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TABLETOP ROLE-PLAYING GAMES AS AUTISM PSYCHOTHERAPY:
A VIDEO-CUED MULTIVOCAL CLINICAL ETHNOGRAPHY

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Adina Rubin-Budick

December 2022

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Adina Rubin-Budick

2022

TABLETOP ROLE-PLAYING GAMES AS AUTISM PSYCHOTHERAPY:
A VIDEO-CUED MULTIVOCAL CLINICAL ETHNOGRAPHY

By

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ABSTRACT

TABLETOP ROLE-PLAYING GAMES AS AUTISM PSYCHOTHERAPY: A VIDEO-CUED MULTIVOCAL CLINICAL ETHNOGRAPHY

By

Adina Rubin-Budick

December 2022

Dissertation supervised by Dr. Elizabeth Fein

This qualitative study is a video-cued multivocal ethnography that analyzed the clinical reasoning and perspectives of psychotherapists using Tabletop Role-Playing Games (TRPG) as a therapeutic treatment for children and adolescents diagnosed with Autism Spectrum conditions. With a growing number of TRPG therapists nationwide using this modality in their clinical practices, this study aimed to develop a clearer understanding of the ways in which their therapeutic orientation, gaming practices, and knowledge of Autism Spectrum Conditions informs their use of TRPG psychotherapy with Autistic clients.

Research that focuses on clinical decision-making and the knowledge that informs clinical interventions and technique generally refers to these as “clinical reasoning”. By observing therapy and interviewing therapists about their clinical practice, this study collected data about the different types of clinical reasoning TRPG therapists use when working with

Autistic clients. Through the use of video-cued multivocal clinical ethnography, one TRPG therapist was observed and interviewed as she conducted TRPG therapy with Autistic clients and described the clinical reasoning behind the design and implementation of this treatment modality. Using ethnographic semi-structured interviewing and Brief Structured Recall (BSR), the video footage of the TRPG therapy served as a video cue for interviews with three other TRPG therapists, allowing the therapists to authentically reflect on the theoretical underpinnings behind their clinical judgement and decisions.

As Autism psychotherapies have been expanding to include approaches integrative of behavioral as well as psychodynamic orientations, TRPG therapy as a “semi-directive” treatment offers an emergent treatment option that integrates directive and non-directive approaches to Autism treatment. TRPG therapists discussed the ongoing tension between non-directive and directive approaches to treatment, which simultaneously mirrored historical debates between these two approaches in play psychotherapy for Autistic patients. The results of this study reveal how TRPG therapists’ perspectives diverge from mainstream and previously held clinical views on Autism diagnosis and treatment. The results of this study show the alternative ways in which TRPG therapists view Autism symptomatology (i.e. sensorimotor needs, Theory of Mind, sociality) and the evolving nature of Autistic comportment that emerges through and is mediated by player immersion in the gaming space and interactions with the game’s structure and mechanics. Operating both as Dungeon Master and Therapist, the TRPG therapists discussed how they simultaneously utilized and integrated these multiple roles with competing paradigmatic perspectives while grappling with gaming, clinical, and cultural perspectives of Autism diagnosis and Autism treatment.

ACKNOWLEDGEMENT

This study had several “key players” whom I would like to acknowledge as early originators of this dissertation, long before any writing started. *All of the names are de-identified for confidentiality and privacy.

The first was Alex*, my five-year old camper at a day camp on Long Island in the camp’s first summer of having an “inclusion program” that was “inclusive” of Autistic campers in name only. Alex would often feel overwhelmed in the loud, overstimulating lunch area and we would go sit in the quiet cubby space – just the two of us, eating Goldfish and watching Finding Nemo (Alex’s favorite movie). Alex knew every word of the film, and would often recite entire scenes to me – which eventually, I memorized as well as a result of our lunches together. This was my first encounter with echolalia, an Autistic trait which I read about in Alex’s Individualized Education Plan (IEP) in a section about his Speech Language goals. As the summer progressed, Alex and I would recite Finding Nemo to each other and the script began to take on different meanings – I realized that moments of recitation were meaningful, had intentionality, and were communicating important things about Alex’s lived experience. At the end of each camp day, Alex would recite Dory the fish’s words to me “Next time” in a sing-song voice – prompting my reply, “Next time” to confirm that I would be seeing him tomorrow. This ritual of ours was a foundational step to this dissertation, and to my belief that what might be construed as “symptom” is multi-valenced and should not only be understood from one, medicalized perspective. This ritual was not just echolalia or symptomatic, it was interpersonal and dynamic. This experience led to the first iteration of this dissertation in the form of a pilot study, in which I noticed the “callbacks”, the recitation of film and video game scripts as well as character catch

phrases, used among Dungeons and Dragons players. I immediately connected these callbacks to the ritual and the familiarity in Alex's echolalia, and the shared meaning he and I had. These shared recitations granted a mutuality and a meaning to what could have been written off as a speech language symptom that should be worked on during the school year. My time with Alex made me yearn for an understanding of Autism that could account for multiplicity and an approach to supporting Autistic individuals that attends to the many lived, dynamic meanings of their experience.

The second was Peter*, a Sophomore student within my self-contained Special Education classroom in a New Orleans high school. Peter introduced himself to me, the teacher, with a huge smile on his face, "Hi I'm Peter, let me tell you about my Autism". Peter continued to share with me about the teachers with whom he had formed close relationships and took out his notebooks filled with printed pictures of dragons and World War II weaponry from the Internet. Peter often felt isolated and misunderstood in social interactions with his peers, leading to times where his understandable frustration would amount to overwhelming episodes as he would storm through the hallways to a quiet outdoor space. When this would happen, the other teachers would cover my class so that I could go sit with Peter and help him calm down as he would take out his notebook of dragons, and share with me all of his knowledge about mythical creatures and military weaponry. I deeply wished that Peter would not experience the intense levels of isolation and distress that led to these moments, but I also felt honored to be Peter's trusted buddy chosen to weather the storm with him and I valued the special moments outside of the classroom where I at last got a chance to talk to him about his interests. Recognizing that I would rather weather the storm with Peter than teach a math class was a pivotal turning point in my career towards psychology, in which I realized I felt more called towards work as a therapist than

as a teacher. Another important realization came to me when I considered the ways in which Peter would share with me. In class, while Peter would often raise his hand and share an interesting WW2 fact – there almost never felt like there was enough space or time in the classroom to truly allow Peter to expound on his interests. I felt torn and ambivalent when designated reading passages and math lessons took precedent over Peter’s passions. I thought of where else and with whom else Peter might have the opening to share about his interests. Although Peter attended a bi-weekly therapy group with the school social worker, most of this therapeutic treatment was geared towards teaching social skills – as is common with many therapies for children on the Autism Spectrum. Peter’s therapy was specifically designed to teach him skills regarding choosing “appropriate” topics and ways to share that would steer him away from sharing perseverative interests. With his same age peers at lunch time or in clubs, Peter often did not find other Sophomores interested in the same things he was. I realized – if not in class, if not in therapy, if not in peer interactions – where does Peter get to talk about what HE wants to talk about? It was with Peter that I recognized the distinct value – for any adult or child, on or off the Spectrum – in having the invitation to share about what you know, what you care about, and what you are interested in without having to censor or interrupt yourself. I believe that the moments with Peter were therapeutic for that exact reason, and it is something I have reminded myself of in other classroom or therapy moments in which patients or students share with me something that they care about. These are the moments in which fantasy, creativity, and play can come alive in a relationship, without any backstop. This dissertation, as well as my clinical work, are devoted to providing this important space for others.

Soon after setting out to research Autism psychotherapy during my doctoral studies at Duquesne University, I was fortunate to start weekly psychotherapy with a new patient Kelsey*

at the Duquesne Clinic. Kelsey identified as “neurodivergent”, though she had never been formally diagnosed, and often spoke about how social interactions were difficult for her – including her previous experiences with talk therapy. Kelsey explained that from an early age, she felt she had to “teach herself” how to conduct conversations and show emotional reciprocity to others – which she guessed likely came naturally to others. When Kelsey began showing neurodivergent traits during her school years, she was recommended to transfer to cyber school - - as is the unfortunate trend with many Pittsburgh students with learning needs. Kelsey continued to report feeling “awkward” and avoidant of our in-person talk therapy sessions, until one day she shared with me about her role as Dungeon Master (DM) in her friend circle’s Dungeons & Dragons (D&D) game. Her eyes brightened and her whole body animated as Kelsey explained that in the role of DM, she felt in control in relation to others in a way that was unlike any other part of her life. This was my first foray into the world of D&D, and Kelsey is to thank for this study. I thought to myself, what could be this powerful that it completely shifted Kelsey’s experience and view of herself? I had to find out.

Kelsey was not my only patient at the Duquesne Clinic who played and loved D&D, and I soon realized that talking about gaming in therapy was a powerful way to invite my patients to share about their identities, fantasies, and social experiences. Another patient Arnold*, who had been experiencing debilitating and severe depression for over ten years, spoke about the D&D character he would play: a biking “electronic DJ” dressed like George Clinton who would ride around Pittsburgh with massive speakers spreading joy and music. This alter ego, or D&D character, was the first time I heard Arnold conceptualize an alternate reality and identity outside of Major Depression, and opened up another possibility for himself that served as a breakthrough in our therapy.

My first acknowledgement is a thanks to Alex, Peter, Kelsey, and Arnold -- and all of the other creative, wise, and wonderful clients with whom I have worked over the years. Thank you for your patience with me and for teaching me.

Next, I want to acknowledge the mentors along the way who have helped support these realizations. For Dr. Harry Segal of Cornell University – thank you for introducing me to the world of play therapy, supporting my very first work as a therapist, and encouraging me to continue the doctoral path at every step of the way. For Kelsey Lambrecht, Andrea Bond, and Amanda Ochoa of Collegiate Academies – your disability advocacy and your commitment to believing in ALL children is world-changing and I could not have gone down this road without your support from the classroom to the CA office to Zoom meetings. For Dr. Ryan Mest of Chatham University’s College Counseling Center – you pushed my thinking, you believed in this project, and you enthusiastically discovered with me as this evolved.

I would also like to thank my clinical mentors throughout the doctoral process, who have helped me become the clinician I am today. For Dr. Lori Koelsch and Dr. Roger Brooke – you both helped me in my earliest stages as a training psychologist and I thank you for your care and support in my development. For Dr. Perry Henschke, Dr. Elsa Arce, and Cindy Kerr – thank you for making Chatham University my favorite place in Pittsburgh and for clinical training that will stay with me for the rest of my career. For Dr. Akiko Motomura – thank you for inspiring me with your expertise in child and play therapy.

I would also like to thank several key players within the Duquesne Psychology department, without whom none of this would have been possible. Thank you to Dr. Eva Simms for being the first eyes on the writing in this project. Thank you to Marilyn Henline and the entire front office staff for your reliability and compassion. Thank you to Linda Pasqualino for

cheering me on and supporting both my clinical and emotional wellbeing. I also would like to thank Dr. Jessie Goicoechea for your continuous help throughout the doctoral degree and your enthusiasm for the “playfulness” in psychotherapy and in this study. I would especially like to thank my cohort – Sadie Mohler, Sean Leadem, Tricia Wang, Christine Heller, Autumn Marie Chilcote, Jose Luiggi Hernandez, and Kaitlyn Abrams– thank you for listening to countless hours of presentations and iterations of this study, and being as committed as I am to changing this world so that all are included and celebrated.

I would like to thank and acknowledge my fabulous dissertation committee, without whom none of this project would have been possible. Dr. Russell Walsh – thank you for your wonderful advising, supervision, support, and considerate feedback since Day 1 at Duquesne. Dr. Rachel Kallem Whitman – thank you for the laughs and for your warmth, this project would not be half of what I wanted it to be without your critical eye and considerate scholarship. And to my director, Dr. Elizabeth Fein – I came to Duquesne excited to work with you, and I have never ceased to be amazed by your brilliance. You allowed me to sit in your office and “nerd out” with you, as well as sometimes spiral out with my ideas. I appreciate your willingness to dive into every thought. Thank you for every meeting, email, edit – this project, this program, and our field are made better by your presence.

I am very grateful for the support of the Duquesne Media Department for generously allowing me to borrow their equipment and expertise. I am indebted to the work of James Vota, whom I thought I would have to sell on this project and was pleasantly surprised by his unwavering dedication to this study at every stage of its development. Thank you for your commitment to psychology as a human science, and for your tireless support throughout the pandemic.

Thank you to my wonderful undergraduate research assistants: Michael Maryniak, Veronica Napolitano, Kiersten Daughtery, and Emma LaRocque. You all brought such enthusiasm, care, and scholarship to this project. I delighted in hearing your observations and watching you all grow as ethnographers and psychology students. Your contribution to this study is immeasurable.

I especially want to thank the incredible “supporting players” who helped make this project a reality. Thank you to Brad, Ryan, Nate, Adam, Travis – my first D&D teachers. Thank you to Andrew Harris of Guild Chronicles for dreaming up this study in its nascent stages. Thank you to Hawke Robinson and Adam Davies for your time and support. Thank you to Jack Birkenstock, Max Yoder, and the entire Bodhana Group family for the RPG trainings, meet-ups, and inspiration. Thank you to Dr. Anthony Bean of Geek Therapeutics for your rich, complex understanding of our field and taking the time to share it with me. And most importantly, thank you to Dr. Erika Busch for the immense time, care, and energy you put into this work – I and so many others are indebted to your clinical expertise and kindness. It was such a pleasure laughing and brain partnering with you, and I will forever be a better clinician and academic because of your mentorship.

I also want to provide a shout out to my cohort and supervisors during my pre-doctoral internship year at Nassau University Medical Center, especially Dr. Lamontanaro and Dr. Forlenza. Their excitement about this project and their support of my clinical work with patients on the Autism Spectrum helped keep this study alive for me during the grueling months of internship.

Last, I want to thank the people in my life who helped me get this far. To Joe and Alex, thank you for feeding me, sheltering me, and playing with me throughout my time in Pittsburgh.

To Miriam (“Mimi”), you make me a better clinician and a better friend with every phone call and every laugh. To my Cornell family, thank you for every NYC dinner and for your understanding at each stepping stone on this long journey. To Jill Thomas and Julie Marcus for keeping me steady and believing in myself and this project. To my Mom and Sylvie, for your reminders of “brute force” and pushing me forward.

