one girl who had a diagnosis of cerebral palsy, and a neurodevelopmental disability. They are all students at the special needs centre where I work. The participants’ ages ranged between 13 and 17 years. They were carefully selected by the multidisciplinary team, comprising of the participants teachers, the psychologist, occupational therapist, and myself because they all met the criteria, namely, age range, difficulties, and diagnosis. All suffered from high anxiety, low self-esteem and displayed obsessive and repetitive behaviour, which is a common trait of autism and intellectual disability. ‘When children with autism spectrum disorder are given the opportunity to play freely, they are likely to pursue repetitive activities that produce the same play over and over’ (Grant, 2017, p.33).

Ethical considerations

The selected participants for this study needed to be considered carefully because they were part of a very vulnerable sector of the population. They were unable to give informed consent and therefore written parental consent was an important ethical consideration to be obtained prior to the commencement of the research. It was also important to inform the participant’s parents of the right to withdraw from the study at an agreed cut-off point, and they had until the end of the first term to withdraw their child from the research programme.

Analysis

The approach used to analyse the data, was a multiple comparison between the quantitative and qualitative data, which included.

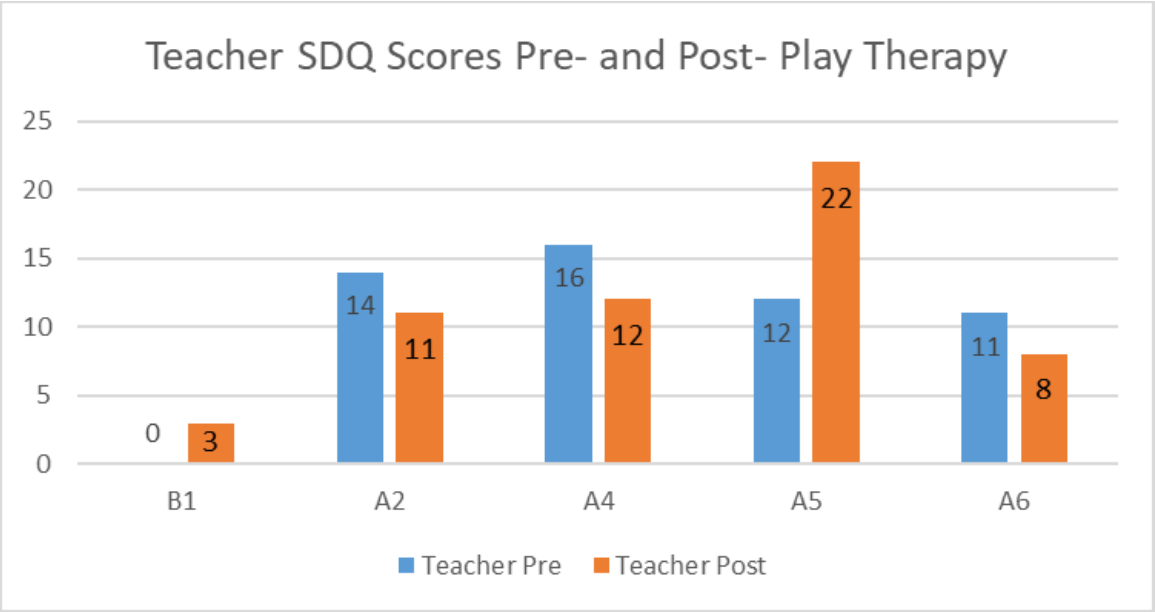
- SDQ from parents and teachers;
- SDQ at each follow-up;
- Questionnaires from parents and and teacher;
- Sessional notes;
- Classroom observations.

The total difficulties scores were compared in relation to the themes that arose within the therapy sessions. Additionally, the behavioural changes were recorded through the sessional notes. and classroom observations which included the parents and teacher questionnaires. Finally, the method of triangulation was implemented to compare and analyse through thematic analysis. these contributing factors across each participant provided the outcome that is explored in the discussion section.

Overall Results

The following information shows the overall SDQ scores for all five participants displayed as charts. The SDQ scores are collected pre and post therapy from the parents and the teachers.

