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Development of the Posttraumatic Play Screening

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ACCEPTANCE

This dissertation, DEVELOPMENT OF THE POSTTRAUMATIC PLAY SCREENING, by GALINA KADOSH TOBIN, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education & Human Development, Georgia State University.

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DEVELOPMENT OF THE POSTTRAUMATIC PLAY SCREENING

by

GALINA KADOSH TOBIN

Under the Direction of Dennis Gilbride, Ph.D.

ABSTRACT

With exposure to potentially traumatic events occurring at high rates (Norris & Slone, 2013), many counselors will inevitably work with children who have experienced trauma. Researchers and clinicians have repeatedly found children who have experienced trauma often demonstrate specific behaviors and themes through their play (Gil, 2017; Chazan & Cohen, 2010; Schaefer, 1994). The combination of a child's affect, play themes, and play behaviors can indicate possible posttraumatic stress (Cohen et al., 2010). The Posttraumatic Play Screening instrument (PTPS) was developed with the aim of providing clinicians a screening instrument for posttraumatic play following a single play therapy session. The PTPS underwent 4 phases of instrument development prior to this study including a thorough review of the play therapy and childhood trauma literature, an external expert reviewer, a focus group, and a pilot administration. Six domains, each with subitems, were identified to be included in the instrument: (a) Play Behaviors, (b) Play Themes, (c) Extreme Negative Affect, (d) Relational Themes, (e) Relationship with Play Therapist, and (f) Behaviors Displayed in Session. Initial criterion validity was established following a pilot administration. The aim of the current study was to assess the psychometric properties of the Posttraumatic Play Screening (PTPS). Instrument reliability was obtained by calculating Cronbach alpha to determine the instrument's level of internal consistency. Findings revealed satisfactory levels for the measure overall and when calculated for the experimental and control video recording separately. Discriminant

validity was established by comparing previously video recorded play therapy sessions of a child with a known trauma history and a child with no history of trauma. The traumatized child's play received a significantly higher overall score on the PTPS. Additionally, the traumatized child's play was rated significantly higher for the *Play Themes*, and *Extreme Negative Affect* domains, as well as the *Negative Play Is* and *Unhelpful Relational Themes* subcategories. Results indicated evidence of reliability and validity for the use of the PTPS as a screening measure to identify a posttraumatic response within children's play.

INDEX WORDS: posttraumatic play, trauma assessment, posttraumatic stress, play therapy, child

DEVELOPMENT OF THE POSTTRAUMATIC PLAY SCREENING

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A Dissertation

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DEDICATION

This dissertation is dedicated to my family. To my parents, Itzhak and Peshi, for instilling in me the value of education, a deep care for others, the importance of Tikkun Olam, and the belief that one person can make a difference. To my husband and beshert, Lawrence, for your belief in me and encouragement to pursue my dreams. You have been my co-pilot through all of my adult years and have supported me through every academic and life endeavor. I am forever grateful for this life we have built, and for our beautiful family.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INITIAL DEVELOPMENT OF THE POSTTRAUMATIC PLAY SCREENING

Trauma has repeatedly been defined as an unexpected, sudden, or extreme experience

that overwhelms an individual's coping abilities (Terr, 1991). Traumatic events may be

dangerous, violent, or frightening events that threaten the lives or safety of a child or loved one

and may result in disruptive ongoing reactions called traumatic stress (The National Child

Traumatic Stress Network, 2011). A review of the literature on the epidemiology of trauma

conducted by the National Center for PTSD concluded at least 25% of the population, including

children, will experience a traumatic event (Norris & Sloan, 2013). Potentially traumatic events

include child maltreatment, family or domestic violence, community violence, interpersonal

violence, medical illness, severe injury, war, mass causalities, natural and manmade disasters,

and traumatic bereavement (Pynoos et al., 2008). The National Child Abuse and Neglect

Database reported 656,000 children were victims of abuse and neglect in the year 2019 with

victim defined as any child who had at least one count of maltreatment substantiated by their

state (Children's Bureau, 2019). Additionally, younger children were the most vulnerable to

maltreatment, with 28.1% of victims under the age of two (Children's Bureau, 2019). The

Centers for Disease Control and Prevention (2021) reported 1 in 7 children experienced some

form of child abuse or neglect in the last year and noted this was likely an underestimate.

Childhood Trauma

Exposure to traumatic events can result in clinically significant levels of distress and

prolonged disruption to everyday functioning and overall wellbeing. Posttraumatic Stress

Disorder (PTSD) diagnostic criteria for adults, adolescents, and children currently includes 4

symptom clusters: a) Intrusion b) Persistent avoidance of trauma reminders c) Negative

alterations in cognitions and mood, and d) Marked alterations in arousal and reactivity (American Psychiatric Association, 2013). It is noted, children may demonstrate intrusive symptoms through play. With the revision of the DSM 5, a new PTSD subtype was created to account for the cognitive and verbal capacities of children under 6 years of age (Scheeringa, 2016). The subtype combines the aforementioned symptoms into three clusters: a) re-experiencing (intrusion) b) avoidance and negative alterations in mood and cognition and c) arousal. The change of clusters was to account for the internalized nature of symptoms experienced among young children and thus only require one symptom for diagnosis (Scheeringa, 2016). In a meta-analysis investigating the risk factors associated with developing PTSD in children, Trickey et al. (2012) found medium to large effect sizes for factors related to subjective experience and post-trauma functioning. Specifically, perceived life threat, peri-trauma fear, social withdrawal, low social support, comorbid psychological difficulties, and poor family functioning were identified. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014) reports trauma survivors may experience "subthreshold" trauma symptoms, which although do not meet the criteria for a PTSD diagnosis, cause interruptions to normal functioning and warrant attention.

Teicher et al., (2016) reported that trauma disruptions during critical periods of development can offset the normal trajectory of brain maturation creating both short-term and long-term implications. Unresolved traumatic stress can result in long-term negative consequences related to a child's social, emotional, behavioral, relational, and cognitive functioning (Nader, 2008; van der Kolk, 2003). Early life adversities have also been linked to an increased risk for poor physical health, substance use, and suicide in adulthood (Felitti et al.,

1998; Dube et al., 2001). Children are especially susceptible to the effects of trauma due to their brain's immaturity and high level of plasticity (Anderson, 2003).

Attachment relationships are thought to be one of the largest mitigating factors to the effects of trauma (van der Kolk, 2003). The attachment bond is understood as a continuous emotional relationship with an individual that provides a sense of safety with their presence and distress with the loss or threat of loss of that individual (Putnam, 2006). The attachment relationship can be affected by adverse events as well as affect the posttraumatic response. Busch and Lieberman (2007) asserted that trauma can threaten the attachment relationship as a child's belief in their parent's ability to offer protection is challenged. Further, the relationship may be destabilized as the child and parent experience posttraumatic stress and the cycle of seeking and receiving comfort is obstructed (Busch & Lieberman, 2007).

Young children develop in relation to their caregivers and rely on their attachment figures for regulatory cues, a sense of safety, and the development of internal resources (Hughes, 2009). Mikulincer et al. (2015) argued that the attachment behavioral system is likely to be activated during exposure to traumatic events "impelling the person to search for external or internalized attachment figures who can protect him or her from trauma" (p. 10). Following a trauma, parents can assist children in their coping by providing protection and nurturance (The National Child Traumatic Stress Network, 2011). Research has demonstrated caregiver support can temper the negative effects of trauma, lesson posttraumatic stress symptomology, and assist in symptom resolution (Woodhouse et al., 2015; Turunen et al., 2014; Busch & Lieberman, 2007). When parents experience their own traumatic stress however, parenting behaviors may be impacted. Previous studies have found high stress situations are associated with low warmth, lack of responsiveness, insensitivity, withdrawal, and harshness (Kiser et al., 2008). Putnam (2006)

further reported, previous studies have demonstrated a mother's stress due to emotional exhaustion or depression can impact a young child's biological system in ways that are believed to be harmful to long-term health.

Medical Illness and Trauma

Pediatric medical experiences, such as those common to chronic illness and serious injury, often involve potentially traumatic events. Children requiring medical care have unique stressors related to illness, pain, injury, hospitalization, and medical treatments. A subset of these children also face life-threatening or terminal diagnoses that layer on uncertainty about the future; as is the case with childhood cancer. Following pediatric illness and injury, many children and families have been found to cope effectively and experience positive changes such as post-traumatic growth (Price et al., 2021). A subset however, experience significant lasting distress that would benefit from intervention (Price et al., 2021). In a study examining posttraumatic stress symptoms (PTSS) among parents and their children admitted to the Pediatric Intensive Care Unit (PICU), Colville and Pierce (2011) found almost half of families were exhibiting significant PTSS 12 months after discharge, with many experiencing a delayed onset of symptoms. Among the children sampled, one-third experienced clinically significant levels of PTSS at 3 months post-discharge, and more than one-fourth continued to exhibit significant levels at 12 months. Further, parents were found to be more likely to continue to have significant PTSS distress when their children were admitted non-electively. The authors conclude, parents and their children who receive PICU treatment are at risk for developing PTSS and should receive ongoing psychological monitoring (Colville & Pierce, 2011).

Posttraumatic stress symptoms (PTSS) have continuously been linked with portions of childhood cancer survivors. Tremolada et al. (2016) found sub-clinical to moderate levels of

PTSS for over 20% of the adolescent and young adult survivors of childhood cancer in their

sample. In a review of the prevalence of PTSS among childhood cancer survivors, Bruce (2016)

found rates of PTSS and PTSD were significantly higher among childhood survivors and their

parents compared to the general public. Bruce (2016) contends "receiving a diagnosis of

childhood cancer (for both the child and their parent) may indeed constitute information which

would challenge existing inner models and ideals about the self, others and the world. The

repeated traumatic stressors inherent in the cancer experience (e.g., medical investigations,

diagnosis, multiple treatments and follow-up appointments) may further exacerbate the process

of schematic assimilation, resulting in a more chronic and persistent symptomatological

presentation" (p.17). Further, Scheeringa and Zeanah (2001) found an association between

parental distress and related relational interactions and child posttraumatic stress outcomes. The

authors conclude, children are especially vulnerable to parental insensitivity when experiencing

their own posttraumatic symptomology (Scheeringga & Zeanah, 2001).

Play as a Coping Mechanism

Play is a normal, expected, and necessary aspect of childhood. Normal play has been

defined in the literature as an "age-appropriate, joyful, absorbing activity. It is initiated

spontaneously, with a developing theme carried to a resolution; there is a natural ending and then

a move on to another activity" (Kernberg et al., 1998, p. 198). The American Academy of

Pediatrics (AAP) released a Clinical Report on the importance of play stating, "play is not

frivolous; it is brain building. Play has been shown to have both direct and indirect effects on

brain structure and functioning" (Yogman et al, 2018, p. 5). Play is fundamental to the

development of executive functioning and social-emotional skills critical in adulthood (Yogman

et al, 2018). Through play, children are also able to gain competence through the creation and

mastery of daily activities (Schaefer, 1980). Play becomes even more critical with the presence of adversity as the shared joy and attunement between a caregiver and child can regulate the stress response system (Yogman et al, 2018).

Play is believed to have many adaptive benefits, including the use of play as a coping mechanism for adversity. As play has been found to occur across many mammals (Siviy, 2010; Pellis & Pellis, 2009), animal models offer insight into the possible coping benefits of play. Pellis et al. (2010) suggested a metatheoretical framework for understanding the adaptive functionality of play that incorporates two leading hypotheses; 1) animals play in order to learn how to cope with unpredictability (i.e. training-for-the-unexpected) and 2) play prepares the young animal's muscles and nervous system for adult behaviors (i.e. motor training). In support of the training-for-the-unexpected hypothesis, Pelis et al. (201) highlight rats that lacked play experiences as juveniles have been found to overreact to situations, escalate to aggression, remain stressed, and display fear responses to novel situations. Whereas rats that experienced juvenile play were able to temper their emotional responses; suggesting play lessens fear to unfamiliar situations. In support of the motor-training hypothesis, Pellis et al. (2010) extrapolate from previous research findings showing rats that lacked juvenile play experiences had the same social skill deficits as rats with damage to their prefrontal cortex (PFC). The authors state play influences the development of the PFC, which in turn inhibits the amygdala and limits emotional reactivity. When these hypotheses are taken together however, Pellis et al. (2010) argue "play trains animals to be resilient by modifying the neural circuitry that regulates emotional responses" (p.292).

Rats engage in complex patterns of play fighting that resembles both primates and humans (Pellis & Pellis, 2009) allowing researchers to study play in a controlled environment.

Rats who were deprived of play during their juvenile period have been found to display

behavioral, cognitive, and socioemotional deficits as adults (Pellis et al., 2010). Further, while

play among juvenile rats has been found to be severely inhibited in the presence of a threat, they

continuously returned to playfulness as the threat lessened, even when continuing to display

caution in other areas (Siviy, 2010). Siviy (2010) argued these findings demonstrate a resiliency

of play behavior even in the face of adversity.