Most of all, thank you to Jeff. You are everything

TABLE OF CONTENTS

	Page
Abstract	iv
Acknowledgement	vi
Chapter 1: Introduction	1
1.1 A Note on Language	4
1.2 Research Question	9
1.3 Literature Review.....	12
Chapter 2: Methodology	40
2.1 Critical Disability Methodology	41
2.2 Clinical Reasoning	43
2.3 Ethnographic Method.....	49
2.4 Video-Cued Multivocal Ethnography.....	50
2.5 Focused Ethnography.....	53
2.6 Clinical Ethnography	54
2.7 Reflexivity.....	57
2.8 Interviewing	58
Chapter 3: Method	61
3.1 Participant Selection and Recruitment.....	61
3.2 First Stage Data Collection, Analysis, Multi-Vocal Text.....	65
3.3 Second Stage Data Collection and Analysis.....	72
Chapter 4: Narrative Vignettes	90
4.1 Beth.....	91

4.2 Jared	108
4.3 Mark	114
4.4 Louis	117
Chapter 5: The Multi-Vocal Text	123
Chapter 6: Autism Conceptualization.....	131
6.1 Clinical Symptoms and Challenges	133
6.2 Sociality	149
6.3 Theory of Mind	153
6.4 Personality/Style	165
6.5 Interests.....	173
Chapter 7: Theoretical Orientations to TRPG	178
7.1 Psychodynamic and Psychoanalytic	179
7.2 Group Therapy.....	187
7.3 Behavioral Therapy.....	199
7.4 Skills-Based Approach.....	208
7.5 Experiential Therapy	223
7.6 Narrative Therapy	235
7.7 Developmental Approach	256
7.8 Play Therapy.....	261
Chapter 8: TRPG Clinical Interventions.....	277
8.1 Preparation	279
8.2 Opening Space	282
8.3 Circles of Communication	284

8.4 Managing Individual Players	290
8.5 Managing Group Dynamics	294
8.6 Process-Oriented Interventions	300
8.7 Tracking Progress	305
Chapter 9: TRPG Gaming Interventions.....	307
9.1 Game or Therapy?	308
9.2 Externalizing and Depersonalizing	310
9.3 Breaking Immersion	311
9.4 Seeding the Bleed	312
9.5 Narrative	313
9.6 Encouraging Role-Play	314
9.7 Non-Player Characters (NPCs)	315
9.8 Risk versus Reward	316
Chapter 10: Therapy Outcomes	320
10.1 Relational	321
10.2 Clinical and Symptom Improvement	334
10.3 Identity	349
10.4 Gaming.....	352
Chapter 11: Discussion	359
11.1 Integrated Paradigms	361
11.2 TRPG as Autism Psychotherapy.....	368
11.3 TRPG as Directive vs. Non-Directive Play Therapy	372
11.4 Directive and Non-Directive Therapy with Autistic Patients.....	379

11.5 Integration of Directive and Non-Directive Autism Psychotherapy.....	387
11.6 Critical Disability Methodology and Autism Psychotherapy	392
11.7 Cultural Understanding of Autism through Therapeutic Gaming	407
11.8 Implications for Future Research.....	409
11.9 Limitations	415
11.10 Closing Remarks	418
Appendices.....	
Appendix A: Semi-Structured Video-Cued Interview Guide (Beth).....	420
Appendix B: Semi-Structured Video-Cued Interview Guide (Jared, Louis, Mark)	422
Appendix C: Child’s Agreement to Participate in Research Study	424
Appendix D: Parental Permission Form	428
Appendix E: Coding Schema.....	433
References.....	437

Chapter 1: Introduction

“There is just this great debunking of core assumptions in ASD like ‘Theory of Mind’. I’ve only worked with one or two guys who had a hard time entering the fantasy world and couldn’t quite get into it real time. But Theory of Mind is not really the root of that challenge though, the challenge is attending to facial expressions in real time. But if I describe the character’s expressions in the game as the Dungeon Master, they are good at guessing at it... they are good at trying to assign motives through story elements. ...you just see these supposed ‘social deficits’ just melt away in game play. Theory of Mind is bullshit.”

“The idea that Autism is less ‘reciprocal’ can completely disappear in certain contexts. Like in [a gaming system] where there is a connection in a shared interest, shared imaginative world, and a rich connection is developed. A genuine back and forth reciprocal conversation”

“Let the child play through it and talk about it later. Let the play go on and let the person stay immersed, not be overwhelmed with how you are fucked up or what your issue is. I’ll give you an example of a kid who was working on his impulsivity, and he needed to play through it. After making impulsive moves in the game, I would try to help him think of a different strategy. We came upon this door one day in the game and instead of opening it immediately, he said he might try something different, like looking through the keyhole of the door first. ‘Wait! I see what you are doing...’ he said to me with a smile. He got it. I’m not beating you over the head that ‘this is therapy’. You know, I’m putting your goals and your skills in, but I’m going to respect you individually.”

These stories are just a few of the many that I had heard previous to beginning this study about how role-playing games allow for the emergence of unexpected capacities among youth diagnosed with Autism Spectrum Disorders (ASD). These therapists are a part of a larger nationwide trend throughout the United States since 2014, in which Table-top Role-Playing Game Therapy (TRPG Therapy) has become a widely used therapeutic tool for children, adolescents, and adults with neurodevelopmental disorders, including ASD and Attention-deficit/Hyperactivity Disorder (ADHD).

As psychotherapists have creatively repurposed TRPGs, like the famous *Dungeons & Dragons* (D&D), as a clinical tool in both individual and group therapeutic interventions with this population, there has not yet been any clinical research that has questioned: why TRPG as a clinical tool?; what does it do?; and why with this Autistic population in particular? Studies, like Elizabeth Fein's (2015) ethnography observing Live-Action Roleplaying (LARP) in a therapeutic summer camp, have found that role-playing can provide meaningful cultural and clinical spaces for Autistic children and teens. Yet alongside the long list of behavioral, psychodynamic, educational, and recreational interventions for Autistic populations both offered in clinical practice and studied in clinical research, this dissertation aims to uncover where TRPG therapy fits in to this spectrum of approaches – as well as how this form of treatment offers innovative and divergent ways to address age-old questions as to how to conceptualize and treat Autism.

As the therapist stories display above, the way in which we conceptualize psychotherapeutic treatments for Autism has a direct correlation with, and immediate implication for, the way we as clinicians understand that we are “treating”. As one therapist denotes above in regard to “Theory of Mind” (ToM) deficit, it is a conundrum for the therapist when the “deficit” the therapy is designed to treat is actually unobservable in client comportment while in the therapy! It is even more problematic when this “disappearing” deficit is a required criterion for the Autism diagnosis (according to the DSM-V). As a training clinician, this dilemma made me wonder – as it seems to make the TRPG therapists wonder – about how well our diagnostic criteria, and the language for that criteria, capture the lived experience of Autism symptomatology. In TRPG treatment, TRPG therapists appear to be observing and noting a distinct quality to Autistic sociality – a way in which “pervasive” social deficits evolve through role-playing and gaming.

In many types of therapeutic interventions, the changing presentation of a client’s diagnosis from therapy room to the outside world would not be problematic. However, Autistic deficits are often considered to be pervasive and inherent to the individual across situations – as seen in the required Criterion A of the DSM-V diagnostic criteria. If TRPG therapists observe and narrate these symptoms, such as ToM, as non-pervasive in that they are not present in the gaming setting, this means that TRPG therapists have a perspective about Autistic symptomatology that differs from the mainstream and medical approaches to diagnosis. This study aimed to understand how TRPG therapists understand how TRPG treatment “works” as a therapeutic tool in regards to this conceptualization of Autistic deficits as non-pervasive, even within a naturalistic setting such as TRPG.

Ultimately, what this dissertation will argue is that there is something unique to the multiplicity of roles occupied by TRPG therapists that contributes to their specific perspectives of Autism diagnosis. When setting out to conduct this study, I had hypothesized that it was perhaps the competing paradigms of simultaneously working as Dungeon Master and Therapist that might lead to tensions in their approaches to treatment. As the anecdotes at the beginning of this chapter describe, TRPG therapists are straddling various theoretical frameworks at once: is this therapy or is this gaming? Is this a deficit or is this not? Is it real or is it fantasy? The dilemmas they face are profoundly significant to the diagnosis and treatment of Autism, and this dissertation will argue for the recognition that perhaps this multiplicity of perspectives, and an integration of approaches, is quite necessary for the future of Autism treatment.

1.1 A Note on Language

Before diving into the research question, there are several acronyms that are important to list and define here as a source of reference for the rest of the dissertation. Language plays a powerful role (no puns intended) in this project: the interviews are conducted verbally and the video observations are of TRPG, which is a form of talk therapy. Both verbal and embodied forms of communication and language are integral to this project, and it is important to note the ways in which this language can also exclude, rather than invite, access for all. In the spirit of a critical disability methodology, it is my aim that this project be inclusive to all ability levels, while also recognizing that written and oral language may be variably experienced by those with learning and sensory differences.

Also inherent to a critical disability framework is an attention to how disability identity is described and languaged. For the purposes of this project, I respect and utilize both the traditions of person-first language (e.g. person with Autism) as well as identity-first language (e.g., Autistic person). A product of the disability rights movement, person-first language is still used today by Autism advocates, parents, and activists. As a clinical researcher and training clinician, I believe that the use of person-first language is something that the clinical and medical community must be careful of.

While person-first language refrains from referring to disabilities as something one “suffers from” (as in a person “suffers from Autism”), it can also individualize the notion of disability as a personal problem that is “with” the individual. However, person-first language is also appropriate at times within a medical context: Autistic scholar Lydia Brown (2011) explains, one would not say “cancerous people” but would instead use person first-language as “people with cancer”. However, here Brown points out that cancer is not a socio-political identity, as Autism is. In this project, I aim to be faithful to a critical disability methodology and utilize identity-first language in recognition of Autism as a socio-political identity. The social model of disability and Autism posits that Autism is a socio-political identity borne out of an individual’s experience with oppressive societal, political, and cultural limitations and barriers. However, while I maintain that Autism is a socio-political identity and appreciate the socio-political explanation of Autism posited by the social model of disability, in this dissertation project I also integrate a perspective of Autism that is lived through the body and the brain in that same world where societal, cultural, and political oppression exists. It is important for this

project, as Brown asserts, that Autism be seen as a neurological and developmental condition, and way of being in the world. Referring to individuals in this project as Autistic is an attempt to resist the conflict between the medical model (e.g., Autism as individual, and something that can be “cured”) and the social model (e.g. Autism as solely produced by societal and institutional oppression) and rather to integrate these two perspectives as will be discussed in later chapters on phenomenological and cultural definitions of Autism.

Some of the definitions covered below will comprise terms related to a critical disability approach, while others are acronyms that are used in role-playing gaming culture.

- ABA: stands for Applied Behavioral Analysis, a form of behavior modification therapy that is widely used with Autistic children, teens, and adults. While it is touted as an evidence-based practice in academic and research circles, it is a controversial and deeply contested form of therapy within the Autism community as will be discussed in later chapters.
- ASD: stands for Autism Spectrum Disorder, the clinical diagnostic terminology used in the DSM-V.
- B.A.D.D.: stands for the Bothered About Dungeons and Dragons coalition, a group of parents and community members who protested the game Dungeons and Dragons as a result of two player deaths.
- BSR: stands for Brief Structured Recall, a qualitative interviewing method designed to be an abbreviated version of the Interpersonal Process Recall interviewing method.

- D&D: stands for *Dungeons & Dragons*, the first and best known table-top role-playing game
- DM: stands for Dungeon Master. This is the person who creates the game's narrative and facilitates the game by role-playing characters and overseeing all game mechanics. In TRPG therapy, the DM is played by the therapist.
- Fit: This is a theoretical term used by critical disability theorist Rosemarie Garland-Thomson (2011) and describe the phenomenal experience of when a “harmonious, proper interaction occurs between a particularly shaped and functioning body and an environment that sustains that body” (p. 594). A fit is a dynamic experience that occurs when environmental factors such as accessibility, inclusion, and support are present.
- GM: stands for Game Master. This is like the Dungeon Master in D&D, but the GM is the designer and facilitator in gaming systems other than TRPG.
- IPR: stands for Interpersonal Process Recall, a qualitative interviewing method.
- LARP: stands for live-action role-playing game. This is not at a table
- MMORPG: stands for multi-media online role-playing game
- Misfit: this is a term coined by the critical disability theorist Rosemarie Garland-Thomson (2011). Rather than meaning that people with disabilities are “misfits” in society, Garland-Thomson uses this concept instead to describe the phenomenal experience that a person has when “the environment does not sustain the shape and function of the body that enters it” (p. 594). This term was developed as a dynamic phenomenological contrast to the terms impairment and disability, which describe static bodily states or conditions.

- Neurodiversity: a term coined by Harvey Blume (1997) which means that all brains are variable. The term has been taken up by Autism advocates and advocates as a way to challenge pathological arguments about Autism identity, as well as combat the assumption that Autism has psychogenic causes – such as “mother-blaming”. The term is often used as a contrast to “neurotypicality”, which describes individuals without intellectual or learning diagnoses and those who behave or think in ways that are considered to be “normal” by the general population.
- NPC: stands for “Non-Player Character”, which is a character in a role-playing game that is not controlled by a player in the game and instead controlled by the Dungeon Master or TRPG therapist. An example of an NPC in the observed therapeutic game was the “Nothic” a monster role-played by the TRPG therapist.
- Pin3C: stands for *Preschool in Three Cultures*, a video-cued multivocal ethnography conducted in 1989 by Joseph Tobin, David Wu, and Dana Davidson.
- RPG: stands for roleplaying games. Role playing games are played in different contexts such as seated at a table (e.g. TRPG) or online (e.g. MMORPG).
- TRPG: stands for table-top roleplaying game. This is a type of roleplaying game (RPG) that utilizes a game board of some sort, and features players sitting around a table. In this study, due to the COVID-19 pandemic and the shift to tele-health platforms, the “table-top” aspect of TRPG was the shared screen.
- ToM: stands for Theory of Mind, a psychological term that describes an individual’s mentalizing capacities. The notion that Autistic people lack ToM is an important and highly contested notion in the field of Autism research.

- Treatment: the notion that TRPG is a psychotherapeutic treatment for Autism might in some way endorse the medical model of disability in which the therapy “treats” or “cures” the client. In this study, I use the word treatment as being synonymous with therapy.

1.2 Research Question

This qualitative study explores the clinical reasoning employed by trained psychotherapists in their facilitation of TRPG therapy with clients identified as being on the Autism Spectrum. The study utilized videotape to observe a TRPG therapy using the game D&D.

Existing clinical research has changed its tune since the 1980s, first considering role-playing games to have a negative psychological effect both inside and outside of clinical settings – only to later conclude in more recent studies that role-playing games actually have positive psychological effects on players. Wayne Blackmon’s (1994) case study employed a qualitative method of utilizing the client’s D&D gaming experiences in the individualized therapy treatment, with positive treatment outcomes. Since 2014 TRPGs have not only been integrated into talk therapy sessions, as in Blackmon’s study, TRPGs have become the clinical tool itself – now known as TRPG Therapy!

These developments point to a gap in the literature as to the psychological effects and purposes of table-top role-playing games not only in their use within a clinical setting, but in

their use as a clinical tool and therapeutic modality themselves. My study elaborated upon this research by seeking to better understand the clinician's perspective as to why role-playing games provide a clinically significant and therapeutically supportive tool for clients. However, unlike previous studies, my study was not about the incorporation of fantasy role-playing in talk therapy, but the actual role-playing game as the therapeutic tool in group treatment.

In TRPG Therapy, therapists are no longer operating only in a traditional clinical capacity – but are also conducting the session as a Game Master or Dungeon Master (GM/DM), and at times also planning the game's story arc ahead of time as the game designer. By interviewing each therapist as they watched a video of a taped TRPG therapy session, I was able to observe the clinical reasoning the therapists employed on a moment-to-moment basis throughout the therapy session so to understand how the therapists conceptualize treatment for Autistic clients. Additionally, by using video-cued interviewing to show the video of treatment to other non-facilitating TRPG therapists – I aimed to understand how therapists understand the clinical motivations, reasoning, and techniques behind therapeutic interventions, as well as the mechanics and storytelling that the therapists as the GM/DM utilizes and for what reason.