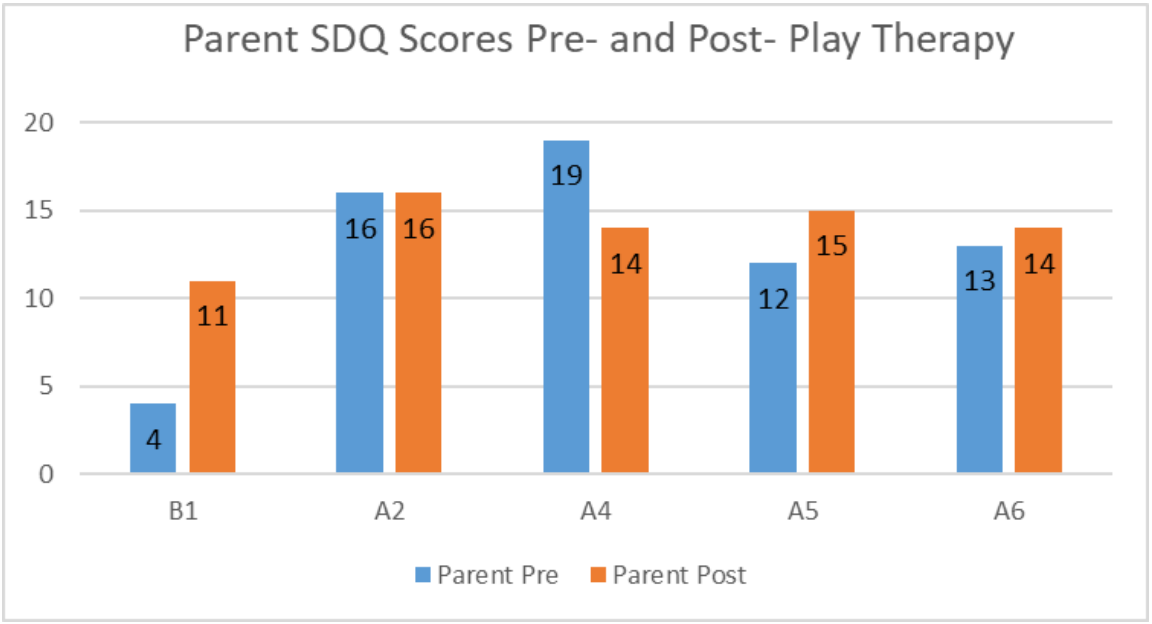
Figure 17: Total Difficulties Score- Teacher Pre- and Post-Scores for Each Participant.



The teacher post-SDQ scores (fig17), showed a reduction for A2, A4 and A6. However, for the case of B1 her score increased by 3 points as she showed an awareness of herself during the therapeutic process. The teacher commented that she was more expressive in class and would sometimes complain about the other students and teachers. In the case of A5, his score increased by 10 points and the teacher reported that this may have been due to the classroom issues he was facing, whereby he was being teased by another student, as a result, some aggressive tendencies would arise. However, the comments showed that he gained an awareness of his feelings and increased independence.

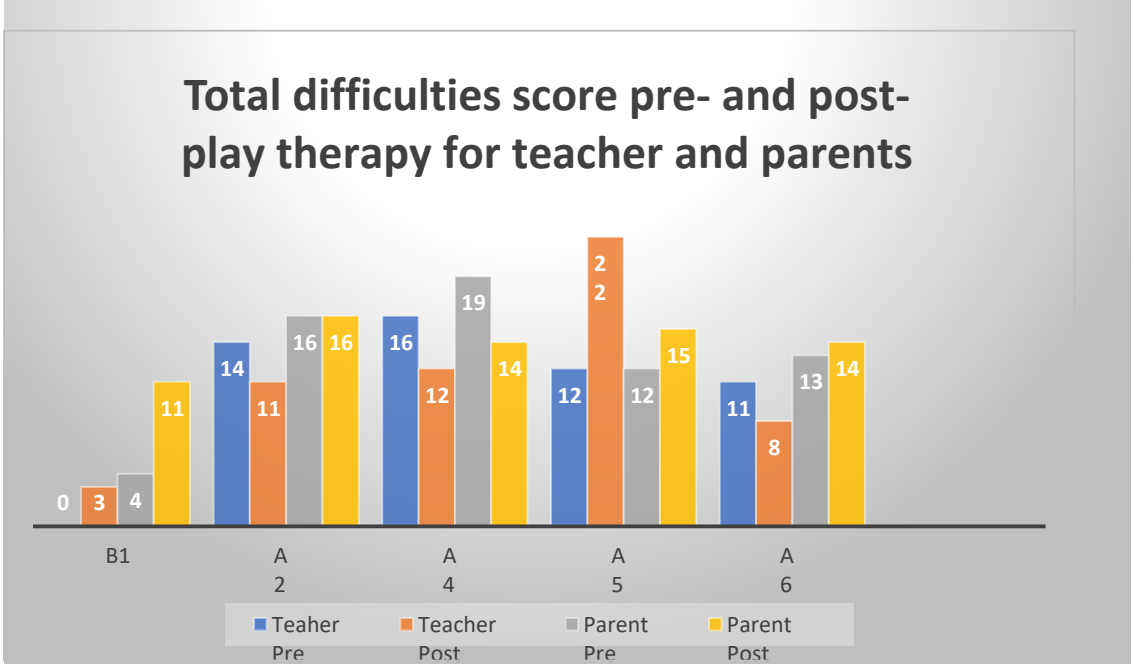
Figure 18

Figure 18: Total Difficulties Score - Parents Pre- and Post-Scores for Each Participant.