Similar findings highlighting the coping benefits of play have been found among

children. Barnett and Storm (1981) compared the play behaviors and anxiety levels of preschool

aged children following a conflict situation to those in a neutral group and found play mitigated

feelings of distress. Following a play period, the children in the conflict group showed decreased

anxiety on physiological tests while their play was found to be significantly more related to the

event than those in the neutral group (Barnett & Storm, 1981). In a follow up study to explore the

function and mechanism of play in alleviating distress, Barnett (1984) classified 74 preschool

children as either high or low anxiety following their mother's departure and divided each group

into play or no play subgroups. Findings revealed that while the Palmar Sweat Index (PSI)

pretest scores did not differ among the high anxiety group, children who played had significantly

lower anxiety compared to those who heard a story at PSI posttest (Barnett, 1984). Additionally,

children in the high anxiety group engaged in more dramatic/fantasy play compared to the

functional play style of their low anxiety peers. Barnett (1984) explains the differences between

high and low anxiety children support the notion of play as a coping mechanism for distress.

Play Therapy as a Treatment Modality

Play Therapy is a form of counseling and widely accepted treatment modality that offers

children a way to express and resolve their experiences. Play Therapy differs from everyday play

as it is systematic, theoretical, and utilizes evidenced-based practices by trained mental health professionals (APT, 2016). Often used with children ages 3-10 (Kottman, 2016; Dripchak, 2007), Play Therapy honors a child's developmental level and recognizes the sequential nature of brain development by offering children a means to express themselves outside of formal language. Play functions as the core agents of change that lead to positive goal attainment (Peabody & Schaefer, 2019). Schaefer and Drewes (2014) outline a transtheoretical theory of 20 core therapeutic factors of play. These included 1) facilitating communication through self-expression, access to the unconscious, and through direct and indirect teaching, 2) enhancing emotional wellbeing through catharsis, abreaction, positive affect, counterconditioning of fears, stress inoculation, and stress management, 3) fostering relationships through the therapeutic relationships, enhancing attachment relationships, empathy, and social competency, and 4) increasing personal strengths through creative thinking, resiliency, moral development, psychological development, self-esteem and self-regulation. Play therapists are trained to think analytically about the verbal, nonverbal, and symbolic material that occurs in a session (Homeyer & Morrison, 2008).

Past meta-analyses have demonstrated play therapy efficacy across age, gender, ethnicity, modality, theoretical framework, and a variety of presenting issues, including trauma symptomology, parent-child relationship stress, and self-esteem (Lin & Bratton, 2015; Bratton et al., 2005; Leblanc & Ritchie, 2001). In their meta-analysis, LeBlanc and Ritchie (2001) looked at reaction to a traumatic event and found statistically significant effectiveness in utilizing play therapy as a treatment method with children ages 3-12. These authors concluded play therapy appears to be as effective as verbal psychotherapy with adults and children based on the estimated effect sizes from previous meta-analyses (Leblanc & Ritchie, 2001).

In a randomized controlled study, Schottelkorb et al. (2012) examined the effectiveness of Child Centered Play Therapy (CCPT) on PTSD symptom reduction, compared to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) among traumatized refugee children. The authors found a significant decrease in severity rating among both the child and parent-reported baseline and follow-up PTSD assessments for both the CPPT and TF-CBT group (Schottelkorb et al., 2012). Further, no significant differences existed between the two treatment groups, indicating CCPT was as effective as TF-CBT in the treatment of these children (Schottelkorb et al., 2012). Additional research (Dugan et al., 2010; Scott et al., 2003; Campbell & Knoetze, 2010) has found play therapy to be effective in improving feelings of safety and control, and in increasing felt sense of competency among children following trauma experiences.

Play Therapy for Childhood Adversity

Children experience and react to emotion before they have the cognitive development and language abilities to verbalize these experiences (Greenberg, 2006). Due to this maturational process, children often have difficulty verbally expressing their trauma-related fears and experiences with traumatic events (Jordan et al., 2013). Further, trauma is stored in nonverbal areas of the brain, such as the brainstem, thalamus, hippocampus, and amygdala, while processing of life events occur in the frontal regions of the brain (Van der Kolk, 2003). As such, words cannot access the sensory aspects of the trauma. Playing, and the replaying of traumatic events however can help shift these memories to the frontal regions for later processing (van der Kolk, 2003).

The lower brain regions, where trauma dysfunction typically occurs, are also less plastic and benefit from therapeutic interventions that offer repetitive, patterned sensory input (Perry, 2006). Play therapy naturally provides this form of intervention through the use of movement,

sand, music, art, and play. Through the therapeutic play relationship, children can gain the repeated experiences of relational safety and predictability needed to overcome instinctual self-protective responses, reduce trauma-related generalizations, and challenge false associations (Perry, 2006; van der Kolk, 2003). Play further helps to re-establish a sense of control and mastery over the traumatic experiences (Webb, 1995).

Through the processes of symbolization, projection, and displacement, play provides children with the safety and distance needed to process difficult trauma material (Schaeffer, 1994). Play materials, such as puppets, figurines, clay, and sand, provide children with the tools to release and process distressing experiences and emotions, enact various related roles, and gain power over those events (Schaefer & Drewes, 2014). Children often experience frightening feelings and thoughts related to their traumas which can be communicated and processed through play (Kottman & Meany-Wallen, 2016; Lin & Bratton, 2015). Play also provides children the tools to depict aspects of their interpersonal and familial relationships that they may not otherwise have the words to describe (Murray et al., 2001).

Like adults, children react and re-experience significantly distressing and traumatizing events. Children however will engage in a form of play, called posttraumatic play, as a means to process these experiences. Posttraumatic play is the repetition of traumatic themes through play (Dripchak, 2007) that is oftentimes initiated by the child and assists the child in gaining mastery over the events and a renewed sense of control (Gil, 2015). Through play, a child can access the process of gradual exposure (Gil, 2017) and engage in a cathartic experience (Baggerly & Exum, 2008).

Components of Posttraumatic Play

Play Behaviors

Posttraumatic play describes the observable play patterns following trauma and has repeatedly been described as repetitive, intense, thematic, rigid, and lacking joy (Gil, 2017, Jordan et al., 2013; Sossin & Cohen 2011; Cohen et al., 2010; Dripchak, 2007; Terr, 1981). Unlike the spontaneous and exploratory nature of normal play, posttraumatic play is often cyclical, controlled, serious, and compulsive (Jordan et al., 2013; Chazan & Cohen, 2010; White & Allers, 1994). Within the child maltreatment literature, White and Allers (1994) identified unimaginative and literal play, and repetition and compulsion as two overarching play themes. Unimaginative and literal play was described as less creative and elaborate, lacking spontaneity and exploration, and play met with sullenness or opposition (White & Allers, 1994).

Repetitive play is defined throughout the play literature as the repetition of specific play themes, sequences, or behaviors that ritualistically arrive at the same ending and may use the same play materials (Cohen et al., 2010; Dripchak, 2007; Findling et al., 2006). Repetition compulsion, the recreation of earlier life states, can be traced back to Freud (Logan, 1986). Among children, repetition compulsion refers to the unconscious reenactment of troublesome events through play (Varkas, 1998). Erickson (1967) asserted children will re-enact their experiences through play in order to gain understanding and ultimately achieve mastery (as cited in Gariepy & Howe, 2003). Varkas (1998) explained, "repetition compulsion serves to reduce anxiety by repeatedly attempting to create a sense of mastery, safety, and control." (p. 48). Sometimes repetitive play resolves on its own. Other times however, repetitive play is rigid, does not move towards a resolution, and appears stuck (Cohen et al., 2010; Gil, 2017). Erickson explains the process of repetition compulsion is repeated until the experience no longer needs to be re-enacted (as cited in Gariepy & Howe, 2003).

Play Themes

Trauma Re-enactment. Re-enactment behaviors in which survivors recreate past trauma experiences are considered a distinct feature off trauma (SAMHSA, 2014). Among children, re-enactments, classified as re-experiencing symptoms, occur through repetitive play "in which themes or aspects of the trauma are expressed" (American Psychiatric Association, 2013, p. 271). Trauma re-enactments are described as behaviors or play that are compulsive, repetitive, and literal, and oftentimes include before, during, and after the trauma (Ogawa, 2014; Grunbaum, 2007; Ater, 2001). Trauma-reenactments may include changes overtime that depict hopefulness, control, or mastery over the traumatic events (Gil 2017). Alternatively, the child may appear stuck and the trauma re-enactment is monotonous, systematic, and offers no relief to the child (Ater 2001; Gil 2017).

Examples of trauma re-enactments can be found within the child trauma literature. For example, Saylor et al. (1992) examined the reactions of preschoolers following a class IV hurricane and found a common theme of re-enactment through play, drawings, and conversations specifically about the hurricane (Saylor et al., 1992). In a longitudinal study, Sossin and Cohen (2011) observed play sessions of young children who had lost fathers in the September 11th terrorist attacks and similarly found the children's play was repetitive, intense, and included trauma-specific play, such as, buildings blowing up and people jumping off of roofs. Likewise, Shelby and Tredinnick (1995) observed repetitive disaster themes in the play of children following a category 5 hurricane.

Sexualized. Sexualized behaviors have repeatedly been associated with childhood sexual abuse and may take the form of excessive interest or preoccupation with sex, sexual behaviors, or sexual play (Putnam, 2003; Homeyer & Landreth, 1998; Gil, 1991; Finkelhor & Brown, 1985). Finklehor and Brown (1985) explain traumatic sexualization refers to "a process in which

a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (p. 531). Ater (2001) proposed sexualized play behaviors may serve various functions; such as a direct or indirect re-enactment of their sexual abuse experience, an attempt to gain control of the relationship, or in an effort to gain understanding of their experience and the world. Examples of sexualized play include overt sexual art or conversation, displays of adult sexual behavior (such as enacting sexual contact between dolls), as well as hitting or cutting off dolls' genital areas (Homeyer & Landreth, 1998; Bennedict, 2006).

Perceived or Actual Death/Loss/Threat. Themes of death and loss have been connected to children's play following traumatic events. Following exposure to terrorism (Cohen et al., 2010; Chazan & Cohen, 2010) and natural disasters (Shelby & Tredinnick, 1995), children were found to display significantly more morbid play themes and focused on death and loss in both conversation and play. Chazan and Cohen (2010) reviewed the play narratives of twenty-three children directly exposed to terrorism and found children who's play was repetitive, overwhelming, and disconnected, had themes of death and morbidity as elements of their reenactment play (Chazan & Cohen, 2010). Similarly, Sossin and Cohen (2011) found common themes of loss and searching (for protective figures) among children whose parents died due to the September 11th terrorist attacks.

Parentification. Parentification is generally defined in the literature as "a functional and/or emotional role reversal in which the child sacrifices his or her own needs for attention, comfort, and guidance in order to accommodate and care for logistical or emotional needs of the parent" (Chase, 1999, p. 5). Parentification differs from the occasional care-taking that a child may perform and is understood as age-inappropriate, unsupervised, and confusing chronic care-

taking towards parents or siblings (Early & Cushway, 2002; Murray et al., 2001; Jurkovic, 1997). James (1994) notes, at times, all children will shift their behavior in order to elicit parental caregiving behaviors. Jurkovic (1997) adds temporarily taking on care-taking roles offers an opportunity to master social skills, rehearse future roles, express caring, experience responsibility, and support self-esteem and identity development. Adaptive parentification, according to Jurkovic (1997), occurs when the role is temporary, not tied to the child's identity, and the child is supported and treated fairly. Inappropriate care-taking behaviors by a child however can overburden the child with the responsibility to protect a parent, sibling, or the family (Jurkovic, 1997). James (1994) differentiates between alterations that are typical versus problematic as roles that must be assumed by children in order to receive basic care and when a child's sense of worth becomes intertwined with the role. Examples include caregiving behaviors towards parents, overcompliance with parents, parenting siblings, and a child in the role of friend, decision-maker, or confidant to the parent (Early & Cushway, 2002; James, 1994).

Previous studies have established a link between child caretaking behaviors, situational influences, and long-term effects. Murray et al. (2001) examined the doll house play behaviors of children with depressed and well mothers and found children who had recently been exposed to maternal depression depicted play themes of the child caring for the mother. *Care given by the child* was defined as personal and practical caregiving of the parent by the child (Murray et al., 2001). Utilizing the Parentification Inventory to assess for retrospective self-reported parentification among adults, Hooper et al. (2011) found a significant relationship between parentification and psychological distress, depression symptomology and alcohol use.

Violence Against Animals. The etiology and implications of animal cruelty has largely been overlooked by researchers, practitioners, and scholars (Flynn, 2000). Recently however,

animal cruelty has been recognized as a potential symptom of exposure to child maltreatment and domestic violence (Ascione et al., 2003). Multiple studies have found an increased prevalence of child abuse among children with histories of animal maltreatment. For instance, McEwen et al. (2014) examined the relationship between animal cruelty and child maltreatment among children 5 to 12-years old and found children who were cruel to animals were twice as likely to have experienced physical maltreatment. Similarly, Boat et al. (2001) reviewed child psychiatric intakes for histories of animal cruelty and found children with previous reported behaviors of animal cruelty were 2.81 times more likely to have experienced sexual abuse than the children without animal cruelty histories. Duncan et al. (2005) found adolescent boys in residential treatment for conduct disorder with histories of animal cruelty were significantly more likely to have experienced physical abuse, sexual abuse, or exposure to domestic violence compared to those without a history of animal violence.

Ascione et al. (2003) examined the association between animal cruelty and sexual abuse and witnessing domestic violence amongst children 6 to 12 years old. These authors found the prevalence of animal cruelty was five times higher among the children with substantiated sexual abuse histories compared to a normative group. Animal cruelty rates were highest amongst boys across all samples and increased with comorbid experiences of sexual abuse and physical abuse. The prevalence was highest amongst girls who had experienced sexual abuse, physical abuse, and parental fighting. Baldry (2003) similarly found boys were two thirds more likely to commit animal abuse compared to girls, and almost half of the children who committed abuse reported exposure to interpersonal partner violence.