As opposed to the commonly used and manualized behavioral treatments often recommended for Autism treatment, TRPG therapy offers an approach that does not solely focus on behavioral modification and teaching social skills to Autistic clients. Research findings that suggest that TRPG players and clients of TRPG therapy experience social improvement and increased communication skills as a result of game play and game therapy are compounded by the anecdotes in the Introduction of this study: these TRPG therapists insist that Autistic clients'

Theory of Mind (ToM) deficits evolve through the game play and are thus potentially non-pervasive as the diagnostic criteria requires. These observations have significant implications that reflect the possibility that TRPG therapists may have an approach to Autistic social deficits and Theory of Mind deficits that differs from the clinical mainstream by noting the non-pervasive nature of clients' social comportment. Based on prior research that has been done on the way disability changes its meaning and impact based on social context and the particular relevance of this for Autism as a profoundly social disability (Fein & Rios, 2018; Mattingly & Lawlor, 2000; Ochs & Solomon, 2010), I wondered how social deficits associated with Autism might shift in their meaning and manifestation in the context of TRPG therapy. In interviewing TRPG therapists, this study aimed to investigate how TRPG therapists narrate Autistic comportment by way of explaining their clinical reasoning for treatment.

The main research questions of this study are summarized by the following:

- What clinical reasoning do TRPG therapists employ when making clinical decisions in the therapy? What existing techniques, orientations, approaches do TRPG therapists utilize in facilitating therapy (both in preparation and facilitation)? What approaches and experiences with gaming, such as mechanics and storytelling, might also contribute to the therapists' facilitation of TRPG therapy?
- How are TRPG therapists conceptualizing this therapy as a treatment for Autistic clients? In other words, what does the facilitation of TRPG therapy reveal about how clinicians understand the lived experiences (i.e. symptoms, challenges, sociality) of their Autistic clients – and how the TRPG therapy supports this lived experience?

1.3 Literature Review

1.3A Autism Spectrum Disorder (ASD) Diagnosis

In order for an individual to be diagnosed with ASD according to the DSM-V, they must meet all four of the following criteria:

- A. persistent deficits in social communication and interaction across contexts
- B. restricted, repetitive patterns of behavior, interests, or activities
- C. symptoms must be present in early childhood
- D. symptoms together limit and impair everyday functioning

The anecdotal quotes from TRPG therapists in the Introduction raise important questions about Autistic symptomatology in the context of TRPG treatment: how and why are these symptoms observed or conceptualized by treating therapists, and how might treatment “work” for these symptoms. In these clinical anecdotes, it is important to note their suspicion about this diagnostic criterion and the markedly different social comportment and behavior observed during TRPG therapy. Their observations of treatment suggest that these seemingly “persistent deficits” in socializing may not be universal or generalizable, and that the treatment setting as well as the treatment modality of the TRPG is a particular space in which Autistic sociality appears differently. These observations lend voice to a significant debate in the research community about what exactly these social deficits are and how they impact Autistic individuals. This debate largely focuses on the concept of ToM, which was mentioned by the TRPG therapists in the

introduction, and will be discussed further in the following sections. These anecdotes reveal the intimate link between Autism conceptualization and treatment, as will be shown in the next section on historic approaches to Autism treatment and how this is directly correlated to historic and ever-shifting conceptualizations of Autism symptomatology.

1.3B Historic Approaches to ASD Treatment

This section briefly summarizes the history of the opposing camps of Autism treatment, and how this opposition was developed through differing case conceptualizations regarding Autism's causes. Due to this heritage, the way in which clinicians treat Autism has everything to do with how they conceptualize it as a diagnosis. This study aimed to investigate the different orientations in this lineage of Autism treatment from which TRPG therapists draw and narrate in their clinical reasoning, as well as the ways in which they conceptualize Autism as a diagnosis and how this relates to treatment decisions.

Today Autism is a contested category, both culturally and historically, with differing diagnostic interpretations of symptomatology. While there is a push in the scientific and medical community to reify Autism into a single diagnostic entity, there is necessary nuance in recognizing Autism's simultaneous biological, relational, and characterological features (Fitzgerald, 2017). The original diagnosis of Autism was first identified and defined by Leo Kanner (1949) in "Problems of Nosology and Psychodynamics of Early Infantile Autism". Kanner (1956) understood the disorder as a sort of innate "childhood schizophrenia" – and like schizophrenia, the root cause of Autism was thought to be a relational deficit in the relationship

with the mother. The child's relational wound from the "refrigerator mother" led to a fragmented sense of self, described infamously by Bruno Bettelheim (1967) in *The Empty Fortress: Infantile Autism and the Birth of the Self*. As a result of this etiological understanding, proposed psychotherapies included "parentectomy" – a milieu therapy for children with Autism wherein they were removed from their parents during treatment to treat the relational wound (Gardner, 2000). This approach also informed the move towards institutionalized medical care for people with disabilities, and calls to memory the disturbing history of institutions, like the infamous Willowbrook State School on Staten Island, in which individuals with disabilities were removed from their families to live in isolated and squalid conditions. This diagnostic conceptualization of Autism as caused by parental relationships, thus treated by removal from parents, led to a major upheaval in the Autism community and eventually led to a backlash towards psychoanalytic treatment pioneered by parents and families of Autistic individuals.

This upheaval, as well as the post-Willowbrook movement to de-institutionalize treatment for individuals with disabilities, contributed to a cultural shift in attitudes towards diagnosis and treatment. In his 1964 book *Infantile Autism: The Syndrome and Its Implications for a Neural Theory of Behavior*, Bernard Rimland was the first to claim that infantile Autism had neurogenic (or neurogenetic), rather than psychogenic, causes – removing the blame from parents and instead opening the door to cite brain chemistry, environmental toxins, diet, and uterine development as root causes for Autism. Although Rimland later changed his theory about Autism's origins, there is still a pervasive notion of "toxicity theories" in the medical mainstream today that Autism is caused by toxic exposures and bodily illnesses despite it being heavily contested by many parent and advocate organizations (Silverman & Brosco, 2007). This clinical

understanding of Autism as a diagnosis, as well as the backlash towards psychoanalytic therapies, has led to the shift towards behavioral therapies like ABA aimed to modify Autistic behaviors. This has meant less access to insight, emotion-focused, or relational therapies that address the experience of Autistic individuals rather than just Autistic behaviors. These contemporary behavioral approaches to Autism treatment will be discussed further in the next section.

However, research conducted by Jan Drucker (2009) and Richard Bromfield (1989, 2000, 2010) suggest that integrating a psychodynamic approach to Autism treatment provides a valuable middle-ground between neurogenic and psychogenic debates and the stemming dilemma between behavioral and psychodynamic approaches. Role-playing games incorporate elements of psychodynamic orientation: providing insight and depth-orientation, an exploration of dream and fantasy, a focus on meaning-making and symbolic systems, as well as experiential opportunities to relate to others and understand relational and affective dynamics (Burns, 2014; Hughes, 1988). In this way, TRPG therapy appears to offer an integrative approach to treatment that diverges from sole reliance on behavioral treatments. This study investigated the ways that TRPG therapists narrate their use of these differing treatment approaches within their clinical reasoning as they pull from psychodynamic, behavioral, as well as many other orientations for Autism treatment.

Bromfield notes that specifically psychodynamic play therapy provides ego building and relational support for Autistic clients. Play therapy as a form of Autism treatment has been shown to yield meaningful results for Autistic children and adolescents, revealing the ways in

which play supports client identity formation, social skills, and emotional self-regulation (Bromfield, 1989, 2000, 2010; Josefi & Ryan, 2004; Mitteldorf et al., 2001; Kenny & Winick, 2000; Getz, 1996; Alvarez, 1996). A study by Goldingay et al. (2013) found that pretend play, not TRPG, in a group therapy with adolescents on the Spectrum led to increases in flexible thinking and self-regulation, crediting the use of pretend narratives and character-creation with these findings. The only existing studies on the use of TRPGs with children on the Autism Spectrum were published by Katō (2019), concluding that therapeutic role-playing games resulted in increase in intentional speech, collaboration and friendship building with others, and contributed to self-reports of “emotional well-being” among Autistic players.

Embedded in these play therapies is role-play, the opportunity for clients to assume and enact characters that allow for self-exploration, as well as safe and structured negotiation of relational space with the therapist (Levenson & Herman, 1991; Miller, 1980). Role-playing, like in TRPG or LARP (Live-Action Role-Play), as a therapeutic group modality offers powerful experiences for Autistic clients to be part of a collective and social world that might otherwise feel threatening or uncomfortable. As seen in Elizabeth Fein’s Journeyfolk study (2015), LARPing at a therapeutic day camp for neurodiverse teens allowed clients to have healing experiences of relating to and identifying with others in a community. Additionally, clinicians from the Wayfinder camp have discussed the concept of “embedded counseling” in LARPing as a framework for RPG therapy in which the therapist is involved in the roleplay with clients with Autism (Atwater & Rowland, 2018). Drama, theater, and improvisation as socio-emotional supports and elements of therapeutic modality have also shown to be effective for adolescents on the Spectrum (Corbett et al., 2011; McCarthy & Light, 2001). While TRPG therapy includes

similar use of play, psychodrama, and improvisation, little research has been conducted on specifically TRPG therapy.

1.3C Theory of Mind (ToM) and Implications for Autism Treatment

The “Theory of Mind” concept originates in developmental psychology as a theoretical position for how and why humans are able to attribute to others the status of a having a “mind” with thoughts, feelings, and perspectives. Disruptions in the development of ToM capabilities are thought to be at the root of many psychological diagnoses, such as Autism Spectrum Disorders, ADHD, addiction, eating and personality disorders as a proposed reason for why individuals with these diagnoses struggle with mentalizing the thoughts, feelings, and opinions of others. Some researchers suggested that ToM was not a “lack of ability” but rather due to processing difficulty or developmental delay during child language acquisition (Baron-Cohen, 2002; Kimhi, 2004). Closely related, although not exactly synonymous with ToM, are notions of empathy and perspective-taking – though these notions often get conflated in literature on Autism that suggests that children with ASD are “not able to connect emotionally through empathy with others... they are often described as socially stiff, awkward, emotionally flat, socially unaware, self-absorbed, lacking in empathy, prone to show socially unacceptable behavior and insensitive or unaware of verbal and nonverbal social cues” (Winter, 2003). According to an earlier generation of ASD researchers, the social deficits associated with ASD were defined as a sort of “mind blindness”, or that a lack of ToM led to difficulties with mentalizing the cognitive and emotional experience of others, resulting in difficulties with social interactions (Baron-Cohen, 1995; Baron-Cohen et al., 1985). Some research suggests that the maintenance of ToM theories

by the Autism research community is directly tied to the backlash against psychogenic and parental causes of Autism by advocating a neurological component rather than a developmental or “family dynamic theory” aspect of Autism (Epp, 2008). The assumption of ToM deficits has direct implications for proposed forms of treatment, leading to the notion that psychotherapies for people on the Autism Spectrum should primarily teach and improve social skills.

A recent generation of ASD researchers, however, critique the theory of ToM deficit as an explanation for Autism – much like the TRPG therapists quoted earlier. A recent shift of ASD research has emerged: some have aimed to debunk the notion of a ToM deficit in ASD altogether, citing ToM as a “myth”(Beardon & Worton, 2011; Chown, 2016; Rogers et al., 2007). In this new wave, cognitive scientists have offered a “sensorimotor” perspective on Autism. Phenomenologist Sofie Boldsen (2018) describes this cognitive science approach as having the emphasis that cognition “must be understood in its dynamic relation to bodily movement, perceptual processes and social interaction” (Brincker & Torres, 2013; De Jaegher, 2013; Donnellan et al., 2012; Glenberg et al., 2013; Leary and Hill, 1996; Robledo et al., 2012; Whyatt & Craig, 2013). The cognitive science approach is directly congruent with the quoted TRPG therapist observations that Autistic clients do not have some sort of deficit in higher-order cognitive abilities, but instead that their sensorimotor differences – such as how a client might divergently attend to facial expression or encounter a stimulus to act – might differently attune these clients with their world. As TRPG therapists account, some feature of the role-playing and the game play, allows for a richer expression of – and observation of – Autistic sociality and processing. The debate has sparked a greater interest in a phenomenological, embodied, and lived understanding of Autism (Boldsen, 2018; Chown, 2014; Chown, 2016; Gallagher, 2004)

and an embracing of neurodiverse sociality in its move away from the notion of deficit and disorder.

The proposed notion of ToM deficits also has significant ramifications for how researchers propose players on the Autism Spectrum might struggle with role-play gaming. There is much debate among role-playing game theorists about how players must utilize ToM capacities whilst playing and what effects this might have on players for whom this might be an issue: Bowman & Lieberoth (2018) noted the critical importance of ToM to role-playing games, in that it aids in the “creation and enactment of a consistent character”. Harris & Leivers (2000) suggested that ToM deficits would lend to difficulties with pretend play and symbolic non-literal communications, and several studies have noted the ways in which ToM deficits – such as the inability to infer thoughts and intentions of others- would prohibit individuals on the Spectrum from engaging with the narrative structures that are crucial for the role-playing game (Bruner & Feldman, 1993; Happé, 1996; Losh & Capps, 2003). However there is also significant evidence that engaging with fictional narratives might enhance affective ToM capacities (the ability to determine others’ emotional states) through the experience of immersion (Kidd & Castano, 2013; Bormann & Greitmeyer, 2015).

Recent research has contradicted the assumption that ToM deficits would prohibit players on the Spectrum from role-playing gaming. In her naturalistic ethnographic study, Solomon (2004) found that Autistic children were just as likely as neurotypical children to launch narratives into conversation – leading to the conclusion that unlike previous research might suggest, players with ASD would be able to engage with the narrative structure necessary in

TRPG. The ethnographic study by Brezis et al. (2016) challenged researchers who study the ToM deficits of Autism “in isolation”, which she warned might lead to the conclusion that people on the Autism Spectrum are “incapable” of engaging with the sort of pre-structured narratives necessary for TRPG due to ToM deficits. In her case study of an adolescent D&D gamer, Brezis concluded that children with Autism utilize immersion in TRPG to engage with fictional narratives and “express his sense of agency in the world”. Brezis suggested that one therapeutic application of her neuroanthropological research would be encouraging Autistic individuals to “co-narrate” fictional narratives, much like in therapeutic gaming.

A study by Breland (2021) utilized conversation analysis to determine whether ToM deficits impacted how players on the Autism Spectrum might operate in TRPGs. The study hypothesized that TRPG would be a good environment with which to study how ToM contributes to ASD patterns due to the need to use ToM capacities to operate as both their player self and their character with a totally different set of knowledge, thoughts, and feelings. The study, much like my own, wondered whether Autistic differences in interaction summed up by ToM such as “disadvantages with perspective taking, switching tasks, and inhibiting information” might be seen in the context of TRPG and whether a TRPG would present challenges to people on the Autism Spectrum as they switch perspectives from self to character. The results of the study concluded the players on the Autism Spectrum had more frequent “violations of pretense awareness context” during role-playing games than neurotypical players, meaning that they would more often break character by meta-gaming (i.e. talking about game mechanics while still in character) or responding to events and direction from the DM not addressed to their character. However, the study concluded that this was not in effect due to

ToM deficits or difficulties with perspective-taking as they had assumed might be the cause for these violations. Instead, researchers suggested that these patterns were likely more a result of a strong desire to participate and feel included in the game by others, as well as possible impact of Executive Functioning issues (such as failure to suppress knowledge or code switch between character and self). Similar discussion will follow in later chapters in which I will show the perspectives of TRPG therapists who describe Autistic players' metagaming habits, and the decisions therapists made in the Autism treatment for helping players stay immersed in the game. Thus, research on ToM in the TRPG context does not point to the conclusion that players on the Autism Spectrum are at any perceivable disadvantage – as previous research may have suggested – as there is no clear indication that these players struggle with the narrative, immersion, or perspective-taking elements that ToM deficits would presume.