For the parents' total difficulties score (fig18), A2 stayed the same, A4 decreased total difficulties and A6 increased by 1 point. For B1, her score increased by 7 points, the emotional score was most significantly raised, as she was better able to express her feelings. Her parents found she had an awareness of herself, concluding that she is now able to deal with her difficulties. For A5 the score increased by 3 points, with the peer score significantly raised which may have been due to the peer difficulties he faced at the centre.

Figure 19: An Overview of the Parents and Teacher Total Difficulties Score for All Participants.



The total difficulties score for teacher and parents (fig19) show mixed results. The SDQ score method is a useful measurement to attain the effectiveness of non-directive play therapy, however, when using it with this population it may not be as effective. Research by Kamran Ali Salayev and Mardanov Qardashlari (2016) tested the effectiveness of using the Goodman's SDQ as a diagnostic tool for autism. They conclude that when using the SDQ for autism it would be preferable to use an additional algorithm to get more decisive results.

Discussion

The purpose of this study was to test the effectiveness of integrative holistic play therapy with adolescents diagnosed with autism and intellectual disabilities. It was also hoped that the results would increase the awareness of the positive impact the practice of integrative holistic play therapy can make, furthermore, to highlight it as a valid therapeutic intervention in reducing these adolescents' social anxieties and self-regulation. The study comprised a multiple case design with quantitative data collected throughout using the Strengths and Difficulties Questionnaires (Goodman, 1997) utilising pre and post SDQ scores. Additionally, the study used a qualitative element by collecting session notes, including comments from the parents and the teacher. The results showed that two of the participants indicated overall positive outcomes in all areas, with a decrease in scores, positive feedback, a reduction in anxious behaviours and improved self-regulation. The other three participants responded to the intervention with mixed results. It is important to take into considerations environmental factors, including the home, and centre events and the use of medication. These contributing factors may have had an impact on the therapeutic process and the outcome.

Self-Regulation and autism

The results of the qualitative data show the participants increased their self-awareness. Reports from the parents and teacher showed that participants were able to deal with feelings appropriately, identify when feeling angry and move away from the situation. They were able to verbalise and communicate when feeling upset and displayed increased independence in daily routines and began thinking for themselves.

Therapeutic relationship

It is very important that the adolescent feels valued in the initial stages for effective integrative holistic play therapy to take place. Axline, (1947), indicates, “The therapist must develop a warm, friendly relationship with a warm, friendly relationship with a child, in which good rapport is established as soon as possible” (p.76). I maintain that the importance of developing the therapeutic relationship, building rapport and trust between the adolescent and therapist is crucial.

Conclusion

This study suggests that integrative holistic play therapy with its non-directive child centered nature can complement more directive therapies, such as Cognitive Behaviour Therapy (CBT), Applied Behaviour Analysis (ABA), and discrete trial training. However, it highlights that some adolescents need a more directive approach which focuses on their particular needs (Grant 2017). It is important here to note that other gold standard therapies for autism are focused on improving play and social skills, eye contact, and modifying behaviours. However, this study has shown that integrative holistic play therapy helped the participants to reduce their anxiety and improve self-confidence and self- regulation. The objective was to highlight the importance of these therapeutic interventions and raise awareness to my colleagues, other professionals and the wider community. My hope was that this would enable these students to integrate into society, understand their emotions and, in so doing, reduce their social anxieties, improve their self-regulation and, at the same time, improve their communication skills.

Outcome and Recommendations

From the results of this work, I believe it would be beneficial that integrative holistic play therapy be available as an option to all adolescents with autism and intellectual disabilities. This, in turn, gives the young person opportunity for self-expression in a safe trusting environment. This, I consider, should be built into their individual treatment plan.

I recommend that integrative holistic play therapy be available to all within special needs schools, centres, and hospitals since it would be a valuable part of mental health rehabilitation. Furthermore, a positive outcome to this study would be to highlight the awareness of play therapy to the local authorities within the United Arab Emirates and to help recognise play therapists as mental health care professionals and establish professional licenses in the field of play therapy in the UAE and provide insurance coverage for the citizens and residents on the country.

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   JOURNAL ARTICLE: Wilson, K. and Ridler, A. (1996) 'Children and literature', *British Journal of Social Work,* **26**(1), pp. 17-36.

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