Extreme Negative Affect

Negative affect (e.g. anxiety, anger, sadness, fear, etc.) has continuously been noted within the play literature as accompanying a child's posttraumatic play (Myers et al., 2011; Cohen et al., 2010; Findling et al., 2006; White & Allers, 2001) and has been referred to as a child's lack of joy or expression of positive affect (James 1994; Schaefer 1994; Terr 1991). Terr (1981) defines trauma as "the injury to the personality that occurs when sudden, intense, unexpected anxiety overwhelms the individual's abilities to cope and to defend" (p. 741). Terr (1991) theorized traumatized children develop both trauma-specific fears and generalized fears and will exhibit panic and extreme avoidance following traumatic events. Through her clinical work, Terr (1991) also noted intense anger, both towards others and one's self, numbing, and depression as characteristic of a posttraumatic response.

Cohen et al. (2010) similarly found children expressed profound negative affect following exposure to severe terror characteristics, loss of an immediate family member, injury to a parent, and with injury to self. In their study, negative affect included fear, anxiety, anger, aggression, sadness and wariness. The researchers highlight considering overall tone, spectrum of affect, appropriateness of tone to content, and affective tone towards therapist when assessing negative affect expression (Cohen et al., 2010).

Relational Themes

Attachment theory informs both the *Relational Themes* domain and the *Relationship with Play Therapist* domain. The *Relational Themes* domain examines a child's experience of their relational world by assessing the child's use and expectations of attachment figures and helpers in their play. Helpers are defined as any character in the play that is more powerful than the child and should be in a position of responsibility for the child (i.e. parents, caregivers, police officers, neighbors, superheroes). While the term *helpers* traditionally denotes a helpful individual,

traumatized children may have experienced individuals in positions of power as the source of their trauma. As such, *helpers* may be coded as hurtful or unhelpful on the PTPS to represent this paradox.

The attachment relationship is understood through John Bowlby's seminal attachment theory which described attachment as a behavioral system that operates to keep infants close to their primary caregivers for the purpose of protection (Thomas, 2005). Attachment theorists proposed children increase attachment behaviors during experiences of stress (James, 1994; Ainsworth & Bell, 1970) and the quality of an attachment relationship is largely impacted by the caregiver's response during times of attachment activation (i.e. child is scared, upset, hurt, or ill) (Benoit, 2004). Through secure attachments, children gain a sense of safety and security through proximity seeking behaviors and venture to exploratory behaviors through the use of the caregiver as a secure base (Bowlby,1988; Bowlby, 1980; Ainsworth & Bell, 1970). A secure attachment produces confidence that an attachment figure will be available for comfort in times of distress and creates trust in the caregiver's stable presence (Crittenden & Ainsworth, 1989; Bowlby, 1980). Insecure attachments, further defined as anxious-ambivalent and anxious-avoidant, often form through repeated interactions where the primary caregiver is unresponsive, inaccessible, or inappropriately responsive to the infant's behavioral cues, or following a traumatic separation or loss of the attachment figure (Crittenden & Ainsworth, 1989). Anxious-ambivalent attachments are understood as the child experiencing uncertainty whether a parent will be available or responsive when needed while anxious-avoidant attachments are thought to form when the child expects to be rebuffed (Bowlby, 1980).

Attachment researchers have repeatedly highlighted the impact of nonresponsive caregiver behavior on parent-child attachment. Within attachment literature, this behavior has

been referred to as *unresponsive* and *inaccessible* (Crittenden & Ainsworth, 1989; Ainsworth et al., 2015) and is considered to occur when a caretaker frequently fails to acknowledge or respond appropriately to their child (Ainsworth et al., 2015). Some indications of anxious attachments include an "undue preoccupation with the whereabouts of the attachment figure and undue difficulty in separating from him or her, lack of trust in the attachment figure, chronic anger and resentment toward him or her, inability to seek or use support from the attachment figure when such support is needed, or absence of feeling toward him or her" (Crittenden & Ainsworth, 1989, p.443). Infants with anxious-avoidant attachments have often experienced caregiver rejection or anger during times of high stress and have been found to display little stress during separations and avoidant behaviors during reunion (Crittenden & Ainsworth, 1989).

Early attachment experiences are believed to influence the child's expectations about relationship roles and future relationships (Shapiro & Levendosky, 1999; Malekpour, 2007). These representational schemas, called internal working models, include both cognitive and affective information (Green et al., 2000; van der Kolk, 2003) and allow children to make predictions if protective figures will be available when needed (Bowlby, 1982; Crittrenden and Ainsworth, 1989). Pietromonaco & Bartett (2000) explain internal working models include information regarding who serves as secure figures, and about the accessibility and responsiveness of these figures. These interactional expectations are especially significant during times of need and are applied across relational partners (Mikulincer et al.,2015). Attachment classifications formed in infancy have been found to be stable through young adulthood (Main & Cassidy, 1988). Putnam (2006) argues "in infancy and early childhood, attachment is the single most important factor that can be measured to predict problems later in life" (p. 5-6). Previous literature has argued a child's internal working model of self and others can be understood and

assessed through children's play themes (Ryan & Edge, 2012; Jacobitz & Hazen, 1999; Bretherton et al., 1990).

Previous studies have utilized doll play completion tasks (Green et al., 2000; Murray et al., 2001) to assess and classify young children's internal representations of attachment relationships. Green et al., (2000) examined the internal working models of attachment among young children and found secure attachment behavior in the child's play was associated with separate ratings of caregiver warmth and sensitivity. Haene et al. (2013) found secure stories included narrative themes of parental protection, emphasis on family cohesion, and open communication about stressors, while insecure stories included parental absence and withdrawal, parental inability to offer comfort, and family conflict and violence. Similarly, Murray et al. (2001) found play depicting poor care and neglect was associated with maternal insensitivity during infancy.

Relationship with Play Therapist

The *Relationship with Play Therapist* domain explores the child's relational patterns through their interactions with the play therapist. The relationship between the child and the play therapist is parsed out to identify relational interactions across the spectrum; those that appear avoidant or under-attached, those that appear developmentally appropriate, and those that appear over-attached. Attachment classifications have been found to correlate with patterns of social and play behavior with adults other than the primary caregiver and are believed to greatly impact children's social relationships across settings and over time (Kennedy & Kennedy, 2004; Page, 2001; Bowlby 1980). Further, relationships with psychotherapists may include similar characteristics to those with primary attachment figures as clients may transfer expectations and perceptions of their attachment figure onto the therapeutic relationship (Kennedy & Kennedy,

2004; Bowlby, 1988). Findling et al. (2006) additionally suggested the child's level of avoidance offers insight to a child's general style of relating to others.

Under-Attached (Avoidant). Children classified as under-attached may avoid attempts to connect and appear indifferent, resistant, or hostile (Kennedy & Kennedy, 2004; Erickson et al., 1985). Typically, under-attached children do not seek comfort in times of distress (Zeanah & Boris, 2012; Bretherton & Munholland, 2008). James (1994) explained intimacy avoidance can occur both with the source of trauma and with other adults and can manifest in various behaviors, such as avoidance of eye contact, withdrawal, aversion to emotional or physical closeness, and an inability to trust adults

Appropriate (Secure). Children with secure attachment behaviors will explore their surrounding environment and seek comfort and reassurance when afraid or overwhelmed through the use of proximity (Bretherton & Munholland, 2008; Pietromonaco & Battett, 2000; Ainsworth & Bell, 1970). When distressed, securely attached children will accept comfort, easily be soothed, and return to play activity (Bretherton & Munholland, 2008; Page, 2001). Further, securely attached children have been shown to engage in more complex play, relate positively to adults, and demonstrate flexibility and socially appropriate emotional expression (Kennedy & Kennedy, 2004).

Over-Attached (Anxious-Ambivalent). Children displaying an over-attached style of relating display socially nonselective (i.e., indiscriminate) behavior towards unfamiliar adults and lack developmentally expected reluctance to strangers (Zeanah & Boris, 2012; Lyons-Ruth et al., 2009; Zeanah et al., 2002). Children may seem clingy, passive, or act aggressively towards adults and typically behave in ways that both seek and resist contact (Ainsworth & Bell, 1970; Bretherton & Munholland, 2008; Pietromonaco & Barrett, 2000). During times of stress, children

with this relational pattern are often difficult to sooth and may demonstrate difficulty returning to play (Bretherton & Munholland, 2008; Pietromonaco & Battett, 2000; Crittenden & Ainsworth, 1989). Exploration during play may be limited due to efforts to maintain proximity and attention (Crittenden & Ainsworth, 1989). Further, unmet efforts for contact often result in increased attempts, anger, and ambivalence (Crittenden & Ainsworth, 1989).

Behaviors Displayed in Session

Sexualized. Sexualized behaviors have long been linked to experiences of childhood sexual abuse. Sexualized behaviors differ from the normative genital interest and play that often occurs between the ages of 2 and 6 (Merrick et al., 2008). In a review of the literature, Putnam (2003) found sexualized behaviors were among the most documented outcomes of childhood sexual abuse. Higher rates of sexualized behaviors were found to be exhibited among younger children, children who had experienced sexual abuse at younger ages, and soon after the abuse experiences (Putnam, 2003). Further, higher frequencies and greater intensity of sexualized behaviors has been found among children with sexual abuse histories compared to normative and psychiatric samples (Friedrich et al., 2001). Sexualized behaviors have also been linked to alternative forms of child maltreatment. Merrick et al (2008) found reports of physical abuse occurring both before the age of 4 and from ages 4 to 8, and reports of emotional abuse during ages 4 to 8, significantly increased the odds of sexualized behaviors (Merrick et al., 2008).

Dissociative. Dissociation refers to various behaviors stemming from lapses in cognitive and psychobiological processes (Ogawa et al., 1997). Dissociative episodes can range from mild occurrences (such as confusion, memory lapse, or blank spells), to pronounced or extreme manifestations (such as shock, trance-like states, or alter personalities) and convey a need for protection (Thomas, 2005). Diseth (2005) clarified dissociation can be a normative experience

when minor and utilized as either a coping strategy to alleviate stress or as a defense strategy as seen with daydreaming. Dissociation can reach pathological levels however when it results in loss or altered behavior (Diseth, 2005).

Dissociation has long been linked with childhood abuse (Thomas, 2005; Diseth, 2005; Brier et al., 2001; Ogawa et al., 1997) and may provide a child enduring trauma with a mental escape when physical avoidance is not possible (Diseth, 2005). Following a systematic review of dissociation in children and adolescence, Diseth (2005) found early childhood traumatization as the most salient factor. In a longitudinal study examining dissociative symptomology risk factors, Ogawa et al. (1997) found abuse in infancy, as well as concurrent experiences of abuse, were strong predictors for dissociation later on in childhood and young adulthood. Additionally, maternal psychological unavailability was predictive of later dissociative symptoms. Ogawa et al., (1997) further found, a classification of either an anxious-avoidant or disorganized attachment during the infant strange situation was associated with higher levels of dissociation in childhood and early adulthood, respectively, compared to those with a secure or anxious-ambivalent classification (Ogawa et al., 1997). More recently, Dutra et al. (2009) explored the relationship between dissociation and the quality of early care and childhood trauma in a longitudinal study spanning infancy until age 19. Dissociation at age 19 was significantly predicted by experiences of verbal abuse and early care; specifically, a lack of positive affective involvement, disrupted communication, and mother's flatness of affect (Dutra et al., 1997).

Dissociation during play has frequently been observed among children who have experienced abuse (Thomas, 2005; Ater, 2001; White & Allers, 1994). Atter (2001) describes dissociative play as disconnecting from the here and now when the play material becomes too overwhelming. Among children with sexual abuse histories, Homeyer and Landreth (1998)

found the presence of dissociative play behaviors, such as staring off and appearing in a trance like state while playing with sand and water. Findings from their study suggest boys and girls may dissociate differently as girls were more likely to dissociate without tactile stimulation and/or reenactment of the abuse compared to boys (Homeyer & Landreth, 1998).

Hypervigilant. Hypervigilance is defined as a heightened attention to danger (Dalgleish et al., 2001). The DSM-5 includes hypervigilance as one of the criteria for PTSD among children and adolescents and may be exhibited as scanning the environment for threat or heightened alertness to noises and movements (Stirling et al., 2008; Varkas, 1998). Among children, this state of increased arousal may present as attentional difficulties or distractibility (Perry, 2003). Brier et al. (2001) found posttraumatic stress arousal was associated with both physical abuse and witnessing domestic violence among children ages 3 through 12.

Childhood posttraumatic stress has been associated with an attentional bias for threat-related information (Dalgleigh et al., 2001). McCrory, et al. (2011) utilized functional magnetic resonance imaging (FMRI) to explore the emotional processing of children exposed to family violence and found heightened activation to angry faces among exposed children. These authors asserted while a risk to long-term development, heightened reactivity offers a short-term advantage of increased vigilance during danger (McCrory et al., 2011). Similarly, Pollak, et al. (2005) explored children's arousal response to background anger and found children who had experienced abuse maintained a state of anticipatory monitoring while their non-abused peers returned to baseline states with the resolution of the anger. Additionally, Pollak et al. (2005) found the abused children did not demonstrate a greater arousal response during the onset of anger but during periods of silence and unresolved conflict.