The shifting attitudes about ToM and Autistic deficits more broadly have challenged the dominance of the most popularly used Autism treatments. Treatments like TEACCH (Treatment and Education of Autistic and Communication related handicapped children), considered “evidence-based”, still mainly focus on social deficit as the primary focus of treatment. Similarly, other reputable and commonly used Autism treatments such as Applied Behavioral Analysis (ABA) still rely on social behavior modification, while individual and group psychotherapy for Autistic clients often consists of manualized treatment geared towards improving social skills for those identified on the Spectrum. These treatment systems still rely on a “deficit model” of Autism, including the presence of ToM deficits, and the assumption that Autistic individuals “lack social awareness, emotional reciprocity, and the ability to sustain conversations” – a sentiment cited from the ABA Programs Guide website. A discussion of ABA

brings up significant controversy within clinical and Autistic communities alike: there are claims of ABA as a form of “torture” for Autistic clients (Dawson, 2004), whereas on the other hand there are first-hand stories from Autistic individuals, such as Alex Lowery’s (2013) review of the BBC Program *Autism: Challenging Behaviour* (2013), as well as their family members and their clinicians (Devita-Raeburn, 2016) that account for ABA’s life-changing and positive effects. As a training psychotherapist, Autism advocate, and former Special Education teacher, I admit that for a long-time I have carried with me a strong hesitation about ABA therapy that I have had to re-visit throughout my training. In an effort to weigh all perspectives in both support and critique of ABA, as well as other forms of behavioral therapies, I am trying to cultivate in this project an open-mindedness to the beneficial, rather than harmful, ways that TRPG therapists might borrow from and may even utilize these approaches in their own practices. As my later chapters with my participants will reveal, TRPG therapists also appear to be considering the sordid history of behavioral treatments in their practice while balancing the possible benefits of a behavioral approach. One of my participants, a TRPG therapist who identified as having a Cognitive-Behavioral orientation, extolled the virtues of behavioral treatments while referring to ABA and Functional Behavioral Analysis as “barbaric”. In an effort to not “throw the baby out with the bathwater”, I am reminded by the question of Jan Drucker who asked in her previously mentioned 2009 article whether psychodynamic psychotherapy has “a place” for patients on the Spectrum given the orientation’s history of parentectomies and refrigerator mothers. Similarly, the responses of my participants in this dissertation had me wondering whether behavioral treatments have “a place” in TRPG therapy for Autistic patients.

It is truly unfortunate that TEACCH and ABA -- our most popular and widely utilized approaches to Autism psychotherapy-- have not yet been modified to account for the shifting attitudes away from a deficit model, putting clinical interventions at high risk for promoting ableist and neurotypical behaviors without also celebrating neurodiverse sociality. This urges the question, if approaches towards Autism treatment were to better align with the shifting away from a social deficit conceptualization of Autism – how then would Autism treatment be different? How would Autism treatment promote Autistic sociality without relying upon curing deficit?

In their observations and anecdotal evidence about the changing sociality of Autistic clients within the context of the gaming setting, TRPG therapists are presenting a unique treatment modality that aligns with a neurodiversity paradigm (Walker, 2012), rather than a “deficit” model, for understanding Autism and thus treating Autistic individuals with a more respectful therapy that acknowledges differences. Thus, at the core of proposing TRPG therapy as an alternative to traditional Autism treatment is a theoretical discussion about disability and Autism identity, as well as how psychologists understand the role of treatment and psychotherapy. In the spirit of using a critical disability methodology, this study observed how therapists who utilize TRPG as a treatment modality with Autistic clients appear to be engaging directly with these questions.

1.3D History of TRPGs

Dungeons & Dragons (D&D) is a fantasy TRPG that was designed in 1974. While there have been many fantasy gaming systems designed and created since D&D that have also been used in clinical practice, D&D stands the test of time as one of the most loved and played TRPGs still today.

TRPGs involve the creation of a character that is then role-played throughout the entirety of the game – or “campaign”, a term used to refer to the length of one D&D game over many sessions that could go on for weeks, and sometimes even years. Once TRPG players create their characters, one player serves as the GM or in D&D games as the DM. The DM designs the story-arc for each game and for the campaign overall, narrating the character’s objectives as well conflicts that players encounter in each event, and facilitating player decision-making (through roll of dice). Campaigns will often meet once weekly, lasting between an hour and several hours. Players will come sometimes dressed in costumes as their character, and there might be gaming music in the background that dramatically scores the play. In a TRPG, the players sit around a table often with a basic-grid gaming board, sometimes with objects or character signifiers on it. Each player has two dice in their possession to roll, taking turns as the dice determine the actions and moves each player can make.

Players must work together and often times face conflict amongst each other and with other encountered characters (played by the DM/GM) as they navigate through the game world as a team. At time the players are traversing through the gaming world in taverns or fields, while at other times players are in combat with monsters. TRPG players whom I have interviewed in the past have discussed the productive tension in game play between “mechanics” and

“storytelling”: mechanics being the ability scores, hit points, attack or damage roles, or skills of a character that dictate how a character can move through the game world especially while in combat, versus the storytelling component of the game in which characters build relationships, discuss their backstory, and have emotional revelations often during non-combat moments. In TRPG therapy, a therapist will often serve as the GM/DM, helping clients to develop their character to role-play as well as designing the overall campaign and each game’s story arc with the therapeutic goals of the clients in mind.

Drawing from the lore of J.R.R Tolkien’s *The Lord of the Rings*, D&D gained wide popularity with fans of science-fiction and fantasy and drawing players of all identities. D&D has been designated a formidable place at the center of “nerd” subculture as the game is widely still played by gamers internationally still today. As technology has developed, role-playing games have moved from the tabletop pen and paper to the virtual space as video games like World of Warcraft allow a deeply personal role-playing component. These newer forms of online RPGs are referred to as multi-user dungeons (MUDs) or Massively Multiplayer Online Role-Playing Games (MMORPGs) which are played in virtual gaming spaces that allow for multiusers across the globe.

However, as with the way in which many gamers today are pathologized by society as introverts lacking real social skills or connections, early D&D gamers struggled greatly with being identified with certain negative pathologies as many in the general public rumored that D&D players had difficulty separating fantasy from reality, perhaps even causing psychotic episodes (Astinus, 2004). The rumors began with the suicide of college student James Dallas

Egbert III in 1979: despite evidence of Egbert's struggles with drug addiction and depression, private investigators and reporters blamed Egbert's suicide on his involvement with D&D, where at school in Michigan he played the game in underground tunnels on campus. In 1982, high school student and D&D player Irving Bink Pullin II died by suicide leading his mother Patricia Pulling to form the Bothered About Dungeons and Dragons coalition (B.A.D.D.) in attempts to sue the game designers and draw the public's attention (Waldron, 2004). She described the game in the following terms:

A fantasy role-playing game which uses demonology, witchcraft, voodoo, murder, rape, blasphemy, suicide, assassination, insanity, sex perversion, homosexuality, prostitution, satanic type rituals, gambling, barbarism, cannibalism, sadism, desecration, demon summoning, necromantics, divination and other teachings. There have been a number of deaths nationwide where games like Dungeons and Dragons were either the decisive factor in adolescent suicide and murder, or played a major factor in the violent behavior of such tragedies. Since role-playing is typically used for behavior modification, it has become apparent nationwide (with the increased homicide and suicide rates in adolescents) that there is a great need to investigate every aspect of a youngster's environment, including their method of entertainment, in reaching a responsible conclusion for their violent actions (Waldron, 2004).

American Christian groups rallied with B.A.D.D. to claim that the game promoted themes of witchcraft and devil worship, leading the game's designers to remove many of the references to "devils" and "demons" from the game. This outcry over D&D led to many players experiencing

varying degrees of social ostracization for their game play. During this, psychologists were called by the public, especially in media sources, to evaluate the emotional and mental health effects of the game with much debate. Many of the psychologists who weighed-in did so without citing any conducted research, while also pathologizing and armchair diagnosing D&D players. This professionally un-ethical behavior jeopardized the D&D community with far-reaching effects on players and perception of their mental health (Waldron, 2004).

These media depictions led to many players experiencing varying degrees of social ostracization for their game play. These pathologizing stances have had long-standing effects not only on D&D players, but on gamers of all kinds – as psychologists today still struggle to make sense of the valuable personal meanings that gamers make in their play, and instead labeling gamers with addiction and dissociation (Griffiths et al., 2013; Young, 1996). There is even still a bias today against Dungeons & Dragons amongst the clinical community, in that psychiatrists and social workers perceive a link between D&D and psychopathology that has never been proven by existing research (Lis et al., 2015; Ben-Ezra et al. 2018). In this way, the psychological community owes a great deal of debt to these gamers – and to investigating properly the ways in which D&D, as well as other RPGs, operate to support players rather than harm.

1.3E Debunking Claims of TRPG's Negative Psychological Effects

Since D&D was only invented in 1974, the first literature ever published on D&D was in 1986 – several years before the moral panic began. Researchers Lewis and Zayas (1986) studied

the use of fantasy role-playing in children's groups. The researchers used a qualitative and observational group study in which they observed a group of eight boys (ages 8-9 years old) in their D&D game play. Researchers observed increase in self-confidence among players, as well as behavioral improvements from baseline including a reduction in acting out. Results concluded that skilled group leaders of D&D play would allow for player benefits of game play to translate into adaptive social and relational skills in the real world. A strength of the study was the way in which the measures were assessing both child and facilitator participants, illuminating the therapeutic benefits of the game from both the practitioner and therapist points of view. However, researchers questioned whether the positive effects observed were due to game play or possibly due to other common factors of therapy, such as a positive relationship with therapist. While during the moral panic media and non-academic sources claimed that playing D&D caused mental illness, social alienation, and emotional instability (Waldron, 2004), academic research at the time sought to better understand the effects of the game play.

While a 1987 paper by Armando Simon concluded no harmful effects were correlated with playing D&D, the study prompted many to question the game's negative psychological effects. Simon's quasi-experimental quantitative study was the first to be conducted during the moral panic around D&D. The results suggested that emotional stability of D&D players was not compromised by playing the game, and thus debunked many of the assertions in media and clinical psychology at that time. Additionally, in comparing adolescent players and adult players Simon concluded that increased number of years of play would not result in increased emotional instability.

Simon's study served as inspiration for the 1990 study by Lisa A. DeRenard and Linda Mannik Kline -- one of the only studies at the time that used empirical data and quantitative analysis. While Simon's study used "emotional stability" as the construct to measure psychological well-being of D&D players, DeRenard and Kline used "social alienation" as the construct to determine whether D&D play had negative psychological effects on its players. DeRenard and Kline compared D&D players and non-players as subjects to compare social alienation between the two. The results of their study corroborated Simon's earlier claim that playing D&D does not seem to have any negative psychological effects, such as social alienation and emotional instability. However, this study only ruled out negative psychological effects without commenting on any possible positive effects – as later studies accomplished, and will be reviewed later in this section.

This study was followed by Lee Ascherman's (1993) qualitative study of game play within a hospital setting, which argued that D&D had negative effects within a therapeutic context. In his observations at the hospital, Ascherman noted the "destructive" impact the game had on an inpatient facility, explaining that "the unrestricted play of such games contributed to the disruption of a treatment setting, resistances to treatment, reinforcement of character pathology, disruption of individual treatments, and to the normalization of violence". However, it was unclear and unproven whether the game itself, or ongoing hospital conditions, led to this disruption. Additionally, the game was not being used as a clinical tool – it was instead a recreational activity that was not supervised by skilled game masters or therapists – only hospital staff unfamiliar with RPGs.

Several studies have de-bunked the notion that role-playing games lead to psychoticism (Abyeta & Forest, 1991), neuroticism (Rosenthal et al., 1998), personality pathology (Douse & McManus, 1993), depression or alienation (Carter and Lester, 1998). Recent years of research have reversed negative stigma towards D&D and TRPGs in general – concluding the positive effects of game play on players.

Researchers Lankoski and Jarvela (2012) used an embodied cognition approach for understanding the role-playing experience in RPGs. Their work explored the processes of “immersion” and “bleed”, which are gaming terms used to describe how players inhabit the identities of their characters and when the thoughts and feelings of the gamer merge and influence the role-play of the character. Lankoski and Jarvela concluded that immersion and bleed were natural processes that occur in daily life as we code-switch in the roles we occupy outside of gaming worlds. Their study also concluded that immersion and bleed facilitate changes in bodily states that produce the psychological effects of role-playing – a finding that was confirmed by Lieberoth’s (2013) study identifying brain neuronal networks used in real life were also activated in role-play gaming. These neural networks used to understand stories and other individuals overlap with the experience of immersion (Mar, 2011), such that our cognitive processing of fictional constructs that occurs in TRPG is similar to real-life processes. Thus, their study debunked the notion that role-playing gamers could get irreparably lost in the worlds of their characters, taken over by fantasy and unable to discern between reality and the game. This finding was corroborated by other research which confirmed that immersion did not lead to self-harm, suicide, or depression in players (Hojgaard & Lieberoth, 2015; Wolpert, 2006).

Perhaps of the largest influence was the quantitative case-control study comparing fantasy role players with the general population conducted by Rivers et al. (2016). The study concluded that fantasy role-playing was correlated with high levels of empathy and absorption (the cognitive capacity for involvement in sensory and imaginative experiences), and could boost empathy and socio-emotional competency. The study concluded that RPGs teach empathy and support the emotional and social well-being of players. The results had massive implications in the role-playing community in concluding that TRPGs could likely be used as an effective clinical and therapeutic tool in terms of supporting sociality and social skill development.

Recent studies have confirmed that role-playing games can improve players' creativity, and that TRPG players show improved emotional capacity as a result of game play (Chung, 2012; Karwowski & Soszynski, 2008; Wilson, 2007). A study by Smith (2014) revealed that adult TRPG gamers also benefit from the game in developing a greater sense of self-efficacy as a result of game play, whereas a study by Wright et al. (2020) touted the game's benefits as helping to facilitate enhanced moral development. Additionally, a recent study by Spinelli (2018) conducted with a college support program for Autistic undergraduate students confirmed the findings that TRPG players score higher in measures of creativity and self-efficacy than non-TRPG players, suggesting that TRPGs would have positive effects if implemented in the treatment of Autistic clients.

Much recent research has also revealed the relational and communal ways in which RPGs benefit players in their social and community-based lives. Several studies have found that TRPG games can facilitate social exploration and collaboration among adolescents (Coe, 2017; Daniau,

2016; Goodall & Truong, 2021). A study conducted by Aubrie Adams (2013) explored the ways in which D&D players fulfilled real-world social needs through gaming interactions in-game. In analyzing communication between players, Adams explained that in-game interactions included meaningful and symbolic efforts of players to express their emotions and motives. Several studies have discussed player benefits of role-playing in role-playing games (Kowert & Oldmeadow, 2013; Smith & Renter, 1997; Tresca, 2011) and the role of play as a tool in role-playing games (Fried, 1992; Smith, 2006) for support of social communication, self-esteem, and confidence.