Disorganized Attachment. Main and Solomon (1990) identified an additional classification of insecure attachment following observations of infant behavior. Infants classified as having a disorganized attachment displayed atypical behaviors including contradictory behavioral patterns, behavioral stilling, confusion, and incomplete or undirected movements and expressions (Main & Solomon, 1990). Untypical caregiver behaviors, such as frightening, sexualized, and dissociative behaviors, could lead to the development of disorganized attachment (Benoit, 2004). Zeanah & Boris (2012) explain "emotional availability, nurturance, warmth, protection and provision of comfort are the most salient caregiver behaviors for the attachment relationship, corresponding to security and trust, balanced emotional regulation, vigilance, and seeking comfort for distress in the young child" (p. 356) and are the predominant domains for understanding disordered attachment. Crittenden offered an alternative paradigm to understand maltreated children and argued children do not have a disorganized attachment, but rather organize themselves around danger using a fluid combination of attachment behaviors to survive the moment (Landa &Duschinsky, 2013).

Infants with a disorganized attachment classification were found to display distinguishable behavioral patterns from their peers five years later; specifically, children were found to act in a parental role through the use of controlling or caregiving behaviors (Main and Cassidy, 1988). Children with disorganized attachments are thought to display aggressive, disruptive, and socially isolating behaviors and engage in interactions that appear rigid, unbalanced, odd, and out of sync with the current interaction (Kennedy & Kennedy, 2004; Jacobvitz & Hazen, 1999). Children may shift between extreme social withdrawal and defensively aggressive behaviors and between controlling and helpless stances (Jacobvitz & Hazen, 1999).

Assessing for Posttraumatic Play

With exposure to potentially traumatic events occurring at high rates (Norris & Slone, 2013), many counselors will work with children who have experienced trauma. While many mental health providers utilize the DSM 5 PTSD diagnostic criteria in order to assess for a posttraumatic response, Kaminer et al. (2005) noted the challenge of utilizing an "adult-centric" model with children. The authors argued many of the PTSD criteria "require a verbal description of internal states and experiences, a task beyond the cognitive and expressive language skills of young children" (p.122). Further, a child may have posttraumatic responses worth investigating even if they do not meet the diagnostic criteria required for PTSD (Kaminer et al., 2005). Assessment tools, especially those concerning children's responses following a traumatic event, can assist mental health providers with accurately identifying symptom origin, intervention planning, and in offering more efficient treatments (Nader, 2008; Whiston, 2013).

Researchers and clinicians have repeatedly found children who have experienced trauma often demonstrate specific behaviors and themes through their play (Gil, 2017; Chazan & Cohen, 2010; Schaefer, 1994). While a few measures currently exist to assess for PTP, they are limited in their application. For instance, The Trauma Play Scale (TPS; Findling, Bratton, & Henson, 2006) and The Children's Play Therapy Instrument - Adaptation for Terror Research (CPTI-ATR; Cohen & Chazan, 2006) were developed specifically for research use. The TPS is an observational measure consisting of 5 subscales of posttraumatic play behaviors and is designed to be used over multiple video recorded sessions and scored at five-minute intervals. The CPTI-ATR is rooted in psychoanalytic theory and requires training on the use of the instrument. While the Checklist for Posttraumatic Play (Gil, 2017) and the Play Therapy Screening Instrument for Child Sexual Abuse (PTSI-CSA; Homeyer, 2001) are available to be used by practicing

clinicians, these measures are narrow in focus. The Checklist for Posttraumatic Play requires the play therapist to have already identified posttraumatic play is occurring as it distinguishes between dynamic and toxic posttraumatic play, while the PTSI-CSA is specific to play following sexual abuse.

Currently there is no simple instrument designed for clinicians to evaluate a child's play and assess for a posttraumatic response following a single play therapy session. The PTPS was designed to meet this need. The availability of such an instrument would support clinicians in recognizing possible trauma, which in turn, would help ensure children are receiving the necessary and appropriate treatment interventions. A measure that can be completed following a single session, rather than requiring repeated observations, has many benefits. Early recognition of a possible posttraumatic response is likely to lead to earlier trauma focused interventions. Clinicians may further gather a client's history, utilize additional assessments, seek supervision or consultation, and respond in session with trauma-informed approaches. Additionally, a simple, single session screening is both practical and feasible to incorporate as a busy professional. A single session screening instrument also provides educators and supervisors a framework to both teach students to identify posttraumatic play, as well as evaluate student competency to work with this vulnerable population.

Method

The Posttraumatic Play Screening (PTPS) is a behavioral observation instrument for posttraumatic play following a single play therapy session. The items of the PTPS were created over four phases of instrument development, including a) literature review, b) expert review, c) pilot focus group, and d) pilot administration. The instrument was developed using scale development procedures (see Devellis, 2012, for more detail). Additionally, the process of

developing the PTPS was comparable with the scale development procedures of recent

counseling measures; specifically, the Trauma Play Scale outlined by Findling et al. (2006) and

the Research Competencies Scale by Swank and Lambie (2013).

Phase One of Development

First, a thorough review of the literature was conducted to generate a pool of items

common to children who had experienced trauma. Childhood trauma literature rooted in various

theoretical frameworks was reviewed, including attachment, psychoanalytic, and client-centered

theories, as well as findings related to childhood trauma symptomology. Themes and behaviors

that were repeatedly identified both within the play therapy literature and the child trauma

literature were included in the item pool. Content validity was established through the

identification of key concepts and items from the literature, which were then cross-referenced

with related existing instruments.

Second, the format and grouping of items was conducted. The first version of the PTPS

included four domain areas with a variety of subcategories that outlined specific themes and/or

behaviors. The four categories were Play Themes, Play Behaviors, Relational Themes, and

Relationship with Play Therapist. The Relationship with Play Therapist domain included a 5-

point Likert scale ranging from 1 = *under-attached* to 5 = *over-attached* and an item selection of

attachment style (Secure, Avoidant, Anxious-Ambivalent, and Disorganized).

Phase Two of Development

In the second phase of instrument development, an expert reviewer was consulted to

assess the appropriateness of each item, clinical utility, and readability. The expert reviewer was

a Licensed Professional Counselor, a Registered Play Therapist-Supervisor, and held a Doctorate

in Counselor Education. Additionally, the expert reviewer had advanced education and clinical

experience with both play therapy and childhood trauma with a wide range of clients. The expert

reviewer had extensive clinical experience with clients of various identities, including race,

ethnicity, gender, and socioeconomic status. The expert reviewer recommended rewording

specific items and reorganizing items from the Relational Themes domain to the Relationship

with Play Therapist domain.

Phase Three of Development

In the third phase of development, the researcher facilitated a focus group of five Clinical

Mental Health Counseling students enrolled in a clinical supervision class from a CACREP-

accredited master's program. Students were all in their last month of a 2-year counseling

program and had previously taken Introductory and Advanced Play Therapy courses, and a

specialized course titled Treating the Traumatized Child using Expressive Arts and Play

Therapy. Additionally, all students were providing counseling services to traumatized children

through their internship. Students were seeing clients that had experienced a range of traumatic

events; including physical, sexual, and emotional abuse, neglect, domestic violence, parent

incarceration, kidnapping, and immigration and deportation experiences. The focus group used

the instrument to score an experimental video recording of a child with a previously identified

trauma and a control recording of a child with no previously identified trauma history. The focus

group also provided feedback regarding the appropriateness of the domains and subitems for

their clientele as well as on the instrument utility. Following the collection and analyzation of

scoring data and instrument feedback, the instrument was clarified, simplified, and reorganized.

Items reflecting behaviors and affect expression were rearranged and expanded upon from

subcategory items to their own domains titled *Extreme Negative Affect* and *Behaviors Displayed*

in Session. Due to this change, the original *Play Behaviors* domain was changed to *Play Is* and

subcategory items were reworded for clarity; *Intense Play* changed to *Intense-Lacking Joy*, *Repetitive or Compulsive Play* was edited to *Compulsive-Repetitive*, and *Literal Play* was modified to *Unimaginative-Literal*. *Play Disruption* was dropped due to limited identification within the literature and the item's difficulty differentiating between the play types, while *Lacking Spontaneity and Exploration* was added to directly capture this play behavior. The *Relational Themes* domain was further divided into two subcategories labeled *Helpers are Hurtful* and *Helpers are Unhelpful.* Lastly, The *Relationship with Play Therapist* domain was modified from containing a five-point Likert scale and separate attachment style selection, to a three-point Likert scale with classifications of *Under-Attached (Avoidant)*, *Appropriate (Secure)*, and *Over-Attached (Anxious-Ambivalent)*

Phase Four of Development

In the final phase of instrument development, a pilot administration was conducted by the researcher to establish discriminant validity. At the time of administration, the PTPS included 6 domains that consisted of 33 items (Play Is, $n = 4$; Play Themes, $n = 5$; Extreme Negative Affect, $n = 8$; Behaviors Displayed in Session, $n = 4$), 2 subcategories (Relational Themes, $n = 12$ [Helpers are Hurtful, $n = 6$ and Helpers are Unhelpful, $n = 6$], and a 3-point Likert scale (Relationship with Play Therapist, $1 =$ under-attached (Avoidant), $2 =$ appropriate (secure), and $3 =$ over-attached (anxious- ambivalent).

Fourteen students in their last week of an introductory play therapy course at a CACREP accredited counseling program in the Southeast were included in the study. Participants had all completed at least a year of their graduate counseling programs and included 13 females and 1 male. Nine students were enrolled in a clinical mental health counseling master's program, 2 in a school counseling master's program, 2 in a counseling psychology doctoral program, and 1 in a

counselor education and practice doctoral program. Within a classroom setting, participants viewed two 20 minute play therapy excerpts of a child with and without a known trauma history. As a single blind study, participants were not provided information on the instrument's specific purpose nor differing child histories of the two children in the videos. Participants were provided two paper copies of the instrument labeled PTPS as well as a list of operational definitions for the instrument's items to review. Participants were asked to independently fill out the instrument during each tape review. An independent-samples t-test indicated the traumatized child's play was scored ($M = 3.93$, $SD = 1.27$) significantly higher than the non-traumatized child's play ($M = 2.43$, $SD = 1.70$), $t(26) = 2.06$, $p = .01$. Results indicated with the use of the PTPS, counseling students were able to recognize the presence of various posttraumatic play domains, as well as discern specific components of posttraumatic play.

Subsequent to the pilot administration, participants were invited to partake in a focus group and the researcher collected an additional feedback regarding instrument understanding. Final instrument edits were made to clarify the scoring procedures; including adding positive *Play Is* descriptors, additional *Relational Theme* subcategories (*Helpers are Helpful*, *Helpers are Not Hurtful*, and *Helpers are Not Applicable*), and eliminating the scaling element for the *Relationship with Play Therapist* domain.

Discussion

With an understanding of the impact of trauma, play therapy can be utilized to address the effects of trauma on the developing brain and promote healing through relational experiences of safety and stability. While intrinsically fun and appealing to children, play invites children to engage in the work of trauma recovery, create positive attunement, and facilitates restructuring of the brain. Play Therapists have the privilege of joining a child's world and understanding their

lived experiences through the child's eyes. Additionally, Play Therapists have the opportunity and responsibility to ascertain areas of needed support and intervention. An initial step however requires the recognition of a child's posttraumatic play.

Previous literature has repeatedly indicated specific descriptors that may constitute a posttraumatic response in a child. When taken together with the play literature, a child who is experiencing posttraumatic distress would likely exhibit a different quality of play, adverse themes, and the presence of negative affect. One would expect to see play that is lacking joy, intense, repetitive, and rigid (Gil, 2017). It is thought that the themes expressed by the child would depict the hurt, fear, and intensity related to experiencing trauma. Extrapolating from past research (Haene et al., 2013; Kennedy & Kennedy, 2004; Murray et al., 2001; Page, 2001), differences in a child's relational interactions, both within the metaphor of play and with the play therapist, would be expected following traumatic and adverse childhood experiences. An assessment tool that could assist clinicians in recognizing these elements of posttraumatic play has been previously lacking. The PTPS can offer play therapy clinicians support in this endeavor.

The Posttraumatic Play Screening (PTPS) was developed with the aim of providing a screening instrument for posttraumatic play following a single play therapy session. Following four phases of instrument development, six domains, each with subitems, were identified to be included in the instrument: (a) Play Is, (b) Play Themes, (c) Extreme Negative Affect, (d) Relational Themes, (e) Relationship with Play Therapist, and (f) Behaviors Displayed in Session. While future research is needed to establish instrument reliability and validity for the PTPS, initial research suggests the PTPS is a promising measure to assess for a child's posttraumatic play.

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CHAPTER 2

RELIABILITY AND VALIDITY OF THE POSTTRAUMATIC PLAY SCREENING

INSTRUMENT

Children who have experienced trauma tend to have specific indexes that indicate a

posttraumatic response within their play. The combination of a child's affect, play themes, and

play behaviors can indicate possible posttraumatic stress (Cohen et al., 2010). Play that is

intense, compulsive, literal, and lacking exploration warrants attention (Gil, 2017). Although

there are numerous play themes that can show up within a child's play for various reasons,

literature findings underline specific themes that are common to children who have encountered

adverse life experiences. For example, a positive correlation was found between the frequency of

Post-traumatic Stress Disorder (PTSD) symptoms and children's rate of traumatic play and

trauma-related affect (Cohen et al., 2010). Play that is sexualized, parentified, depicts death,

animal cruelty, or reenacts a trauma experience are among these nuanced differences that may

present during posttraumatic play. The expression of extreme negative affect has also repeatedly

been considered a staple of posttraumatic play (Myers et al., 2011).

A child's experience of their relational world and expectations of relationship roles can

be assessed through a child's play themes and relational style (Ryan & Edge, 2012; Kennedy &

Kennedy, 2004). Children may also depict their internal representations of their attachment

relationships through play (Murray et al., 2001). For example, children who have experienced

relational trauma or parental insensitivity may exhibit distinct play characteristics such as play

portraying poor care and neglect (Murray et al., 2001; Green et al., 2000). Children requiring

ongoing medical care may hide or downplay their distress in an attempt to maintain normal social interactions or protect adults from the realities of what they are experiencing (Clark, 2003; Webb 1995). This in turn can lead to a lack of needed reassurance and comfort (Clark, 2003). The play of children with chronic illness have also been linked with themes involving mastery, threat of death, and fear (Nabors et al, 2013; Clark, 2003). Gariepy and Howe (2003) examined the play of children with cancer and found they engaged in less play overall when compared to their control peers, played less when anxious, and had repetitive themes from week to week.

Positive outcomes have been found among the use of play therapy with a variety of childhood medical conditions, illness, and hospitalizations. Therapeutic medical play has repeatedly been found to decrease feelings of anxiety and distress, lower fear of upcoming medical procedures, and improve overall wellbeing (Diaz-Rodriguez, 2021; Zengin et al., 2021; Williams, 2019; Moore et al., 2015). As themes are thought to represent a child's inner world, play therapy can assist children in re-creating and processing their medical experiences, re-establish control, and relieve stress (Williams, 2019; Webb, 1995).

A single play session can provide insight into a child's processing of a traumatic event (Cohen et al., 2010). While the play literature highlights specific play behaviors that distinguish play following trauma from normative play, the availability of an assessment tool to evaluate a child's posttraumatic response following a play therapy session is lacking. The Posttraumatic Play Screening (PTPS) aims to fill this gap. Initial content and discriminant concurrent criterion validity were established following the pilot administration as the PTPS was able to differentiate between the play of a child with a known trauma history and a child with no identified trauma at two levels of specificity among a student population. Among counseling students, overall PTPS scores were significantly higher for the experimental recording than the control recording.

The Current Study

The present study utilized a clinician population with play therapy experience to determine the reliability and validity of the PTPS. Specifically, the study explored both overall and subcategory (domains) reliability estimates. Additionally, the study explored discriminant validity by evaluating differences on PTPS scores of play therapy video recordings of a child with and without trauma. The research study was guided by the following research questions:

RQ1: **Does the PTPS have overall estimated instrument reliability across play therapy clinicians?**

RQ2: **What are the subcategory reliability estimates for each of the 5 domains of the PTPS?**

RQ3: **Does the Posttraumatic Play Screening (PTPS) display discriminant validity? Specifically, does the PTPS differentiate the play of a child with a known trauma history compared to a child without a known trauma history in a structured play therapy setting when used by play therapy clinicians?**

RQ4: **Does the PTPS display concurrent criterion validity? Does the instrument accurately determine the difference between a child with a trauma history and a child without a trauma history amongst each of the 5 domains**?

Method

Participants

The population for this study was credentialed play therapy practitioners. All participants held state licensure and either the Registered Play Therapist, School-Based Registered Play Therapist, or Registered Play Therapist- Supervisor credential. The credential denotes all participants have met the stringent requirements for both play therapy specific training and supervised clinical experience. Emails of credentialed play therapists were gathered from the

Association of Play Therapy research mailing list and 3475 direct emails were sent. Based on a power analysis, the study was closed once a sample of 65 participants had been recruited.

Procedures

Prior to beginning this study, approval from the institutional review board (IRB) at the researcher's institution was obtained. This study was an instrument design study which utilized an experimental and control video recording. Qualtrics, an online system, was used for data collection. Individual emails were sent to credentialed play therapists that included an individualized link to access the study. Prospective participants were informed that the purpose of the study was to establish reliability and validity for a new measure regarding play themes and behaviors that may occur during a play therapy session.

No identifying information was linked to the data collected or analyses. Participants who completed the study were provided with the option of receiving a $15 Amazon gift card or donating their earnings to The Atlanta Children's Shelter, a local organization assisting families facing homelessness. Forty-one participants chose to contribute their earnings and a total of $615 was donated to The Atlanta Children's Shelter COVID Emergency Family Fund. Participants who chose to receive an Amazon gift card were directed to a new unlinked survey and were asked to provide their name and email address.

Video Recordings

The experimental recording was selected for its demonstration of many posttraumatic play items that have repeatedly been noted in the literature. The experimental recording consisted of excerpts of a 9-year-old Caucasian female in a play therapy session with a previously identified posttraumatic stress response. Previous clinical assessment of the child revealed an ongoing experience of a life-threatening medical disease and related medical treatments. The

client was previously diagnosed with a cancerous brain tumor and had undergone a year of chemotherapy, 3 brain surgeries, 2 chest surgeries, and 2 months of radiation. Following remission, the client was diagnosed with brain necrosis and experienced "pseudo seizures" as a result. The control recording was matched for age, sex, and race, and depicts a 9-year-old Caucasian female in a play therapy setting. Based on thorough clinical background information, the clinical assessment indicated no trauma nor previous diagnoses. The play therapist and play therapy setting were consistent across the two recordings. Both recordings were edited for length and an average of 10 minutes was maintained for each recording. Parental consent was gained for the use of these recordings for research purposes.

Data Collection

The recordings were embedded directly into the Qualtrics system to reduce the risk of being saved, downloaded, or viewed once the next page was loaded. Prior to gaining access to viewing the videos, participants underwent two checkpoints. First, participants were provided with the informed consent, which included an agreement on protecting the confidentiality and privacy of the children in the videos. Second, consenting participants provided credentialing data to ensure individuals met inclusion criteria. Participants that neither consented nor held a play therapy credential were sent directly to the end of the survey. Following these two checkpoints, participants viewed the recordings and completed the measure for each recording. The order of the recordings was randomized by Qualtrics. Additionally, participants were not provided with any information regarding the differing histories of the two children in the videos.

Demographic Survey

Questions in the demographic survey (see Appendix C) included participants' age, gender, race, degree, licensure type, whether they hold a play therapy credential, and years

practicing play therapy. Additionally, participants were asked to indicate whether they had provided play therapy services within the last year and to how many clients.

Scoring the Instrument

Due to the nature of the study design and experimental recording fit, it was decided prior to data collection that 5 of the 6 domains on the Posttraumatic Play Screening (PTPS) would be included in the analyses. The 6th domain, *Behaviors Displayed in Session*, was not included in analysis as it was determined by an expert rater and the researcher that the descriptors were not relevant to the trauma history, nor applicable to the child in the recording. The expert rater holds a doctoral degree in Counselor Education and Practice, a License in Professional Counseling, and a Registered Play Therapist – Supervisor credential, and specializes in the use of play therapy with traumatized children. Additionally, the expert rater was the play therapist conducting the play therapy sessions and had additional knowledge regarding each of the children and their behaviors.

The 5 domains included in the instrument scoring (See Appendix A) were *Play is*, *Play Themes*, *Extreme Negative Affect*, *Relational Themes*, and *Relationship with Play Therapist*. The *Play Is* domain was further divided by positive and negative descriptors for data analyses as the negative descriptors identify the potential posttraumatic play. As such, only the *Play is: Negative* descriptors were included in the total scores used for each of the analyses. Additionally, the Relational Theme domain includes positive descriptors (i.e. helpers are "helpful" and "not hurtful") and negative descriptors (i.e. helpers are "unhelpful" or "hurtful") with subcategory descriptive items (e.g. "unresponsive"). Only the negative descriptors and related subcategory items were included in the scoring and analyses related to the *Relational Themes* domain. Similar to the *Play Is* domain, *the Relational Themes* negative descriptors represent the play behaviors

that may be indicative of a posttraumatic play response. The "helpful" and "not hurtful"

descriptors are included in the measure for the purpose of rating clarity. Lastly, when designing

the survey for an online format, answer options of "None" and "N/A" were included for ease of

use (as well as the subcategory *Helpers are Not Applicable*). These options were not included in

the final analyses as they interfered with the data outputs and were not linked with a potential

posttraumatic response.

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Results

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Descriptive statistics for the instrument and each domain were calculated and will be

outlined first. As shown in Table 2, the experimental recording ($M = 5.77$, $SD = 3.41$) had a

greater total score than the control recording ($M = 1.48$, $SD = 3.04$). The control recording ($M =$

3.22, $SD = 0.93$) received a higher overall score for the *Play is: Positive* subcategory compared

to the experimental recording ($M = 2.91$, $SD = 1.01$). The play descriptors

Exploratory/Spontaneous (93.8%) and Mastery-Oriented (87.7%) were selected most often for

the control recording, while forward-moving (90.8%) was most frequent for the experimental

recording (see Table 3). The *Play Is: Negative* rating was higher for the experimental recording

($M = 1.06$, $SD = 0.98$) compared to the control ($M = 0.45$, $SD = 2.00$), with the Intense-Lacking

Joy descriptor most frequent (61.5%) for the experimental recording. Overall, the control

recording was rated higher for 3 out of the 4 positive descriptors while the experimental

recording scored higher for all 4 of the negative descriptors.

As can be seen in Table 3, 92.3% of the participants identified a *Play Theme* with the

experimental recording ($M = 1.92$, $SD = 0.96$), while 83.1% selected No Play Themes for the

control recording ($M = 0.25$, $SD = 0.73$; see Table 3). More than 60% of participants identified

Trauma Reenactment, Perceived/Actual Death/Loss/Threat, and Parentification as play themes

present in the experimental recording (see Table 3). The presence of *Extreme Negative Affect* was identified in the experimental recording by 76.9% of participants, with anxiety and fear selected most frequently. Eighty percent reported no extreme negative affect for the child in the control recording (see Table 3).

For the experimental recording, the majority of participants rated helpers as either helpful (78.5%) or unhelpful (21.5%), while the control recording was most frequently rated as helpful (60%) or not applicable (36.9%). Helpers were overwhelmingly seen as not hurtful (92.3%) for the experimental recording and were split between not hurtful (55.4%) and not applicable (43.1%) for the control recording. The *Relationship with Play Therapist* domain was rated most consistently between the recordings with the children identified as securely attached in both the experimental (87.7%) and control recordings (86.2%).

Table 1

Frequencies and Percentages for Participant Demographic and Training Characteristics (n = 65)

Variable	n	%
Gender		
Male	4	6.2
Female	61	93.8
Age		
25-34	14	21.5
35-44	21	32.3
45-64	28	43.1
65 and over	2	3.1
Race		
Asian	2	3.1
Black/African American	3	4.6
Hispanic/Latinx	4	6.2
White	58	89.2
Education		
Master's	54	83.1
Ph.D.	9	13.8
Psy.D.	2	3.1
Licensure		
LPC	33	50.8
LCSW	19	29.2
LMFT	11	16.9
Psychologist	2	3.1
Credential		
RPT	35	53.8
RPT-S	30	46.2
University Courses		
No Courses	21	32.3
Introduction to Play Therapy	33	50.8
Advanced Play Therapy	21	32.3
Child-Centered Play Therapy	18	27.7

Sandtray Therapy	17	26.2
Adlerian Play Therapy	7	10.8
Filial Play Therapy	14	21.5
Group Play Therapy	20	13
Treating the Traumatized Child with Play Therapy	12	18.5

Table 2

Means and Standard Deviations for Instrument and Domains (n = 65)

Scale	Experimental			Control		
	Mean	Standard Deviation	Range	Mean	Standard Deviation	Range
Play Is						
Positive	2.91	1.01	4.00	3.22	0.93	3.00
Negative	1.06	0.98	4.00	0.45	0.71	2.00
Play Themes	1.92	0.96	3.00	0.25	0.73	5.00
Extreme Negative Affect	1.88	1.47	5.00	0.35	1.01	7.00
Relational Themes	0.77	1.51	7.00	0.31	1.78	14.00
Relationship with Play Therapist	0.14	0.35	1.00	0.12	0.33	1.00
Total	5.77	3.41	17.00	1.48	3.04	19.00

Table 3

Frequency and Percentages for the Posttraumatic Play Screening (PTPS) by Item

Domain	Item	Experimental		Control	
		Frequency	Percent	Frequency	Percent
Play Is: Positive					
	Exploratory/Spontaneous	51	78.5	61	93.8
	Mastery Oriented	50	76.9	57	87.7
	Forward- Moving	59	90.8	40	61.5
	Joyful	29	44.6	51	78.5
Play Is: Negative					
	Intense-Lacking Joy	40	61.5	13	20.0
	Compulsive-Repetitive	11	16.9	4	6.2
	Unimaginative-Literal	11	16.9	7	10.8
	Lacking Spontaneity/Exploration	7	10.8	5	7.7
Play Themes					
	Trauma Reenactment	43	66.2	4	6.2
	Sexualized	-		1	1.5
	Perceived/Actual Death/Loss/Threat	41	63.1	9	13.8
	Parentification	40	61.5	1	1.5
	Violence Against Animals	1	1.5	1	1.5
	None of the Above	5	7.7	54	83.1
Extreme Negative Affect					
	Sadness	26	40.0	2	3.1
	Despair	16	24.6	1	1.5
	Sullen	5	7.7	3	4.6
	Flat/Numbing	10	15.4	11	16.9
	Anxiety	42	64.6	3	4.6
	Fear	18	27.7	2	3.1
	Anger	5	7.7	1	1.5
	No Extreme Negative Affect	15	23.1	52	80.0
Relational Themes					
	Helpers-Helpful	51	78.5	39	60.0
	Helpers Unhelpful	14	21.5	3	4.6
	Unresponsive	5	7.7	1	1.5