A series of works by Sarah Lynne Bowman studied the ways in which players of RPGs, TRPGs, and LARPs used role-playing games to create community, solve problems, explore identity, and even navigate difficult socio-political dynamics (2010, 2013). In her work, Bowman discusses the many possible educational and therapeutic uses of RPGs as well as the ways in which role-playing already has a pervasive role in academic and professional settings (2013). Similarly, Betz (2011) concluded that RPG players learn through the game the importance of working as a team, and suggested that RPG would provide valuable lessons about risk-management and collective problem solving in the context of psychotherapy. Several other researchers have recently concluded that the positive psychological effects of role-playing games show significant promise for their use as clinical tools with patients of all ages, especially adolescents and young adults (Daniau, 2016; Henrich & Worthington, 2021; Orr et al., 2022;).

This section shows that while research has begun to identify the benefits of role-playing games in the gaming context, there is still much to learn about their benefits in the therapeutic context.

1.3F Clinical Use of TRPGs

In 1994 psychologist Wayne Blackmon published a clinical case study of a client who played D&D, in response to the studies by Simon, DeRenard & Kline, and Ascherman. Blackmon provided weekly individual psychotherapy to a young adult D&D player diagnosed with a schizoid personality structure, utilizing the client's participation in his D&D campaign as a way of analyzing his relational and personality style. The results of this clinical case study concluded that talk therapy including discussion of D&D play was supportive in providing therapeutic benefits for the client, such as increased emotional stability. Blackmon also argued that the consistent structure of the game would preclude the possible risks inherent in existing critiques of fantasy-based therapies – like Acherman's -- and would instead support a safe experience for players. Blackmon's study bolstered the notion that a structured use of the game as an adjunct to individual therapy is recommended for use of the game as a clinical tool.

Since Blackmon's study, research on the clinical use of D&D as well as other TRPGs has slowly been increasing as TRPG therapy has continued to be discussed as a therapeutic modality since 2014. Some of this research has studied the short-term and small-group use of RPGs in a clinical setting, evaluating the observed impact of the therapy on the clients as a way of assessing the treatment impact, efficacy, and outcomes. Most of these studies have been

conducted with children and adolescents, although TRPG therapy is being used with adults as well. Like Blackmon, Raghuraman (2000) published a case study of encouraging an adolescent patient in art therapy to utilize their D&D play in sessions. The study concluded, like Blackmon, that the inclusion of D&D content in therapy allowed for the patient to vent frustration and find control and stability in the midst of diabetic illness.

Enfield (2007) conducted a study with 9 to 11 year old boys in RPG therapy with a gaming system similar to D&D. The therapy focused on issues of impulsivity, ADHD, PTSD and aggression. Reports from the children's home and school revealed that the RPG therapy provided positive outcomes for the child clients, including decreased impulsivity and detention sentences, while experiencing improved communication and social capacity. Similarly, Rosselet and Stauffer (2013) conducted short-term (3-day) RPG therapy with children (ages 8 to 16) evaluated by school psychologists as "academically gifted". After conducting observation notes, the counselors reported that children an improved social interactions, cooperative skills, and emotional self-regulating.

One study by Emma Rose Nathanson (2016) interviewed child clients (ages 10-11 years old), as well as their teachers, about their experiences with Guild Chronicles, a TRPG therapy used as a group intervention in their classrooms. Nathanson used an interpretive-phenomenological analysis, concluding that the students and teachers felt that the TRPG therapy had positive effects on the children's ability to develop social connections and skills. Nathanson related the tendency for children with underdeveloped social skills to be either formally or informally diagnosed as Autistic, and appeared to link her finding that TRPG therapy appeared

to support social skill development to the possibility that Autistic children might be helped and better understood by TRPG therapy.

A recent study conducted by Gutierrez (2017) interviewed clinicians about their use of TRPG in therapy with adolescents. The qualitative study by Gutierrez, a training social worker, analyzed the various ways that D&D was being used in clinical settings and its reportedly positive effects within individual and group therapy. The author recognized that the study interviewed only a small sample of practitioners, and that those interviewed had a particular bias towards use of the game as a clinical tool due to their prior utilization of the game in a clinical setting. Gutierrez's study was the first to focus on clinician perspectives, as they described their reasoning for why they believed the game worked as a clinical tool. His study reveals the importance of clinician perspectives when it comes to therapeutic gaming, not only because of the historic need to shift clinician attitudes towards D&D and role-playing games, but also as a tool for understanding how TRPG operates as a clinical intervention. My study takes inspiration from Gutierrez in that it also interviewed TRPG therapists, however I sought to understand their TRPG practice from an ethnographic lens and with use of video-cued interviewing in order to understand their in vivo clinical reasoning and use of interventions.

A study by Abbott et al. (2022) found that a group of adults with social anxiety and depression volunteered to take part in structured D&D group rather than a regular group therapy because of the reduced pressure to talk about their feelings. This group benefited from improved confidence, comfort with mistake making, and feelings of belonging. This study's findings corroborate anecdotal reports from TRPG therapists who explained that patients were more

likely to participate and benefit from TRPG treatment if it were not framed as being a form of therapy. Additionally, there is some literature on LARP as a psychotherapeutic tool mentioned earlier in this literature review: Fein's 2015 study as well as Atwater and Rowland's journal article about embedding counselors and therapists in LARPing to support the therapeutic experience and gains of players.

The momentum behind the clinical use of TRPGs was the inspiration for this study: with increased nationwide use of TRPGs in treatment settings there is a strong need for research, like this study, that aimed to provide a clear theoretical explanation of the game's psychotherapeutic use from clinician points of view. No study had yet observed TRPG therapy sessions, nor had any study interviewed clinicians about in-game specifics and clinical interventions. Gaining understanding of clinicians' perspectives around TRPG therapy served as an important learning tool for the participants in this study, and has the potential to support the TRPG therapy community at large.

1.3G Theoretical Approaches To TRPG Therapy

The players of D&D, while once pathologized for their game play due to stigmatized mental health features prominent among players, have become the TRPG therapists creating a cultural therapeutic through the development of TRPG as a therapeutic tool. One feature of TRPG therapy is the teaching of intentional community, offering its player-clients the tools with which to find and locate their own gaming communities. Andrew Harris of *The Guild Chronicles*, a TRPG group within Massachusetts General Hospital in Boston, designates part of

the therapy as bringing the player-clients to local comic book and gaming stores in order to introduce them to players outside of the therapeutic group. In this way, the social skills bolstered through the therapy are put into direct action within a cultural setting.

Yet at the same time, TRPG therapists are participating in a medicalized continuum – one which they are aware has greatly harmed and pathologized their player-clients in the past. The Bodhana Group, a TRPG therapy practice in Pennsylvania, explains that oftentimes TRPG therapists do not even refer to their services as “therapy” past the initial intake as it will often steer away clients who have had far too many negative therapeutic experiences. However, as will be discussed in great detail in Chapter 4 of this dissertation, TRPG is therapy: there are intakes, progress notes, and treatment planning. TRPG therapists participate in the diagnostic process and gear treatment towards diagnosis. There are clear dialectical tensions throughout TRPG therapy: client or player, or both; therapist or dungeon-master, or both; Autistic or wizard; or both?

Clinicians come to use TRPG therapy from a variety of theoretical orientations that shape their approach to the practice. As discussed earlier, when it comes to Autism treatment – TRPG therapists are at an intersection between different historical approaches to treatment between psychodynamic and behavioral therapies. More generally, TRPG therapists are also located between two approaches to transformational interactional processes in regard to gaming and psychotherapy: these two theoretical approaches to transformation include different sets of histories and underlying assumptions. The goal of this study is to understand how these different models work and how clinicians use them.

As the literature review shows, with only a few studies available about the clinical use of TRPGs, there has not yet been a single study to discuss the different clinical orientations, perspectives, techniques, and approaches that clinicians use while treating clients – especially clients with ASD. Basically, the question still stands of how TRPG therapists facilitate TRPG therapy and what clinical reasoning they employ to do so. This question is not about treatment efficacy or outcome – but as the Gutierrez study suggests, has to do with clinician beliefs about the value of RPGs, what types of techniques and approaches they use in TRPG therapy, and how they narrate the treatment modality in its use with Autistic clients.

This study aims to explore how TRPG therapists understand TRPG therapy as a growing Autism treatment, situated within a large scope of other psychotherapeutic approaches and orientations. Although there are limited published works on how TRPG draws from various psychotherapeutic modalities, I have spoken to several TRPG clinicians and attended TRPG therapist trainings in which clinicians cite influences from psychodynamic therapies, psychodrama, exposure therapy, and cognitive-behavioral therapy. Adam Harris from Games2Grow (in Seattle, WA), one of the two largest national TRPG clinical groups, explains that the G2G approach draws from a number of traditions including: developmental, relational, narrative, play therapy, and transference-based therapies. The therapist training manual for The Bodhana Group (from Lancaster, PA) the other largest national TRPG clinical group, cites multiple orientations and approaches including psychoanalysis, Dialectical Behavioral Therapy, Exposure Therapy, and developmental approaches to treatment.

While there is much research regarding role-playing as a psychotherapeutic method (Levenson & Hermann, 1991; Yalom & Leczcz, 2008) and its efficacy as a technique, such as in Emotion-Focused Therapy and the practice of Gestalt therapy, how therapeutic interventions work in TRPG therapy is still not well understood. In interviewing RPG players, Sargent (2014) suggests that the therapeutic experience of playing an RPG in a non-therapy setting aligns with psychodynamic theory – specifically citing the relational theory of psychodynamic relational psychotherapist Paul Wachtel (2008) in describing the importance of subjective experiences within a relational context. Bowman (2010) and Blatner (2000) emphasize that the therapeutic method of psychodrama utilizes role-playing exercises as way of supporting clients in their social skills, empathy, and working through of trauma.

To fill this gap in the literature, this study aimed to better understand how TRPG clinicians conceptualize their treatment in the scope of other psychotherapeutic traditions – and from which theoretical orientations and approaches they draw in their practice. The questions of how clinicians formulate and execute clinical decision-making and what information they use to do so is often defined as “clinical reasoning”. Additionally, TRPG therapists use their gaming backgrounds and experience to create the story and character development as the DM/GM to influence the course of TRPG therapy. This study observed TRPG therapy, and interviewed the TRPG therapists regarding the reasoning behind their practice. Subsequent analysis and coding of these interviews revealed different types of reasoning used by TRPG therapists.

Chapter 2: Methodology

Introduction

In this chapter, I will review the various methodological approaches I utilized for this study that operated as a frameworks of principles and ideals from which this research was born. Both the critical disability and ethnographic methodologies employed in this research point to the qualitative nature of this study and the importance of qualitative methods for research on disability. This study sought to observe a very specific understanding of Autism Spectrum Disorders and the utility of TRPG as its treatment from the perspectives of TRPG therapists. As Scott Campbell Brown (2001) discusses in the Handbook of Disability Studies, applied research conducted on or about disability must grapple with what Kuhn (1996) refers to as the “paradigm change” in the natural sciences and take into account both value paradigms (i.e. positivist and constructivist) and the accompanying methodological paradigms (i.e. quantitative and qualitative).

While Brown asserts that quantitative methods assume the underlying positivist value paradigm that there is “the notion of one reality”, disability theorists such as Michael Oliver (1992) and John Rowan (1981) suggest that positivist models are particularly problematic in research on disability in that they assume only one particular definition – often the medical model’s definition – of disability. However, disability theorists argue that the types of data rendered by qualitative methodologies can account for the contextual, cultural, and socially constructed aspects of disability not captured in positivist models (Creswell, 1998; O’Day &

Killeen, 2002). This way of viewing disability and research on disability is active in this study with the hypothesis that the diverse and multiple TRPG therapist understanding of Autism reflect that dynamic, lived and fluid nature of the disability itself. A qualitative methodology also allows for the “interpretive, naturalistic” approach to observing a real-life TRPG treatment (Denzin & Lincoln, 2000).

2.1 Critical Disability Methodology

“The methodology of disability studies as I would define it, then, involves scrutinizing not bodily or mental impairments but the social norms that define particular attributes as impairments, as well as the social conditions that concentrate stigmatized attributes in particular populations.”

(Julie Avril Minich, 2016)

In her 2016 dissertation for Duquesne University, Kathryn Wagner explained the disability studies methodology as having “no singular approach”, but rather is an “interactional model” in which the researcher must think about their relationship to disability and “re-imagine” conventional forms of analysis and access as it pertains to the disabled experience (p. 21). In this project, I am distinctly aware of and perpetually reminded by the ways in which psychotherapeutic treatment and the field of psychology as a whole have repeatedly excluded those with disabilities. Although disabled people are the largest minority in the United States with 19% of American identifying as having a disability, most clinicians report that disability received the least focus in their clinical training as compared with other identity issues such as race or gender (Kemp & Mallinckrodt, 1996). This oversight in clinical training poses

frustrations and questions as to how clinicians, with limited understanding of disability identity and issues, might be able to treat and support disabled clients. Additionally, this omission highlights the lack of nuance and understanding in defining disability, especially as this definition expands to include not only individuals with physical and neurological differences – but also those whose psychiatric diagnoses as a result of personality and mood differences are also qualified by “disability” status in terms of employment, policy, and access.

As mentioned in the previous section, there is much controversy regarding the use of any therapeutic modalities other than behavioral approaches, like ABA. With such little variation in psychotherapeutic treatment approaches for Autistic individuals, the notion of utilizing a psychodynamic treatment approach for Autistic clients has been rebuked in research communities as a non-evidence based approach and has led to scarce reimbursement by insurance companies (Drucker, 2009). For this reason, many disabled people are barred access to non-evidence based therapies due to prohibitive costs. Although TRPG therapy is being used nation-wide by organization such as The Bodhana Group, Wheelhouse Workshop, and Games2Grow, without any research completed yet to provide evidence on treatment outcomes, it is not technically a reimbursable form of therapy just yet – making it an expensive form of treatment that these agencies attempt to supplement through sliding scale fees, grants and scholarships. As my participants detailed in their interviews, much of the way in which TRPG therapists have had to justify this form of treatment to insurance companies is by marketing and facilitating these groups with both evidence-based interventions and outcomes such as cognitive-behavioral and social skills approaches. These realities mirror the very narrow way in which the medical field, and insurance companies by proxy, have traditionally understood psychotherapy

treatment for Autistic populations – and the unique way in which TRPG therapists are potentially disrupting this traditionally rigid perspective of only CBT and social-skills approaches as “evidence-based”. This study also reviewed the ways in which the COVID-19 pandemic and the resulting utilization of tele-health platforms have recently provided additional access to treatment for TRPG players not on either coast – providing more financial access and choice as well.

With these realities being an obstruction to client choice in regard to treatments like TRPG, I am reminded of the societal barriers that constitute the lived identity of disability. I approach this dissertation project with not only a background in Disability Studies, but with a theoretical framework borrowed from Critical Disability Theory and put into application for the use of clinical psychology practice. While holding a position within the medical treatment continuum, we must resist resting solely upon the medical model of disability which views the disabled individual as impaired or in “deficit” – as with the Criterion A of ASD diagnosis. This deficit model denies the socially constructed barriers that co-constitute the experience of being disabled, such as the inaccessibility of treatment modalities.

2.2 Clinical Reasoning

In questioning the clinical reasoning of TRPG therapists, this study borrows from approaches to ethnography and narrative analysis most widely used within occupational research, such as the Clinical Reasoning Study of Cheryl Mattingly and Maureen Fleming (1994). Lawlor and Mattingly (2000) explain that an ethnographic approach with narrative interviewing and narrative analysis is particularly important for understanding the varying beliefs and attitudes

about disabilities, such as Autism Spectrum Conditions, cross-culturally, cross-disciplinarily, and even intra-disciplinarily.