	Nonprotective	2	3.1	1	1.5
	Emotionally Unavailable	5	7.7	1	1.5
	Neglectful	5	7.7	1	1.5
	Inconsistent	3	4.6	2	3.1
	Missing	6	9.2	2	3.1
	Helpers N/A	2	3.1	24	36.9
	Helpers- Not Hurtful	60	92.3	36	55.4
	Helpers-Hurtful	4	6.2	2	3.1
	Hostile	1	1.5	1	1.5
	Threatening	1	1.5	1	1.5
	Frightening/Dangerous	1	1.5	1	1.5
	Violent	-*	-	1	1.5
	Abusive	-	-	1	1.5
	Rejecting	3	4.6	2	3.1
	Helpers N/A	3	4.6	28	43.1
Relationship with Play Therapist					
	Under-Attached (Avoidant)	-	-	5	7.7
	Appropriate (Secure)	56	86.2	57	87.7
	Over-Attached (Anxious-Ambivalent)	9	13.8	3	4.3
Behaviors Displayed in Session					
	Sexualized	-	-	-	-
	Dissociative	2	3.1	-	-
	Hypervigilant	10	15.4	1	1.5
	Disorganized	12	18.5	3	4.6

* No participants selected this item

Instrument Reliability

To test RQ 1, Cronbach alphas were calculated to answer whether the PTPS has overall instrument reliability across play therapy clinicians. Alpha is often considered to be of acceptable value at .70 (Christmann & Aelst, 2006; Tavakol & Dennick, 2011). As such, alpha values of .70 were used as the cutoff for reliability in this study. The internal consistency of the PTPS for both the experimental and control recordings together was calculated and was estimated to be satisfactory (59 items; α= .80). Results show Cronbach alpha was high for the control recording when calculated using all 5 domains together ($\alpha = .88$) and more than sufficient for the trauma recording ($\alpha = .74$; see Table 4).

Table 4

Internal consistency reliability (Cronbach alpha coefficient) for the Posttraumatic Play Screening (PTPS), Control, and Experimental Recordings (n = 65)

Scale	Item Number	Cronbach alpha
PTPS Total	59	.80
Experimental	28	.74
Control	31	.88

To answer RQ 2, Cronbach alphas were also calculated to determine the subcategory reliability estimates for each of the domains of the PTPS. Alpha was calculated for each of the 4 domains (*Play Is [both positive and negative descriptors]*, *Play Themes, Extreme Negative Affect,* and *Relational Themes)* on both the control and experimental recording. The *Relationship with Play Therapist* domain could not be calculated as it only contained 1 item. As can be seen in Table 5, The internal consistency was satisfactory for 3 of the 4 domains (*Play Themes, Negative Affect, Relational Themes)* when calculated separately for the control recording. Internal consistency was

sufficient (α = .76) for the *Relational Themes* domain when calculated for the experimental recording. The remaining domains displayed low results for the experimental recording. For both the control and experimental recordings, the strongest alphas were calculated for the E*xtreme Negative Affect* and *Relational Themes* domains (see Table 5).

Table 5

Internal consistency reliability (Cronbach alpha coefficient) for Play is, Play Themes, Extreme Negative Affect, and Relational themes by Recording (n = 65)

Scale	Experimental		Control	
	Item Number	Cronbach alpha	Item Number	Cronbach alpha
Play Is				
Positive	4	.44	4	.43
Negative	4	.47	4	.29
Play Themes	4	.29	5	.72
Extreme Negative Affect	7	.55	7	.79
Relational Themes	12	.76	14	.97

Instrument Validity

To test RQ 3 and answer whether the PTPS can differentiate the play of a child with a known trauma history compared to a child without a known trauma history in a structured play therapy setting when used by play therapy clinicians, a paired samples t-test was conducted to determine discriminant validity. As displayed in Table 6, there was a statistically significant difference, at the .001 significance level, between the mean of the experimental recording total

score and the control recording rating. Results show the trauma recording received a greater total score on the PTPS.

To test RQ 4 and answer if the instrument can accurately determine the difference between a child with a trauma history and a child without a trauma history amongst each of the 5 domains, paired samples t-tests were run to calculate the concurrent criterion validity. Results indicate a statistical difference, at the .001 level, for experimental and control recording ratings for the *Play Is* negative descriptors, *Play Themes*, and *Extreme Negative Affect*. The *Play is* positive descriptors were found to be significant at the .05 level with less items selected for the experimental recording. When calculated to include both unhelpful and hurtful descriptors, The *Relational Themes* domain was not significant. When run as two separate t-tests however, the experimental recording received significantly higher scores ($M = .62$, $SD = 1.22$) for the unhelpful descriptors than the control recording ($M = 1.69$, $SD = .93$) $t(64) = 2.47$, $p = .016$. The *Relationship with Play Therapist* domain did not display a significant difference between the control and experimental recording (see Table 6).

Table 6

Descriptive Statistics and t-test Results for Total Scores, Play Is, Play Themes, Extreme Negative Affect, Relational Themes, and Relationship with Play Therapist (n = 65).

Scale	Experimental		Control		95% CI for Mean Difference	t
	M	SD	M	SD		
Total Score	5.77	3.41	1.48	3.04	3.18, 5.40	7.69**
Play Is						
Positive	2.91	1.01	3.22	.93	-.61, -.01	-2.05*
Negative	1.06	.98	.45	.71	.35, .88	4.70**
Play Themes	1.92	.96	.25	.73	1.37, 1.98	11.03**
Extreme Negative Affect	1.88	1.48	.35	1.01	1.11, 1.93	7.40**
Relational Themes	.77	1.51	.31	1.78	-.09, 1.01	1.68
Unhelpful	.62	1.22	.17	.93	.08, .81	2.47*
Relationship with Play Therapist	.14	.35	.12	.33	.13, .26	.26

Note. df = 64.
* p < .05.
** p < .001.

Discussion

The current study was designed to determine the reliability and validity for the PTPS as a screening instrument for posttraumatic play. In this study, the PTPS was able to accurately and effectively distinguish between the child with no known trauma history and the child with a medical trauma history exhibiting a posttraumatic response. In line with the expectations from the literature, the child with the trauma history was rated as exhibiting more items descriptive of posttraumatic play than the control child. Further, the trauma recording had a significantly higher rating on the *Play Themes* and *Extreme Negative Affect* domains, and on the *Play is: Negative* and *Unhelpful Relational Themes* subcategories.

Each research question will be briefly discussed. RQ 1 and RQ 2 explored instrument reliability as it was important to establish high reliability coefficients for the PTPS. Instrument reliability was established by calculating the internal consistency of the measure overall and by recording. Cronbach alpha has routinely been selected to measure the internal consistency of a scale, thus indicating whether the items on a test measure the same construct (Tavakol & Dennick, 2011). The PTPS is comprised of various domains that constitute the observable themes and behaviors known as the construct of posttraumatic play. Findings revealed the PTPS met and exceeded the threshold necessary to demonstrate instrument reliability. The inter-relatedness of these scale items was highly satisfactory with alpha levels ranging from .74 - .88. To note, a maximum alpha value of .90 has been recommended to reduce the risk of redundant items (Tavakol & Dennick, 2011). Subcategory reliability estimates demonstrated lower internal consistency which is likely due to the limited number of items in each domain. Cronbach alpha is sensitive to the number of items included in the test and too few items have been shown to result in a reduced alpha statistic (Tavakol &Dennick, 2011). Future factor analyses could assist in

understanding the interrelatedness of the domains and the items. Overall, the findings support the reliability of the PTPS as a screening instrument for a posttraumatic play response and raise important questions for future research.

Discriminant and Criterion Validity

With the purpose of the instrument to assess for posttraumatic play, it was hypothesized with RQ 3 that the experimental recording would receive a greater overall score compared to the control recording. This hypothesis was met with a high level of significance. The findings from this study indicate that the PTPS was able to identify a child exhibiting a posttraumatic response through their play. It was additionally hypothesized with RQ 4, that the child with the posttraumatic response would have higher domain scores compared to the control child. This was met with the exception of the *Relationship with Play Therapist* domain. These specific findings shed light on the possible play behaviors and themes present for a child with medical related posttraumatic play.

Each of the specific Domains will now be discussed:

Play is Domain

The child with the trauma history exhibited play activity that was significantly more negative in quality than the nontraumatized child. Further, the nontraumatized child engaged in significantly more positive quality play. While the non-traumatized child's play was overwhelmingly rated as lacking any negative qualities, the traumatized child's play was rated to include positive play qualities. Consistent with the literature (Gil, 2015; Dripchak, 2007), this study found posttraumatic play included the replaying of the trauma, lacked joy, and was accompanied by negative affect and intensity. The results also indicated the presence of mastery

play and offers support for previous literature (Nabors et al., 2013; Clark, 2003) highlighting mastery play amongst children experiencing chronic illness and medical treatments.

The presence of mastery-oriented and forward-moving play within the posttraumatic play offers support to the theoretical views of "positive" (Marvasti, 1994; Dripchak, 2007) and "dynamic" (Gil, 2010) posttraumatic play; a child engaged in posttraumatic play can also display active play qualities that assist the child in regaining a sense of power and control. Positive posttraumatic play is thought to include a child's sense of control over the play (Marvasti, 1994). Similarly, dynamic posttraumatic play is believed to occur when there is a decrease in intensity and arousal, an active change in the play story, and an increased sense of self-efficacy (Gil, 2010). Conversely, negative posttraumatic play has been described as restricted, depicting a sense of danger, involving negative affect, not alleviating anxiety or reaching resolution, and the child appearing stuck in the traumatic experience (Marvasti, 1994; Dripchak, 2007). Similarly, toxic posttraumatic play is described as repetitive, noninteractive, rigid play that lacks change in content or process (Gil, 2015). The "stuckness" is argued to indicate a possible retraumatization (Gil, 2015).

Atypical positive descriptors were also identified as part of the experimental child's play. More than three-fourths (78.5%) of participants identified exploratory-spontaneous play and almost half (44.6%) identified the presence of joyful play for the child with the trauma history. These qualities deviate from the literature that depicts posttraumatic play as joyless, rigid, and controlled. It is possible that the affective and unconstrained quality of the play were misidentified in this study. It is also plausible however that the curative factors of play shined through as the child in the experimental recording was nearing the end of her counseling process. These positive play findings, in conjunction with the play being described as intense-lacking joy,

and the child's affect rated as negative, suggest that posttraumatic play may not be as clear-cut as either "healing" or "re-traumatizing". Perhaps posttraumatic play is an even more nuanced experience where portions of the trauma experience can be accessed, resolved, and mastered, while other aspects are still overwhelming to the child. In fact, the presence of both negative and positive play aspects supports the theoretical notion of play as a mechanism for gradual exposure in which the child is able to process their experiences within their own window of tolerance. As was seen with this experimental recording, the quality and affect related to the child's posttraumatic play ebbed and flowed as the power of play was harnessed to moderate the process of trauma exposure.

Another interesting finding concerns the Unimaginative-literal play descriptor for the child with the trauma history. Surprisingly, only 16.9% identified the presence of unimaginative-literal play even though two-thirds noted a trauma-reenactment had occurred. Trauma-reenactments include behaviors or play that are literal and often depict events before, during, and after the trauma (Ogawa, 2014; Grunbaum, 2007). This sequence and quality of play occurred twice in the experimental recording; once in the sandtray depicting the events related to a medical trauma, and once through discussion where all play activity ceased. Yet, the Unimaginative-literal play descriptor was not frequently selected. This may be due to the nature of the study design as participants only viewed the play session once and selected relevant items from memory. It seems this item was unmemorable in the larger context of the child's thematic play. Similarly, the item Lacking Spontaneity-Exploration was infrequently selected for the experimental recording despite the rigid organization of kitchen materials in one segment and the cessation of play activity in another. It is possible that the other segments of play that were exploratory-spontaneous in nature stood out more in participants' minds. While it was noted in

the directions to select descriptors that reflected the presence of play observed, even if contradictory to each other, the task may have been counter-intuitive and unnatural during the selection process. Alternatively, the above two findings may show additional training is required to accurately identify the subtle play qualities present with posttraumatic play

Play Themes Domain

Like the other domains on the PTPS, the adverse play themes included on the measure were selected based on previous findings from the childhood trauma and play literatures. As such, it was hypothesized that the child with the trauma history would engage in the themes relevant to their experiences while the control child would not engage in any of these themes. As hypothesized, the presence of adverse play themes within the children's play showed to be a highly significant indicator of a posttraumatic response. There was overwhelming agreement among participants that the child with the trauma history engaged in adverse play themes while the child in the control recording did not (92.3% and 83.1% respectively). Over 60% identified the presence of each of the following play themes; a trauma re-enactment theme, a theme of perceived/actual death/loss/threat, and a theme of parentification. The themes identified in this study add support to the literature regarding the specific themes that may appear following medical trauma. Consistently, Clark (2003) previously identified the threat of dying as a play theme present among children living with chronic illness.