Occupational therapy is a field that was explicitly created to recognize and support what disability theorist Rosemarie Garland-Thomson calls a “misfit” (2011): the interaction of a client with a disability with his/her/their own environment that produces disabling effects¹. To support this “misfit”, occupational therapists design treatment plans that aim to create a sense of “fit” for disabled clients, helping them navigate otherwise inaccessible tasks, situations, and settings with accommodations, modifications, and self-support strategies. Garland-Thomson refers to fit as occurring “when a harmonious, proper, interaction occurs between a particularly shaped and functioning body and the environment that sustains that body”.

Clinical reasoning is the process by which clinicians determine and explain their clinical judgement, decision-making, and approach to treatment by taking into account various clinical traditions, diagnostic information, and expertise (Barrows & Tamblyn, 1980; Toukmanian & Rennie). In this study, the therapists’ clinical reasoning is the process of determining how treatment might produce this experience of “fit” for Autistic clients. Psychotherapy research on clinical reasoning suggests that case conceptualization, which is the therapists’ working diagnostic hypothesis about what “causes precipitates and maintains a person’s psychological, interpersonal, and behavioral difficulties” is a major determinant of the types of treatment goals and interventions that a therapist might use (Betan & Binder, 2010; Ivey, 2006; Levenson &

¹ To be clear here, the term “misfit” is not suggesting that disabled or Autistic people are “misfits” in society or in their environments. The “misfit” does not refer to the individual, it refers to the dynamic and fluid experience of feeling in harmony between body and environment. While an individual may experience a “fit” in one setting, such as TRPG therapy, they might experience a “misfit” in another setting (e.g. a classroom) moments later.

Strupp, 1997). Thus, determining how treatment will create a “fit” requires case conceptualization, as in the identification of the causes of the “misfit”. For this reason, identifying through analysis of interviews how TRPG therapists discuss case conceptualization, diagnosis, treatment, and outcomes alongside one another is important for determining the causal relationships that constitute clinical reasoning.

From ethnographic interviews with occupational therapists, Mattingly and Fleming found several types of clinical reasoning. Alongside “scientific reasoning” (Bruner, 1986)-- defined as the type of clinical reasoning that focused on data, research, and scientific hypothesis formulation that clinicians utilize when deriving diagnosis and planning treatment-- the analysis revealed that there was also a “narrative” reasoning that clinicians used, in which therapists attended to the lived, individual, context-specific, and phenomenological. Mattingly found that therapist “chart talk” (1998), their discussion of diagnosis and pathology, revealed a type of storytelling about the client as well as a storytelling that occurred *with* the client about their lived experience of their disability. Both the therapists’ perspectives and the clients’ perspective played a role in shaping how the therapist came up with a diagnosis – identifying a “misfit” – and the treatment. Mattingly and Fleming’s narrative analysis revealed the different values, beliefs, attitudes, and knowledge base, that factor in when therapists determine what a diagnosis is and what treatment might provide a disabled client the most access to an otherwise inaccessible world.

There is much research on the use of narrative reasoning by medical doctors and professionals (Good & Good, 1980; Hunter, 1991). In this study, as I planned to interview TRPG

therapists about their clinical reasoning – I expected to hear scientific and narrative reasoning to how they conceptualize clients and treatment: drawing from logico-scientific explanations of Autism alongside context-specific and cultural interpretations of diagnosis and treatment. Using a narrative analysis for interviews, I aimed to investigate the causal relationships between diagnosis, treatment, and outcome inherent in clinical reasoning.

Like in occupational therapy, TRPG therapists treating clients on the Autism Spectrum are providing experiences of “fit” through treatment: TRPG therapy encourages the social and communication facilities of Autistic clients, allowing them access to social interactions and communal spaces that they might not otherwise have had. When TRPG therapists observe the non-pervasive nature of Autistic social deficits between treatment room and outside world, I believe that they are inherently noting the “fit” that TRPG treatment and the therapeutic setting provides Autistic clients while in TRPG therapy. Yet I believe that this phenomena is attributable to more than just the notion that TRPG therapists are not observing their Autistic players from a deficit perspective, a la the medical model of disability. Instead, this phenomena of witnessing Autistic players think critically, empathize, and deeply connect amongst others is a reflection of the unique experience of TRPG therapy in which Autistic players have greater access to these sorts of relational experiences – hence a “fit”. This study aims to uncover the clinical reasoning TRPG therapists utilize when considering TRPG therapy as that unique experience and, better yet, a treatment that provides “fit” for Autistic clients: How do they narrate the techniques, practices, beliefs, values, and approaches that they employ in considering the “misfit” that occurs in the world of Autistic clients, and the “fit” that treatment might provide?

Garland-Thomson's notion of "misfit" highlights the very material experience of being disabled in the world as a "dynamic encounter of flesh" (2011)². Her work draws from the phenomenological tradition as she explains that the misfit is a product of lived experience and encounter with the world: thus, disability is not solely embodied in the flesh, nor is it primarily societally or structurally produced. A "fit" is a phenomenal experience, not a bodily modification or a barrier removal. Although Garland-Thomson's work has been taken up by camps devoted to the social model of disability as a call for more just social policies, while that is certainly an important and necessary effort, it is critical to acknowledge that individuals with disabilities may still experience a sense of "misfit" as a product of disability identity that is not removed by virtue of social access via environmental modifications and socio-political change. This reality denotes the embodied sense of disability that disability theorists utilizing phenomenological theory have tried to bring back into the fold (Hughes & Patterson, 2010). Conversely, the same is true of notions aligned more with a medical model of disability: just as the environmental modifications proposed by the social model do not necessarily lead to a phenomenological experience of "fit", psychotherapy proposed by the medical model as aiming to "treat" Autism also does not produce an experience of "fit" by simply modifying Autistic behaviors to make them more neurotypical. Thus, if psychotherapy cannot "fix" or "cure" Autism, what can and does TRPG therapy do?

The answer lies in a deeper interpretation of "fit" as a dynamic experience, rather than as a static solution. Both role-playing and psychotherapy are activities that invite a dynamic interaction and coordination with one's environment. In RPGs, the terms "bleed" or "immersion"

² Garland-Thomson suggests that dynamic experience that occurs in coordination with one's environment produces the phenomenological experience of a "fit". This pairs nicely with the individual-environment and bio-cultural models of disability.

(Lankowski & Jarvela, 2012) are used by gamers and game designers to describe the way RPG players are able to embody their characters and access shared fantasy in group settings. Bowman and Lieberoth (2018) explain, “the act of immersion into a character and a fictional world is psychological at its core” and links the experience to the power of narrative fiction in facilitating players’ development with “experience taking” and “temporarily adopting the emotions and concerns of a fictional character in lieu of one’s own” (Kaufman and Libby, 2012). Role-play theorists note the phenomenological nature of immersion (Pohjola, 2004) as an “altered state of double consciousness” in which players’ sense of self remains intact while they can also experience reality with two frames of understanding (their own and their character’s) and without cognitive dissonance (Hopeametsa, 2008; Saler, 2012; Stenros, 2013). These studies, along with Jarvela and Lankowski’s grounded cognition research, provide a solid psychological argument for why and how role-playing “works” as a phenomenal experience for players as a coordination between brain activity, bodies, sense of self and the physical as well as relational environment – and seems to be a crucial piece in understanding the experience of “fit” in an RPG context. On the other hand, psychotherapy invites a dynamic interaction with one’s environment through intersubjective experiences (Stolorow et al., 2002), and what relational therapists refer to as “mutual coordination of affect (Fosha, 2001)” with others, including the therapist: “the human brain is inherently dyadic and is created through interactive interchanges” (Tronick & Weinberg, 1997).

It is in this way that I believe TRPG therapy provides an experience of “fit” that produces the “disappearance” of Autistic diagnostic features while not removing Autism diagnosis, identity, or symptomatology. To clarify this position further, I do not mean to suggest that the

experience of fit that occurs in TRPG therapy leads to a removal of Autism symptomatology or identity. Rather, I believe that the phenomenal experience of “fit” via TRPG therapy is one that likely provides an inclusion, accessibility, and belonging for Autistic individuals and enhances, rather than diminishes, Autism identity. This powerful result of TRPG therapy is what I had observed in this study, and is what I believe the anecdotes from TRPG therapists in the Introduction are trying to describe.

This study explored how therapists conceptualize their clients’ individual experience of misfit in his/her/their world, by investigating how therapists’ beliefs, attitudes, experience and clinical expertise influence diagnosis and treatment. How the therapist facilitates an experience of “fit” through the therapy was observed in video observation and interview footage: the techniques, approaches, and orientations to the therapy as well as gaming that the therapists refer to. Last, the way in which TRPG therapists discuss therapy outcomes for clients as well as goals for treatment is a way that they theorize what an experience of “fit” might look like for each client.

2.3 Ethnographic Method

Within the framework of a critical disabilities methodology, I used an ethnographic method pioneered by Joseph Tobin et al. (1989) in *Preschool in Three Cultures* called Video-Cued Multivocal Ethnography (also known as “the Pin3C method”) that draws from both focused ethnography and video ethnography. Additionally, because this project is clinical in nature and observed the therapeutic setting as well as address clinical reasoning, I took much inspiration

from the method of clinical ethnography. The term clinical ethnography is often used to mean ethnography conducted with the benefit of clinical training. As a training psychotherapist, this clinical ethnography was conducted with the unique perspective of a clinical psychology background and simultaneously contributed to my own clinical training. As a psychotherapist, teacher, and care provider, I have worked for over 10 years in a variety of settings (schools, camps, clinics, agencies, colleges) with individuals on the Spectrum.

In using ethnography, I aimed to observe the “natural setting” in which the culture of the game play and the culture of the clinical space interact and interweave to inform a clash of dialectics that inform TRPG therapist clinical reasoning in general and specifically around disability and Autism discourse. This study took inspiration from ethnographic research conducted in the fields of psychological and medical anthropology, in which psychologically and clinically significant phenomena – as well as their healing practices and treatments are analyzed from cultural perspectives (Good, 2012; Good & Good, 1980; Csordas, 2002). This study also drew from the compelling ethnographic works in Autism studies about the individual and cultural meaning-making systems through which Autistic lived experience is observed and understood through research (Fein & Rios, 2018; Mattingly & Lawlor, 2000; Ochs & Solomon, 2004; Sterponi & Shankey, 2014).

2.4 Video-Cued Multivocal Ethnography

The Pin3C video-cued method both “collapses and accelerates” the process of traditional ethnographic fieldwork, while still meeting the parameters of what one might call an ethnography. Tobin explains that the video footage serves as the interviewing cue, rather than

data. This method is distinctly compatible with both a clinical and a phenomenological perspective in regard to a psychotherapeutic treatment, as the video method captures the materiality, intercorporeality, and spatiality of the therapy dyad – or, in this case, the group. Video-cued interviewing thus allows the interviewee to observe the material and embodied aspects that are difficult for practitioners to access through mere words and reflection – observing the gaze, posture, facial expression for use as a pedagogical tool.

Pin3C serves as the major source of inspiration for this dissertation: the study observed a school day in three different preschools, used video-cued interviewing to understand the teacher’s perspective, and then used the footage with teacher interview as a laid-over track to show to “Insider’s” – administrators, parents, other teachers both from that school and in other countries. In this way the project created a “multi-vocal” text, garnering the perspectives of multiple parties regarding the same video footage. The finished written study incorporated multivocality in layering the sections of perspectives of the ethnographers, the teachers, the Insiders, as well as Outsiders.

Integral to the Pin3C method, and the multivocal text, was the field notes of the ethnographers as they recorded and reviewed video of the schools. Field notes are a cornerstone to ethnographic research, and supported the Pin3C researchers in cultivating their own account – to be later added to the multivocal text – of what they were observing and experiencing as they collected data. This aspect of the method is crucial to my own project, as I will discuss later my own use of field notes and development of reflexivity in the next section. This method has been modified and expanded by researchers such as Akiko Hayashi and Jennifer Keys Adair, who

have provided valuable guidance regarding filming and editing. However, while these researchers argue for the use of multiple cameras operated by researchers, much of their ethnographic studies have taken place in educational settings. For the purpose of respecting the clinical environment, and the distraction that filming might cause in the therapy room, I had planned to not be in the therapy room while recording was taking place. While I had initially planned to use stationed camcorders in the therapy room for filming the therapy, I ultimately had to utilize the built-in recording features of the Google Hang platform because the therapy was all virtual due to the COVID-19 pandemic. My screen was not shown during the recording, as to create a more naturalistic setting for the observed patients.

The use of videotaping in ethnography has been especially popular for clinical research as it allows for clinicians to view the video recorded materials and reflexively discuss their practice. Joseph Schaeffer (1995) describes the advantages of using video for ethnographic researcher as allowing for coverage of complex activities, such as therapy, in their natural setting and without the direct presence of a researcher in the room. He also explains that the use of video in ethnography allows for “scientific rigor” that can contribute to connections and inferences in the analysis process (Schaeffer, 1995).

For this study I determined that the data was not going to be the actual observation of the T-PRG therapy session as I felt strongly that researcher presence in the room would not be beneficial for the experience of the clients or the therapists – nor would it render the data I was interested in. I wondered whether this structure would still “count” as ethnographic research, if I were not to be observing directly or over an extended period of time. However, researchers that

use the method of video ethnography – as well as the focused ethnographic method– contend that direct observation is not the only way to experience the “natural setting” in order to experience and interpret the culture present.

2.5 Focused Ethnography

With multi-vocal video-cued ethnography as the main method of my research, the influence of focused ethnography plays an important role due to the limited number of sites and participants offering TRPG therapy.

Rather than in systematic ethnographic research where the researcher is often situated for long periods of time within a specific community or location in order to conduct the research, a focused ethnography is a well-suited ethnographic alternative for clinical research due to its selection of events or times specific to the treatment question at hand. Muecke (1994) defines and summarizes focused ethnography with the following:

Focused ethnographies are time-limited exploratory studies within a fairly discrete community or organization. They gather data primarily through selected episodes of participant observation, combined with unstructured and partially structured interviews. The number of key informants is limited; they are usually persons with a store of knowledge and experience relative to the problem or phenomenon of study, rather than persons with whom the ethnographer has developed a close, trusting relationship over time. (p. 199)

A focused ethnography made sense for this study due to several factors. First, although there are a growing number of TRPG therapists, there are still only a few nation-wide located in dispersed areas. I was not attempting to locate and recruit all TRPG therapists, but only the therapists who have practices in which they advertise TRPG as a service. I was also not aiming to observe therapy over a long period of time, but only “selected episodes” of observation – or several sessions within a therapy treatment (Muecke, 1994, pg. 199). The point here is not to have a comprehensive or longitudinal picture of treatment over time, but rather to discuss a small snapshot of how the therapists think, facilitate, and conceptualize within a few sessions. These reasons prevent the need for a long-term deployment of one of these practices. The semi-structured interviews are a snapshot of a specific event, which is the therapy session video-taped.

2.6 Clinical Ethnography

Another ethnographic lens through which this study was conducted is the lens of clinical ethnography. The term was first used by Gilbert Herdt to distinguish clinical ethnography from anthropological ethnography due to the “application of disciplined clinical training to ethnographic problems” (Herdt, 1999). The methodology of clinical ethnography is a perfect fit for the study of TRPG therapy. As a training psychologist, I have a unique understanding of the perspectives used by therapists in their clinical reasoning and can comport this knowledge to make this a clinical ethnography – not an anthropological one.

Clinical psychologist and ethnographer Joseph Calabrese defines clinical ethnography as, “culturally- and clinically- informed self-reflective immersion in worlds of suffering, healing,

and wellbeing to produce data this is of clinical as well as anthropological value” (2013, pg. 51). Through conducting and analyzing interviews as well as participating in social activities, Calabrese explains that clinical ethnography “seeks a dialectical understanding, that encompasses thickly descriptive ethnography, as well as clinical evaluation and interpretation, allowing for some base of clinical competence from which to evaluate what is observed in the field” (2013, pg. 17). For this reason, Calabrese utilizes clinical ethnography as a method for observing dialectical frameworks embedded in our culture – one of which he terms “cultural psychiatry”, which is the “interplay of cultural and psychiatric realities as a focus of interdisciplinary investigation”.

Citing Thomas Kuhn (1970/2012) as the inspiration for the term “paradigm clashes”, Calabrese’s clinical ethnographic method exposes the dialectical frameworks at odds with one another apparent in a study of cultural psychiatry: on the one hand there is the medicalized dialectical framework, and on the other the local cultural framework – both of which convey different meaning-making systems for what constitutes “health” or “suffering” (2013, pg. 14). In Calabrese’s words these dialectics are “(1) the influence of cultural realities on clinical realities and (2) the influence of clinical realities on cultural realities” (2013, pg. 25). In many ways, this tension between local-cultural versus medicalized meaning-making systems mirrors the conflicted definitions of Autism as a diagnosis, and Autism treatment between medicalized and gaming communities.

This study on TRPG therapists’ clinical reasoning assumed in its initial design that TRPG therapists draw from a number of different paradigms in treatment when treating Autistic

individuals. Specifically in the occupational therapy research mentioned in the section on clinical reasoning, there are many different types of reasoning that therapists use when conceptualizing disabled clients as different cultures, societies, as well as medical traditions view disability differently (Lawlor & Mattingly, 2000). As Mattingly and Lawlor emphasize in their research on disability, the way therapists approach diagnosis and treatment are undoubtedly shaped and influenced by both the clinical and the cultural.

Even more importantly, TRPG therapists are not solely acting in the therapist “role”: they are also “role-playing” as the DM/GM. This role requires extensive gaming knowledge and experience, contributing to the ways in which the TRPG therapists design the treatment’s story arc, mechanics, and storytelling. Thus, therapists in the “therapist role” are acting more within the “clinical realities on cultural realities” dialectic Calabrese distinguishes – whereas their role as DM/GM might be more aligned with the way culture impacts the clinical.

Calabrese (2013, pg. 25) also draws from the work of Mattingly and Fleming (1994) on “therapeutic emplotment”, which he explains in his own work investigating the role of clinician in the cultural-therapeutic milieu as “interpretive activity or social application of a preformed cultural narrative placing events into a meaningful story or otherwise supporting, health, for example, by enhancing expectations of recovery or by discouraging unhealthy behaviors”. In therapeutic emplotment, both Calabrese and Mattingly explain that the therapist intimately participates in the narrative structure of the therapy: the diagnosis, the process of therapy, and the outcome. In this study, I invited TRPG therapists to reflect on their therapeutic emplotment by way of discussing the interpretive activities and clinical reasoning they employ when facilitating

therapy as the therapist and designing the story arc of the game as the Game Master. This study's use of narrative analysis aimed to illuminate the narrative reasoning that therapists use when explaining decision-making as GM and as therapist.

2.7 Reflexivity

Incorporating reflexive practice into research is a cornerstone of the ethnographic method. Calabrese notes three different types of reflexivity used in his clinical ethnographic method: psychological or clinical reflexivity, socio-cultural reflexivity, and disciplinary reflexivity (2013, pp. 59). All three of these are important to this study. As a training clinician, I utilized clinical reflexivity as I considered my own approaches to treatment and – as Byron Good discusses – the countertransference as well as my own clinical orientation. As a researcher, socio-cultural reflexivity was also a must for this study as I attempted to hold my able-bodied identity when considering the identities of my therapist-participants and their clients. Disciplinary reflexivity also was important as I considered the multiple contexts in which TRPG has been used, the variety of ideologies, assumptions, and techniques that my therapist-participants hold, and how my own academic identity and/or degree may influence my perceptions in this project. Integrating an intentional reflexive practice into this project supported me as a researcher in helping me to hold my own clinical judgement and reasoning, while also identifying any ableism or countertransference I might be having in the process.

On a more practical level, I also integrated a reflexive practice by engaging with the ethnographic tradition of writing and utilizing field notes. The immersive fieldwork in this

project, as it is both a focused and video ethnography, is the observation of the therapy video and the interview with therapists. During and after observation of the video, I diligently took my own field notes as I gauged and recounted my own reactions, judgements, and clinical reasoning that arise. These field notes, as in Pin3C or Calabrese's project, served a critical role in helping me to note my changing observations and perspectives throughout the project – as well as whatever surprises or challenges might arise. The field notes also helped me to spot any emerging criteria for therapy clip selection in interviews with the recorded therapist, as well as identify emerging material that I incorporated into the semi-structured interviews. The semi-structured interviewing methods of IPR and BSR, discussed in the following section, inherently comprise a degree of researcher reflexivity – as the open-ended nature of the interview guides create room for the unfolding and dynamic responses of both researcher and participant (Larsen et al., 2008; Rennie, 1992).

2.8 Interviewing

The method of multi-vocal video-cued ethnography involves the use of semi-structured interviewing “cued” by video. Just as this method denotes “video-cued”, the aligned interview methods of Interpersonal Process Recall (IPR) and Brief Structured Recall (BSR) call for “video-assisted” strategy. While video-cued interviewing has been utilized in clinical settings such as hospitals, the multi-vocal video-cued has formally only been used in educational settings. For this project then, it is important to discuss and utilize IPR and BSR due to their use in clinical research pertaining specifically to psychotherapy. These interview methods have been especially

useful in studies on clinical supervision aiming to understand the clinical reasoning and techniques used by psychotherapists.

The interview method for the initial interview with the TRPG therapist followed the Interpersonal Process Recall (IPR) strategy developed by Benjamin S. Bloom in 1954 for understanding student thought process and adapted in a more popularly used method by Norman Kagan in 1975 for observing clinician thought process. IPR allows the researcher to ask about the psychotherapeutic process, or clinical reasoning, behind therapist actions and conceptualizations in a session. In this method, participants are interviewed while watching video-tape of a precedent event and asked to discuss what happened. IPR has been a popular clinical research method for research on clinical supervision. The interview takes place immediately following the session or within 48 hours of the session.

Although Bloom's original use of IPR was highly structured, contemporary uses of IPR designated by Kagan's IPR successor, Robert Elliott, rely on a semi-structured interview to give space to the varying content of the videos. The researcher induces a "psychological set" to focus the therapist on specific experiences and perception occurring during the time of the session (Elliott, 1986). Elliott notes that a major limitation of IPR is that the interview is time-consuming with each interview possibly lasting more than three hours depending on the length of the film. Elliott found this limitation so burdensome that he developed a separate method, Brief Structured Recall (BSR), to apply IPR framework to much shorter video data.

Another limitation of IPR that Elliott attempts to correct with BSR is the variability of what constitutes an important moment in the therapy. BSR aims for both therapist and client perspectives to highlight and discern important moments. Before the interview, both I and the TRPG therapist watched clinical footage independently and selected several clinical moments ahead of interview to highlight in our discussion.

Summary

Overall, this chapter reviewed the various methodological approaches at play in this dissertation. Drawing from critical disability methodology, I discussed how the research of occupational therapists, such as Cheryl Mattingly, help orient this dissertation's focus on the clinical reasoning of clinicians working with individuals with disabilities. I also reviewed the various ethnographic methodologies at work in this study, including a more focused, local approach to studying the culture of clinical settings like role-playing game treatments. This chapter also reviewed the video-taping methods used in other ethnographic studies for studying the varying cultural perspectives regarding child development and supportive practices that contribute to the type of research I will be conducting on psychotherapy with Autistic youth. Finally, I discussed the utility of a video-cued interviewing method for eliciting clinician perspectives and clinical reasoning in a naturalistic way.

Chapter 3: Method

Introduction

This chapter describes how I selected my participants, observed TRPG therapy, interviewed the facilitating therapist, utilized ethnographic field notes, transcribed all data from the observations and interviews, and selected video for the multi-vocal text used in the interviews with other TRPG therapists. I will also explain how I coded the transcribed interview data through a program called MAXQDA, and used the qualitative method of narrative-thematic inquiry in order to determine the different themes in the therapists' clinical reasoning and understand the causal relationships in their clinical reasoning.

3.1 Participant Selection Criteria, Recruitment, and Demographics

Participants for this qualitative study met the following criteria: at the time of the interview, they were therapists-in-training or licensed therapists; they were currently and/or had previous experience working with clients on the Autism Spectrum; and they utilized the TRPG modality in their work with these clients.

I conducted recruitment of TRPG therapists and secured four participants. Recruitment took place at TRPG conferences and through professional emails. In recruitment, I assessed whether the TRPG therapists would be willing to conduct the informed consent process for videotaping with their clients within their own practice, and describe the therapy observation and

subsequent interview processes. Throughout this study, I will refer to these participants with pseudonyms (see names in quotation marks below) as to obscure their identities.

Name	Degree/Specialty	Years in Practice	Workplace Setting	Years of TRPG Practice	Years as Gamer
“Beth”	PsyD Clinical Psychology, Children and Adolescents	10+	Private Practice	5+	20+
“Jared”	Master’s in Human Services, Adolescent Sex Offender Specialist	25+	Non-profit organization, mental health services	5+	30+
“Mark”	Master’s in Human Services, Adolescent with Intellectual Disabilities	10+	Non-profit organization, mental health services	4+	20+
“Louis”	PhD Clinical Psychology, Children and Adolescents	10+	Private Practice, Non-profit organization	8+	30+

			mental health services		
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As will be discussed further in this chapter, the first stage of data collection consisted of Beth being video-taped as she facilitated several TRPG sessions and subsequently interviewed following each session. In the second stage of data collection, Jared, Mark and Louis separately watched the recordings of Beth’s sessions and interviews, and discussed their reactions in their respective interviews.

The following characterizes the demographics for this participant population:

- Race: All four participants identify as white
- Gender: Three participants are male-identified, one therapist is female-identified
- Disability: At least one of the participants identifies as having a non-apparent disability, and at least one therapist identifies as neurodivergent without a formal diagnosis. The disability status of the other participants is unknown.
- Education: Two therapists hold a doctoral degree (PsyD or PhD) in Clinical Psychology. The other two therapists hold Master’s level degrees in Human Services.

I am attuned to the distinct implications of these demographics, and the role that these identities might play in this project. As discussed in the section on critical disability methodology, I am aware of the societal structures and power dynamics inherent in the therapist-client dyad especially in which there is a presumed hierarchy between the two of non-disabled therapist and disabled client. As I acknowledged before, I would like to continue to hold

disability identity and neurodiversity on a spectrum – especially as the disability status of two of my participants is currently and might remain unknown throughout the project. The implications of the participant demographics will be further discussed in Chapter 11’s Discussion chapter in conjunction with data analysis in order to fully gauge how these identities interacted with the material of this study.

I chose to observe the TRPG treatment of Beth because she had a private practice and did not work through an organization or agency – allowing for more freedom in the study design and execution. This choice allowed Beth to flexibly conduct consent procedures and schedule sessions. This ease was a great asset to this study, especially when – in the sudden emergence of COVID-19 pandemic– all sessions were switched to tele-health. Due to the pandemic, the overall design of the study had to shift from in-person observation of the TRPG treatment to observation of the treatment while utilizing a secure tele-health platform.

The gaming system that was used in this TRPG therapy was *Dungeons & Dragons* (D&D). The facilitating therapist, Beth, had previously used both D&D and an off-shoot TRPG called “Monster of the Week”. In the switch to virtual tele-therapy, Beth had found Monster of the Week to be a good substitute for D&D over tele-health due to the less heavy planning burden. I collaboratively discussed with Beth whether to continue with the Monster of the Week gaming system or switch back to D&D for the purpose of this study. Beth felt that her clients would be excited to return to their D&D characters and campaign, and went forward with planning a five-week D&D campaign.

The TRPG treatment I observed included five of Beth's clients who had either previously been formally diagnosed with an Autism Spectrum Disorder, or were suspected of being on the Autism Spectrum by their treatment team. For the entirety of this study, the clients will be referred to as "players", with the use of pseudonyms ("Player E", "Player R", "Player S", "Player J", "Player B") to obscure their identities. Three of the clients (Player E, Player R, and Player B) had formal Autism diagnoses, whereas two of the clients (Player J and Player S) were either in the process of Autism evaluation or had suspected Autism diagnoses. According to the facilitating therapist, the clients' presenting concerns according to their individual therapists, caretakers and support teams included a range of issues related to anxiety, social skills, flexibility, attention deficit, sensorimotor needs, and emotion regulation. The age range of the clients were 6th and 7th graders, roughly 11 years old to 13 years old. According to the facilitating therapist, all of the clients were both interested and willing to engage in TRPG treatment and provided consent for treatment at treatment onset.

In preparation for this study, I created all consent procedures for parental consent (see Appendix D) and utilized IRB consent protocol, which Beth then conducted with the clients and their guardians on an individual basis. All clients and their guardians consented to this study and reviewed protocols ahead of time (see Appendix C).

3.2 First Stage Data Collection, Analysis, and Creating the Multi-Vocal Text

This study required two phases of data collection, with data analysis following each phase. The first phase was the observation of a five-week TRPG therapy and subsequent

interviews with Beth. While this observation was initially planned to take place in-person, due to COVID-19 all sessions were conducted using tele-health over Google Hang, the platform chosen by Beth for its security and encryption. The plan before COVID-19 had been to travel to Beth's private practice and set-up a video/audio recording in the therapy room each session. However, with the shift to tele-health I had the opportunity to observe the therapy real-time as a silent observer in each session. This allowed me to both have the in-vivo experience of the treatment as it was happening, as well as have subsequent viewings of the recordings after the session was complete.

3.2A First Stage Data Collection

Observing TRPG Therapy: The observation of Beth's TRPG treatment took place in July 2020 with five sessions lasting until the first week of August, each session taking place on a Wednesday evening. The therapy consisted of weekly 1.5 hour treatment with five players. I observed each session in real-time as a silent participant with both my camera and microphone turned off. While observing, I also recorded both the video and audio from each session using the Google Suite recording tool. After the recording of each session, I shared password-protected access of the observation video with Beth.

Preparing for Interview: Separately, before the subsequent interview after each session, Beth and I watched that week's video observation and selected specific video clips to discuss in our interview – the criteria of this selection is discussed further in the next section. The post-observation viewing before the interview allowed me to take detailed field notes as I observed

the tapes and employed my own clinical and academic reflexivity. These field notes helped me to reflect on what was emerging for me as the researcher throughout the process.

I explained to Beth that although we would select specific clips ahead of time, we would still have an opportunity to watch the entire therapy video together. The criteria for our individual clip selection includes moments of therapeutic intervention, therapeutic interaction, and narrative moments in the session where the therapist must set up the story arc of the game. These criteria served as an initial guideline, and were subject to change based off of any emerging criteria that becomes apparent as the semi-structured interviews reveal what the therapist determines to be relevant. My semi-structured interview questions accounted for these emerging criteria by asking the therapist directly why they chose the clip to discuss.