Extreme Negative Affect Domain

Negative affect was overwhelmingly identified as present for the child with the trauma history and not relevant for the control child. Findings revealed there was greater overall agreement regarding the presence or absence of negative affect compared to the specific descriptors selected. This suggests it is simpler to identify the general expression of negative

affect in a child than to parse out the specific emotion being expressed. Anxiety and sadness however seemed to uniquely stand out with almost two-thirds selecting anxiety and 40% selecting sadness as present for the traumatized child. This finding along with previous literature (Zengin et al, 2021; Delvecchio et al., 2019 Nabors et al., 2013) suggests children with chronic illness experience heightened anxiety which appears through their play. Anxiety may be dominant within this population due to the medical and existential stressors related to childhood illness and future wellbeing.

Relational Themes Domain

Attachment literature highlights the influence of early attachment experiences on a child's relational expectations, including the availability and responsiveness of attachment figures (Malekpour, 2007; Pietromonaco & Bartett, 2000). Trauma and attachment are intrinsically woven together as both influence a core sense of safety. While some families are able to adapt and reach positive outcomes in the aftermath of a trauma, other families experience negative changes to functioning (Kiser et al., 2008). Trauma and attachment are linked in the following ways; A) trauma can disrupt parental attunement and responsiveness, B) trauma can occur within the attachment relationship, and C) posttraumatic stress symptomology is impacted by the attachment relationship. For these reasons, it was hypothesized the children's play would differ in their use of helpers in play. Findings revealed the *Relational Themes* domain did not yield significant differences amongst the children's play when calculated to include the unhelpful and hurtful descriptors together. The insignificant findings for this domain may be due to recording selection as the play displayed in this study did not depict hurtful adults. As such, this domain may yield different results with various trauma experiences. For instance, one would expect a child to depict hurtful adult behaviors with the presence of interpersonal trauma such as

abuse and domestic violence. Pulling from previous medical play findings, one would expect to

see a child with a severe medical illness display play themes related to both needing support

from adults (Nabors et al., 2013) and attempting to downplay their distress in an effort to protect

adults (Clark, 2003; Webb, 1995). Following this logic, further analyses were run to determine if

the *Relational Themes Unhelpful subcategory* differed between the two children. Analyses

revealed the unhelpful subcategory was significantly higher for the experimental recording, thus

demonstrating a significant difference between the children's use of helpers in play.

The frequency statistics offer an alternate explanation for the larger *Relational Themes*

insignificant finding. While the analyses did not include the positive descriptors of *helpful, not*

hurtful, or *not applicable*, the frequency information for these items suggests a misunderstanding

of this domain. More than half of the participants rated the child's play in the control recording

as having both *helpful* and *not hurtful* helpers even though the child did not depict any relational

themes in their play and a selection of *not applicable* was the appropriate choice (as was selected

by the overwhelming majority of the remaining participants). The *Relational Themes* domain

was defined in this study as "the child's use of helpers within metaphoric play when the presence

of an adult would reasonably be expected" while helpers were defined as "any character in the

play that is more powerful than the child and should be in a position of responsibility for the

child (i.e. parents, caregivers, police officers, neighbors, superheroes)". Based on the response

regarding the control recording child, it is possible the "helper"/ "adult" in this scenario was

mistaken for the play therapist rather than the metaphoric adult. If so, then the same

misunderstanding could account for the high occurrence of the experimental recording child's

play being rated as helpful (i.e. the play therapist was rated as helpful rather than the metaphoric

adult the play therapist was asked to play). If this were the case, one would expect to see an even

higher rating for the experimental recording's *not hurtful* rating as both those that understood (i.e. the metaphoric adult was not hurtful in behavior) and those that misunderstood (i.e. the play therapist was not hurtful) the item would have selected this descriptor. Further analyses confirmed this expectation. A misunderstanding of the *Relational Themes* domain would also explain the disconnect seen between the child's play theme being highly rated as parentified yet rating the helpers as helpful. The instrument instructions may require modification to clarify the purpose and scoring of this domain.

Relationship with Play Therapist Domain

Lastly, the *Relationship with Play Therapist* domain did not yield a significant difference between the trauma and no trauma recordings. This is likely a result of the recording selected as both children displayed a secure relationship with the play therapist. At the time of the recorded play therapy session, the child in the experimental recording had been in counseling with the play therapist for over 2.5 years and had developed a trusting relationship. The experience of adverse medical experiences may impact relationship formation differently than alternative traumas where the source of pain or fear is the attachment figure, such as the case with child maltreatment. It appears the child in the experimental recording maintained the ability to engage in a cycle of exploration and comfort seeking in the presence of a safe, consistent adult. This finding in conjunction with the themes of parentification and unhelpful helpers, suggests there may be unique relational experiences that occur with the diagnosis and treatment of a life-threatening diagnosis. More research is needed to understand the impact of childhood illness on parental distress, relational interactions, and a child's internal working models.

With only a 1.5% frequency difference, the appropriate (secure) *Relationship with Play Therapist* domain item was rated the most consistently of all the items on the PTPS. Following

these results, play therapists seem to be able to recognize and identify a secure relationship. While some children with trauma histories may have insecure styles of attachment that require attention and intervention, other children may have developed secure attachments that can provide healing benefits to their trauma recovery (Mikulincer, 2015; Aspelmeier, et al., 2007). As such, understanding a child's attachment relationship and related internal working models is imperative to posttraumatic recovery as a safe attachment relationship can either be bolstered or developed for support.

Limitations and Future Research

There were several limitations associated with this study. First, only two video recorded play therapy sessions were used. The experimental recording consisted of a Caucasian, female-identified child with a known medical trauma history. As such differences may exist in the play themes and behaviors associated with various medical experiences, different trauma histories, as well as various identities. Future research would benefit from a larger, more diverse sample of children that included various genders, races, ethnicities, and socio-economic status. Additionally, because the play sessions were previously recorded, it was not possible to utilize additional trauma instruments to assess for posttraumatic stress symptomology. The PTPS would greatly benefit from further validation of scores with existing trauma exposure and symptomology instruments. The study was also limited by the edited 10-minute play therapy segments. Most play therapy sessions are longer and provide the play therapist with more time to observe the issues. Lastly, this study used a control child with no previous diagnoses. It would be beneficial to explore the validity of use among children with trauma responses compared to children with differing diagnoses.

Another limitation was that participants were only able to view the video one time and then complete the screening without prior knowledge of what they would be asked to rate. It is possible that certain parts of the recorded play session stood out more in their memories than others. In order to eliminate the possibility of a priming effect, it was necessary to withhold instrument specifics. Finally, due to the recording's short duration, the experimental recording was not able to convey the presence of repetitive play. While this may have been resolved with a longer play session, it is also possible this element gets lost due to the instrument's one session rating design. It would be interesting to see if various themes or behaviors stand out more if the PTPS were used repeatedly over multiple sessions. Additional research could examine the use of the PTPS as a tracking tool to assess for changes within the posttraumatic play over time.

Future research is also needed to understand the various posttraumatic play profiles that may exist. Children who have experienced different types of trauma may exhibit different play behaviors, themes, affect, and relational interactions. Additionally, the type of negative affect may differ with trauma experience. Further studies are needed to explore which play themes and behaviors are consistent across trauma type and which vary.

Implications and Conclusions

The findings from this study indicate that the PTPS demonstrated estimated reliability and validity and was consistent with the play literature. The themes and behaviors theoretically associated and previously linked with PTP were found to be present for the child with the trauma response and not for the normative child. For instance, trauma re-enactment and negative affect were both highly rated for the traumatized child. Further, themes related to different trauma etiologies were not present; such as sexualized play and violence against animals. Additionally, a

large portion of the child literature discusses child maltreatment and these results indicate

potential differences that may exist with childhood medical trauma.

The PTPS is a valuable addition to the literature that provides ongoing research

opportunities to understand the posttraumatic play response to childhood trauma. It can further

be used for educational and evaluative purposes as it offers practitioners, counselors-in-training,

and counselor educators a framework for recognizing posttraumatic play. The frequency data

suggests the play therapists in this study were easily able to identify when a play descriptor was

not present in the recordings but had greater variability in identifying exactly what was occurring

when something was present. Further, while the prevalence of thematic identification was

promising, there were still over one-third of participants that were unable to identify a trauma re-

enactment, parentification, and the presence of death, loss, or threat. The pilot study conducted

during the initial phases of instrument development revealed similar results; students

overwhelmingly had difficulty identifying specific affective expressions and failed to identify the

presence of a trauma re-enactment. Additionally, the pilot study revealed while the PTPS was

able to differentiate between posttraumatic play and normative play, students had limited

understanding of both normative and atypical play behaviors. The current study found

posttraumatic play included both positive and negative quality play, which may contribute to the

apparent difficulty in discerning PTP. It appears posttraumatic play can include components that

are both reflective of the trauma experience and elements that resembles the characteristic play

of childhood. As a result, identifying posttraumatic play may require a keen eye and

understanding of the continuum of play that may be present.

This study's sample consisted of credentialed play therapy clinicians which indicates all

participants had met the threshold for play therapy specific education, and supervised play

therapy experience in order to earn this designation. While the overwhelming majority of participants accurately identified the control child's play as positive, a considerable number missed the negative play and adverse themes present for the experimental child. The demographic data collected offers additional information regarding these results; almost one-third of participants in this study reported they never had a university-based play therapy course. Further, Introduction to Play Therapy was the most common course with over 50% of participants selecting this option. One-third of participants indicated an Advanced Play course as well. Only 18.5% of the participants however reported taking a play therapy course specifically focused on child trauma even though almost 80% of participants reported trauma and PTSD as a primary issue of their clinical practice. The findings outlined above speak to the greater need for specialized trauma-focused play therapy training at the university level. Specialized training would be beneficial to assist with the identification of the negative play qualities, affect, and adverse themes that are common with posttraumatic play, as well as to discern when a posttraumatic response is occurring even if positive play is present.

Counseling programs would benefit from an increased educational focus on child development that spans both normative and abnormal processes unique to special child populations such as those experiencing trauma. The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) requires counseling students are trained in developmental considerations and trauma interventions across the lifespan. Additionally, counselors are allowed to practice in new specialty areas only after receiving education, training, and supervised experience (ACA, 2014). Existing trauma competencies further highlight awareness, understanding, and trauma-specific counseling skills as minimal expectations required to work with this population (Abrahams, Ali, Davison, Evans, King, & Poplawski,

2010; American Psychological Association, 2015). Counselor educators play an integral role in developing competent clinicians able to work with traumatized children. The PTPS can serve as a tool for counselor educators to teach students about the various elements and manifestations of posttraumatic play that may arise. Educators can additionally use the PTPS to assess student play competencies and preparation to provide play therapy to children who have experienced trauma. Further, the PTPS provides students with a template to assess a child's play for a posttraumatic response. This in turn may assist students in conceptualizing the abstract elements of a play session and indicate when additional assessments or interventions may be necessary.

There is an increasing need to support and develop counselors as they provide services to children who have endured trauma. Previous studies have found graduate counseling students lack the necessary training to work with children who have experienced trauma (Russ, 2016; Stewart-Spencer, 2010; Hinkelman & Bruno 2008). This insufficient training of children's mental health providers has contributed to the gap between children's mental health needs and services available (Tolan & Dodge, 2009; Huang, Macbeth, & Dodge, 2004; Koppelman, 2004). Children who have experienced repeated trauma often meet criteria for multiple mental health diagnoses due to the various resulting developmental delays (van der Kolk, 2003). Psychopathology resulting from changes in the brain's processing following child maltreatment may serve adaptive purposes to promote survival within the current threatening environment (Teicher et. al, 2016). Masten (2016) explains however, an adaptive response in one domain of function may have long-term costs on development.

Lack of trauma knowledge can result in a mismatch of treatment intervention. Behavioral and emotional symptoms may be targeted for treatment while the root cause is overlooked. van der Kolk (2003) explains, impulsivity, emotional reactivity, attentional difficulties, distrust, and

problems with relational intimacy all relate back to a loss of self-regulation, while learning and memory difficulties can be understood as a consequence of narrowing attention to detect sources of threat. This hypervigilance can also explain the presence of a full stress-response to seemingly minor stressors (van der Kolk, 2003). Further, children may continue to react to their environment as dangerous even when they are physically safe, leading to a prolonged activation of survival systems (van der Kolk, 2003). This is often expressed through aggression, difficulty sustaining attention, difficulty self-regulating, dissociation, physical problems, and problems with interpersonal relationships (van der Kolk, 2003). Lastly, social withdrawal and bullying may be a result of difficulty reading social cues and regulating emotions due to exposure to violence (van der Kolk, 2003). An accurate understanding of posttraumatic stress and related symptomology is necessary for appropriate treatment selection.

Treatment interventions have been found to be effective in reducing posttraumatic stress symptoms in children (Morina, Koersson, & Pollet, 2016; Gutterman et al., 2016). In a meta-analysis on the effects of psychological treatments for child and adolescent PTSD, Gutterman et al. (2016) found smaller effect sizes when analyzing traditional trauma-focused therapies with younger children. The authors contend this may be a result of the cognitive components of these treatment interventions, as well as a need for assessment instruments that can accurately capture PTSS among younger children. Within the play therapy literature, existing posttraumatic play assessments are scarce and limited in their application and availability. The PTPS was designed as a screening instrument to assess for a posttraumatic stress response within a child's natural language. The PTPS is simple to complete and can be used following a single play therapy session, offering clinicians insight into the child's functioning and potential areas of needed support. Play Therapy can assist children in healing from posttraumatic stress through individual

treatment and caregiver involvement. With the awareness of the presence of posttraumatic stress, clinicians can foster childhood healing through the power of play, safe therapeutic relationships, targeted interventions, and advocacy for larger systemic change. The PTPS provides play therapists with a developmentally appropriate and validated instrument to screen for a posttraumatic response within our youngest and most vulnerable population.

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APPENDICES

APPENDIX A

Posttraumatic Play Screening

Play Is *(check all that apply)*:
- Exploratory-Spontaneous
- Mastery Oriented
- Forward-Moving
- Joyful
- Intense - Lacking Joy
- Compulsive - Repetitive
- Unimaginative - Literal
- Lacking Spontaneity and Exploration

Play Themes *(check all that apply)*:
- Trauma Reenactment
- Sexualized
- Perceived or Actual Death/Loss/Threat
- Parentification
- Violence Against Nonthreatening Animals

Extreme Negative Affect *(check all that apply):*
- Sadness • Despair • Sullen • Flat/Numbing • Anxiety • Fear • Anger

Relational Themes Helpers are defined as any character in the play that is more powerful than the child and should be in a position of responsibility for the child (i.e. parents, caregivers, police officers, neighbors, superheroes). *(Check all that apply):*

- **Helpers Are Helpful**
- **Helpers Are Unhelpful:** • Unresponsive • Nonprotective • Emotionally Unavailable
  - • Neglectful • Inconsistent • Missing

- **Helpers Are Not Hurtful:**
- **Helpers Are Hurtful:** • Hostile • Threatening • Frightening/Dangerous
  - • Violent • Abusive • Rejecting
- **Helpers Are Not Applicable:**

Relationship with Play Therapist:

- Under-Attached (Avoidant)
- Appropriate (Secure)
- Over-Attached (Anxious-Ambivalent)

Behaviors Displayed in Session *(check all that apply):*

- Sexualized -Examples include overt sexual behaviors towards the play therapist, exposing or touching of own genitalia, excessive sexual curiosity, enacting sexual contact between dolls, overt sexual art or conversation.

- Dissociative - Appears disconnected from the here and now, staring off in space, or in a trance-like state.

- Hypervigilant - Scans for environmental threat, displays a heightened alertness to noises outside of the room and to movements of the adult in the room.

- Disorganized - Shifts between extreme social withdrawal and defensively aggressive behaviors or between controlling/bullying and helpless stances (i.e. passive submission/resistance). Reciprocal interactions seem rigid, unbalanced, and child may display odd behaviors out of sync with the current interaction.

APPENDIX B

Posttraumatic Play Screening Operational Definitions

Play Behaviors:

Exploratory-Spontaneous: Child actively explores their environment and surrounding stimuli. Play is uninhibited and unconstrained.

Mastery Oriented: Play that focuses on accomplishment, or skill acquisition and demonstration.

Forward - Moving: Play is fluid and incorporates shifts within themes, sequences, and characters.

Joyful: Play is accompanied by positive affect expression

Intense – Lacking Joy: Play is serious, driven, and lacking joy. Play appears extremely absorbed or focused and seems to hold specific meaning to the child.

Compulsive - Repetitive: Child repetitively plays out specific play themes, sequences, or behaviors. Repetitive play is rigid, does not move towards a resolution, and appears stuck.

Unimaginative - Literal: Play is less creative, less elaborate, and may appear mechanistic. Play may be met with sullenness or opposition.

Lacking Spontaneity and Exploration: Play is rigid, controlled, and/or constricted.

Play Themes:

Trauma reenactment: Play that is often repetitive, intense, and literal in which themes or aspects of a trauma are expressed. Oftentimes trauma-reenactments include before, during, and after the trauma.

Sexualized: Sexualized play that occurs within the context of metaphoric play, including overt sexual art or conversation.

Perceived or Actual Death/Loss/Threat: Depictions or expressions of death, dying, killing, or threat to life. The death or threat may be a result of natural causes, aggression, or an accident.

Parentification: Play that consists of the child, or a metaphoric child, in a caretaking role for parents or siblings. Play may depict the child assuming developmentally inappropriate child-rearing responsibilities and child may display pseudo-maturity.

Violence against nonthreatening animals: Physical aggression or violence towards animals that are not playing threatening or attacking roles, not including typical hunting or fishing activities.

Extreme Negative Affect:

Child expresses profound negative affect during the session. Rating is based on affective tone, rather than frequency, and is often exhibited through facial expressions and body language (e.g. inhibition in play or tension).

Relational Themes:

The Relational Play Themes is concerned with the child's use of helpers in play when the presence of an adult would reasonably be expected. In determining which relational theme(s) to code, note the presence of adult figures (or lack thereof), behaviors, verbalizations, and emotional environment created within the metaphoric play. Additionally, pay attention to any verbalizations or nonverbal expressions by the child as him/herself.

Helpers are Helpful: Adults demonstrate nurturing, protective, and/or supportive/assistive behaviors.

Helpers are Hurtful:

Hostile: Adults are excessively harsh or aggressive in tone or behavior and may be ridiculing.

Threatening: Adults express intent to harm or hurt.

Frightening/Dangerous: Adults are the source of danger or fear.

Violent: Adults use harmful or destructive physical force**.** For example, an adult throwing objects around the room would be considered violent.

Abusive: Adults use physical or sexual violence, or emotional cruelty directly towards a child. For example, an adult throwing objects directed at a child would be considered abusive.

Rejecting: Adults are dismissive, appear to consider the child inadequate, or fail to show affection or concern.

Helpers are Unhelpful:

Unresponsive: Adult does not respond, either verbally or behaviorally, to child.

Nonprotective: Adult fails to protect child from danger, set limits, or keep the child safe.
Emotionally unavailable: Adults demonstrate a lack of emotional openness or a mis-attuned response to child's needs. Responses to child figure lack warmth and sensitivity.

Neglectful: Adults fail to provide proper physical or emotional care for the child. Child may depict a need or explicitly express a request for assistance that the adult neglects to give.

Inconsistent: Adults respond to child and behave in ways that are contradictory to former behaviors and may appear unpredictable.

Missing: Adults are not present in the play scenario when reasonable to expect their presence. Examples include, a monster attacking the house and no mention of parents, a child's direct verbalization stating parents are not home, or a baby driving an ambulance to an emergency situation.

Relationship with Play Therapist:

Under-Attached (Avoidant): Child appears indifferent or resistant and does not seek comfort in times of distress. Child may avoid interactions and attempts to connect. Child may avoid eye contact, withdraw, avert emotional or physical closeness, and/or display distrust or suspiciousness.

Appropriate (Secure): Child explores surrounding environment and seeks comfort and reassurance through proximity when afraid or overwhelmed. Child accepts comfort, is easily soothed when distressed, and returns to play activity. Child engages in more complex play, relates positively to adults, and demonstrates flexibility and socially appropriate emotional expression.

Over-Attached (Anxious-Ambivalent): Child displays socially nonselective (i.e. indiscriminate) behavior towards unfamiliar adults and lacks developmentally expected reluctance to strangers. During times of stress, child is difficult to sooth and may demonstrate difficulty returning to play. Child behaves in ways that both seek and resist contact. Exploration may be limited due to efforts to maintain proximity and attention while unmet efforts often result in increased attempts, anger, and ambivalence.

Behaviors Displayed in Session

Sexualized: This rating depicts sexualized play in relation to the play therapist. Examples include overt sexual behaviors towards the play therapist, exposing or touching of own genitalia, excessive sexual curiosity, enacting sexual contact between dolls, overt sexual art or conversation.

Dissociative: Child may appear disconnected from the here and now, staring off in space, or in a trance-like state.

Hypervigilant: Child appears to scan for environmental threat and may display a heightened alertness to noises outside of the room and to movements of the adult in the room.

Disorganized: Child may shift between extreme social withdrawal and defensively aggressive behaviors, or between controlling/bullying and helpless stances (i.e. passive submission). Reciprocal interactions seem rigid and unbalanced, and child may display odd behaviors out of sync with the current interaction.

APPENDIX C

Demographic Questionnaire

1. What is your age in years?
   - 18-24
   - 25-34
   - 35-44
   - 45-64
   - 65 and over

2. What is your gender identity?
   - Woman
   - Man
   - Transgender
   - Non-binary/non-confirming
   - Prefer not to respond

3. How would you describe yourself?

   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Hispanic or Latino
   - White
   - Write-in:

4. Which of the following describes your highest educational degree?
   - Masters
   - Ph.D.
   - Psy.D.

5. What is your licensure?
   - Licensed Professional Counselor
   - Licensed Clinical Social Worker
   - Licensed Marriage and Family Therapist
   - Psychologist
   - School Counselor

6. Do you have any of the following play therapy credentials?
   - Registered Play Therapist
   - Registered Play Therapist- Supervisor
   - School-Based Registered Play Therapist
   - No credential

7. Have you taken any of the following play therapy courses at a University?

- Introduction to Play Therapy
- Advanced play therapy
- Child Centered Play Therapy
- Sandtray
- Adlerian play
- Treating the Traumatized child through Expressive Arts and Play Therapy
- Filial Therapy
- Parent Child Interaction Therapy
- Group Play Therapy
- Other [add in any courses you had that aren't listed here]

8. How many years have you been practicing play therapy?
   - Fill in _____

9. Have you provided play therapy services within the past year?
   - Yes
   - No

10. Which of the following presenting issues do you primarily work with?
    - ADHD
    - Adoption
    - Anxiety
    - Behavioral issues
    - Depression
    - Developmental Disorders
    - Family conflict and divorce
    - Intellectual disabilities
    - Grief
    - Medical illness
    - OCD
    - Relationship issues
    - School issues
    - Self-esteem
    - Trauma and PTSD

APPENDIX D

Post Survey Feedback Questions

1. Did you understand the questions being asked of you?
   - o Yes
   - o No
   - o (Place to write why) _____

2. Did you find the measure easy to use?
   - o Yes
   - o No
   - o (Place to write why) _____

3. Would you use this instrument in your practice?
   - o Yes
   - o No
   - o (Place to write why) _____

4. Would this instrument be useful to you in your work with your clients?
   - o Yes
   - o No
   - o (Place to write why) _____

5. Is there any feedback you would like to provide?

APPENDIX E

Georgia State University
Department of Counseling and Psychological Services
Informed Consent

Principle Investigator: Dr. Dennis Gilbride
Student Principle Investigator: Galina Tobin

I.   Purpose:
You are invited to participate in a research study. The purpose of the study is to validate a newly developed screening instrument regarding play themes and behaviors that may occur within a play therapy session. You are invited to participate because you have been identified as a credentialed Play Therapist. Your participation will require about 45 minutes of your time.

II.   Procedures:
If you decide to participate in this study, you will watch two 10-minute excerpts from previously recorded play therapy sessions and fill out the screening instrument after each recording review. Additionally, you will be asked to fill out a demographic survey at the start of the study and a set of brief feedback questions following the study. All data will be de-identified prior to data analysis and storage.

III.   Future Research:
Researchers will remove information that may identify you and may use your data for future research. If we do this, we will not ask for additional consent from you.

IV.   Risks
There are no anticipated risks with this study. You have the right to stop participating at any time.

V.   Benefits
Participation in this study may benefit you professionally. This study hopes to establish validity for a newly developed instrument that would asses for play themes and behaviors that may occur in a play therapy session. The instrument is designed to be used following a single play therapy session allowing for a concise, practical, and feasible way to assess a child's play.

VI.   Alternatives
The alternative to taking part in this study is to not take part in this study.

VII.   Compensation
If you complete all steps required in the study, you will have the option of receiving a $15 Amazon gift card or contributing your earnings to a larger donation pool. At the end of data

collection, the total amount collected will be donated to The Atlanta Children's Shelter, an organization assisting families facing homelessness in Georgia.

VIII. Voluntary Participation and Withdrawal:
Participation in this research project is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. Your desire not to participate will be respected.

IX.   Confidentiality:
We will keep your records private to the extent allowed by law. Only Galina Tobin and Dr. Dennis Gilbride will have access to your original surveys (demographic information and completed measures) while the study is live. All data will be be de-identified prior to data analysis and storage. The study will close after 5 weeks and no identified data will be saved. De-identified data will be stored on a password protected computer. De-identified data will also be used to summarize and report findings in group form for publication an presentation.

By agreeing to participate in this study, you agree to protect the privacy and confidentiality of the children in the play therapy recordings. As such, you agree not to disclose any information regarding these children or their recorded play sessions. Additionally, you agree to view these recorded play sessions in a confidential location.

X.   Contact Persons:
Contact Dr. Dennis Gilbride at dgilbride@gsu.edu if you have questions, concerns, or complaints about this study. Call the GSU Office of Human Research Protection at 404-413-3500 or irb@gsu.edu if you want to talk to someone who is not part of the study team. You can also call this office if you have questions or concerns about your rights in this study.

XI.   Copy of Consent Form to Participant:
Please save or print a copy of this consent form to keep.

If you are willing to volunteer for this research, please continue with the survey.