This step of data collection allowed me to exercise reflexivity as a researcher, as I took detailed ethnographic field notes upon viewing each video. These field notes helped me to track how my observations might be changing throughout this process, and what surprises or challenges to my perspective might arise. As noted earlier in the discussion of ethnographic methods, reflexivity is an integral part of any ethnographic research – especially the video-cued multivocal method – and served as a supportive measure for my understanding of TRPG therapy as I watched as the treatment developed over the course of a campaign. This practice of reflexivity helped me in gauging emerging themes, as well as criteria for clip selection.

Interviewing Beth: After reviewing the tape from each week's session, I virtually met with Beth each week to review the Wednesday night session, oftentimes having our interview on the

following Saturday or Sunday afternoon. There were five interviews with Beth in all. Each interview was three-hours, and consisted of watching video from the session using a semi-structured interview method inspired by ethnographic interviewing as well as IPR and BSR. Both Beth and I selected clips to discuss in our interview. The purpose of the interview was to understand Beth's clinical reasoning, case conceptualization, therapeutic orientation, and decision-making.

In my first interview with Beth, I briefly asked introductory questions regarding her orientation and approach as both a therapist and a game-master. This introduction was meant for collection-gathering for the researcher, as well as to prime Beth for thinking about clinical reasoning. Each interview with Beth consisted of watching the entirety of each video-taped session, and I explained to Beth that both of us are allowed to stop the video at any time for discussion. In the study, I expected to pause at different moments throughout the video to discuss selected clips according to the criteria described in the previous section. When we paused, I led Beth through the semi-structured interview questions (See Appendix A) and Beth was asked to share her clinical reasoning and case conceptualization during the therapy session. I also asked Beth to reflect on why she chose specific clips ahead of the interview to discuss, in order to account for any emerging criteria for clip selection. This video-cued interviewing allowed Beth to share about the intentionality in her clinical practice, as well as her thought process as the Game Master.

3.2B First Stage Thematic Analysis

The first stage of analysis in this study took place directly after the completion of the first stage of data collection, and specifically included a review of the videos and transcripts of the five observed TRPG sessions and the five interviews with Beth. I relied on the transcription support of my three research assistants and I reviewed all of the transcripts of the observations of the TRPG treatment as well as the interviews with Beth.

My primary goal for this first stage of analysis was to identify the common themes present across all five sessions and selected clips from each of the sessions that would correlate to these themes. I also wanted to preserve the narrative structure of both the treatment and of the story arc of the D&D campaign, so I was selective of clips that would adequately convey the treatment as a whole. I distinguished key moments in the therapy according to both the broader themes I observed and the narrative arc of the campaign. There was a lot to consider in what I was aiming to observe in this first stage of analysis. I wanted to look for moments of tension in the therapy which included conflicts among players, as well as points in which the players were stuck. I also wanted to identify moments where the facilitating therapist, Beth, described the components of her approach to treatment and her clinical reasoning. I especially aimed to highlight Beth's major therapeutic interventions and techniques so that they could be discussed with the TRPG therapists. I also selected themes from our interviews that would be most applicable to the topic of Autism diagnosis and treatment. Finally, I had to be mindful of time limitations while choosing what I felt were the most impactful moments for the participants to

view and discuss, as these identified themes would later indicate what clips would be pulled out for the multi-vocal text.

With the goals of this study in mind, I chose to conduct a thematic analysis while utilizing prior research on thematic analysis of psychotherapy sessions with a distinct focus on the “talk” aspect of the “talking cure”. One of the thematic methods of analysis included the extraction of core themes from the sessions and analyzing how these themes developed over the course of several psychotherapy sessions and changed during the sessions (Meier, 2002). Thematic analysis of Beth’s interviews and her narration of clinical reasoning designated her talk as the “narrative” from which I delineated themes in the treatment (Glaser & Strauss, 1967). I utilized Avdi and Georgaca’s (2007) definition of the “narrative” in psychotherapy as the therapist’s “long stretch of talk on a specific talk”. Additionally, I relied on my transcriptions of the observed therapy sessions as well as my ethnographic field notes for additional analysis of what I was remembering from the observations of the treatment as well as considering during my interviewing with Beth. For this portion of the analysis, I took inspiration from the narrative analysis methods of Grafanaki and McLeod (1999, 2002) whose studies analyzed transcriptions of interviews with therapists using Brief Structured Recall (BSR). My study also used BSR for interviewing and eliciting therapeutic narrative of key moments in the therapy and their accompanying clinical reasoning. Overall, my attention to the narrative structure of the treatment – as expressed by the psychotherapist in how she created the story arc of the campaign and described the narrative structure of the five sessions of treatment– contributed to the creation of the multi-vocal text in preserving both the emerging themes from the thematic analysis as well as

the overall narrative structure of the sessions that would come through in the compilation of the tape.

3.2C Creating the Multi-Vocal Text

After these initial themes were identified from the thematic analysis, I selected the aligned clips that best illustrated these themes – as well as the clips that were important to portraying the campaign and story arc. After compiling these clips and undergoing many edits for timing, I sent these clips of the observations and interviews to my video editor, who had a background in psychology research and an academic background to support scholarly study. With the videographer’s assistance, I was able to integrate the selected clips from the treatment observations and interviews with Beth in order to create one “multivocal text”: a tape with clips of the TRPG therapy with the interview of Therapist #1 after each clip. Having the multi-vocal text complete signified the completion of the first stage of data collection and analysis, and ushered in the second stage in which the multi-vocal text would be shown to the other TRPG therapists over the course of a three-hour interview each.

I review the emerging themes of this first stage of thematic analysis in Chapter 5 of this study, where I will discuss the themes that emerged to form the “Multi-Vocal Text” and share my process for selecting the clinical tape of the observations and interviews that would later become the “multi-vocal text” shown to the other interviewed TRPG therapists: Jared, Mark, and Louis.

3.3 Second Stage Data Collection and Analysis

In *A Pre-School in Three Cultures*, researchers developed the method of multi-vocal video-cued ethnography, creating a multi-vocal video text in which classroom teachers discussed video from their classrooms and then this multi-vocal text was viewed by “Outsiders” – the parents, school administrators, and educators from the same country as well as others. Their expertise and knowledge base created a rich secondary perspective on the video footage, weighing in on the choices they heard the classroom teachers describe in the interview audio. In this study, my “Outsiders” are Jared, Mark, and Louis – other TRPG therapists who weighed in on the practices, techniques, and clinical interviewing observed in Beth’s treatment and interviews portrayed in the multi-vocal video. The final step of data collection is bringing the multi-vocal text – the video of Beth’s TRPG sessions with her interview audio – to Jared, Mark, and Louis.

The second stage of data collection included conducting interviews with TRPG therapists, showing them the multi-vocal text, and discerning their perspectives of the observed treatment and Beth’s clinical reasoning as to illuminate how it both aligned and diverged from their own. In this section, I will describe the process of interviewing the TRPG therapists and the various methods I used in analyzing the interview data.

3.3A Second Stage Data Collection

The second stage of data collection included separately interviewing the three other TRPG therapists (Jared, Mark, and Louis) while using the multi-vocal text. While I had initially planned to travel separately to each TRPG therapist for an in-person interview, due to COVID-19 all interviews took place in the virtual platform of Google Hang. Prior to each interview, I performed an informed consent process with each TRPG therapist which all complied with. I also provided each participant with a “Virtual Player Map” with de-identified lay-out of each player’s names in the video so that they could refer to it while watching the multi-vocal text.

Each interview was three-hours and consisted of watching the multi-vocal text as a video-cue. In each interview, I first provided a brief explanation of the study and some background about the therapeutic setting. I also asked each therapist brief introductory questions regarding their orientation and approach as both a therapist and a game-master (See Appendix B). These introductory questions served to not only gather demographic information about each therapist and their practice, but were also used as a strategy to prime each therapist about the aspects of their clinical reasoning.

Using the same semi-structured interview method as described previously, I interviewed each TRPG therapist to discern how they responded to treatment in the multi-vocal text, and how they might conduct treatment in their own practice similarly or differently. Prior to the viewing of each clip from the multi-vocal text, I provided a brief two-sentence summary of what was happening in the treatment so that the TRPG therapists were oriented towards the multi-vocal text. I provided clear instruction to each TRPG therapist that they could signal to pause the clip at any time to ask questions or provide statements, as well as they could wait for the clip to be

over in order to discuss their perspective. At the end of each clip, I initiated the brief-structured interview questions: encouraging the participant to pause and reflect what they are experiencing and observing in the tape – such as clinical techniques, intentional gaming design, and questions.

3.3B Second Stage Data Analysis

In this second stage of data analysis, my research assistants transcribed the second set of interview data from the TRPG therapists. Using these transcriptions, I coded all interview data from Jared, Mark, and Louis in the MAXQDA platform and then revisited Beth's interview data in order to code with emergent themes.

In this section, I will review my evolving approach to data analysis as informed by my ethnographic and critical disability methodologies and introduce my method of narrative-thematic analysis (Bager-Charleson et al., 2018) before explaining my coding and the organization of my results.

This study aimed to observe the clinical reasoning present in TRPG therapy as TRPG therapists conceptualize, plan for, and facilitate TRPG treatment – as well as discern the ways in which other TRPG therapists understand the taped TRPG therapists' clinical reasoning – such as the potentially causal relationships between diagnosis, treatment, and outcome. When first designing this study, I had initially proposed the use of a narrative analysis to identify the causal relationships between conceptualization, treatment, and outcome to understand how these concepts inform clinical reasoning. I was initially drawn to the narrative analysis method of

Cheryl Mattingly and Maureen Fleming (1994), who used narrative analysis in their ethnographic *Clinical Reasoning Study* to distinguish types of clinical reasoning employed by occupational therapists working with disabled clients. I figured that in a qualitative study on the clinical reasoning of psychotherapists when working with disabled clients, Mattingly and Fleming's research would provide a strong guide towards discerning the types of clinical reasoning TRPG therapists utilize when considering TRPG therapy as a treatment that provides what Rosemarie Garland-Thomas calls a "fit" for Autistic clients.

However, I soon realized after my second stage of data collection that a further meditation on "clinical reasoning" as it pertains to psychotherapy research would be important before continuing forward with my plan for data analysis. My initial plan had been to conduct a thematic coding of the interviews with TRPG therapists to discern what Mattingly and Fleming (1994) refer to as the "types" of clinical reasoning and then conduct a separate stage of data analysis using a narrative analysis method to observe the relationships between these thematic "reasoning modes" (Miles & Huberman, 1994). This approach to data analysis had been utilized in an ethnographic study by Carolyn A. Unsworth (2005) in which video observation of occupational therapists was transcribed and analyzed by researchers first with a thematic analysis of therapist clinical reasoning and then with a second phase of analysis to review the patterns and relationships between the reasoning modes identified through the thematic analysis. In the first stage of thematic analysis, Unsworth explained using the "a priori codes" of Mattingly and Fleming (1994) as well as Schell and Cervero (1993) to distinguish the types of clinical reasoning according to their theoretical framework – and that emerging themes, and their codes, would be identified in this second stage of analysis. Her study revealed that therapists utilized

Mattingly and Fleming's reasoning modes of procedural, interactive, and conditional reasoning – as well as a newly identified type of reasoning emerged through the study – generalization reasoning. However, seeing as my study was on the clinical reasoning used in psychotherapy, not occupational therapy, despite being used with disabled patients – I realized that I needed to deliberate further on what my “units of analysis” or “a priori codes” would be in order to discern clinical reasoning of TRPG therapists. This choice point led me to return to the literature on clinical reasoning in order to deliberate my method of analysis.

Discerning “a priori” codes to be used in a thematic analysis necessitated that I revisit what I believed were the components of clinical reasoning in psychotherapy. Rogers (1983) described clinical reasoning as “the thinking that guides practice”, and Schon (1983) was the first to define clinical reasoning both as “tacit knowledge-in-action” as well as technical rationality, or “factually-based scientific problem solving” (Unsworth, 2005). These varying definitions of clinical reasoning as something that is both lived by the clinician “in-action” and through interaction with the patient, as well as something that is factual (i.e., research-based, scientific) gets to the heart of the historical debate in the field of clinical reasoning as well as Mattingly's unique position within that debate which was of the utmost use to this project. The study of clinical reasoning as it pertains to the practice of psychotherapy confronts this dilemma. Betan and Binder (2010) weigh the varying sources of clinical reasoning, noting case conceptualization as one primary skill in clinical reasoning in which a therapist can utilize “analytic” models (Eva, 2004) of clinical reasoning such as utilizing the medical literature to analyze symptoms and draw conclusions about diagnosis as well as “non-analytic” reasoning such as past experience to make sense of a patient's situation (Norman et al., 2007). Ultimately, Betan and Binder (2010) suggest

that this non-analytic clinical reasoning driven by a therapist's experience and expertise is what leads to the "capacity to come to know why an adaptation of an intervention or a unique clinical stance worked" – and referred to Schon's (1983) "reflection in action" to describe this reflexive capacity inherent to clinical reasoning. This experience and "capacity", they argue, is what fuels the therapist's implementation of interventions in treatment that are not only routine or manualized in practice, but also contribute to the therapist's ability to respond with intervention to what arises organically over the course of treatment (Myopoulous & Regehr, 2007).

In her research on occupational therapy and clinical reasoning with disabled patients, Mattingly (1991) argued that Schon's theory of clinical reasoning demonstrated that "accumulated knowledge of a field can never be adequate to provide solutions to all problems presented by clients". Just as Schon suggests that any practice must be inclusive of the theory that "emerges through transactions with the patient", Mattingly delineated a framework for clinical reasoning that would account for the emergent, dynamic content that occurs within the therapeutic interaction between patient and therapist by noting both the narrative and phenomenological aspects of clinical reasoning. Mattingly argued (1991), clinical reasoning with disabled patients must be a phenomenological task in that it attends to the lived experience of a person with a disability – in this way distancing clinical reasoning from the scientific process and locating it within a phenomenological perspective. Mattingly expressed that a phenomenological approach to clinical reasoning was necessary for a person with a disability in that it would provide a "whole person" view of the patient that goes beyond medical diagnosis. To improve clinical reasoning, Mattingly argued that therapists must "take their phenomenological tasks more seriously" by attending to the meaning of disability as it is lived by the patient. This notion

of attending to the types of clinical reasoning that emerge as a product of the lived interaction between patient and therapist led me to revisit my notion of using “a priori” thematic coding, and led me to think more deeply on how to blend a narrative and a thematic process in which the emerging aspects of clinical reasoning of TRPG therapists could be used in my data analysis process. Ultimately, Mattingly’s work suggested that when conducting research on clinical reasoning regarding disability – a different mode of clinical reasoning must be used that goes beyond mechanistic paradigms (such as medical diagnosis) that put constraints on therapist’s decision making. As a result, I reasoned that my thematic coding and thematic analysis would have to venture beyond what I had previously thought were the “types” of clinical reasoning I would find in this study.

To summarize my process of choosing a method for analysis thus far, a reconsideration of Mattingly’s work made me revisit my assumptions about what constitutes clinical reasoning in psychotherapy and in therapy more generally with patients with disabilities, and thus how to conduct a thematic analysis without solely relying on the “a priori” codes for clinical reasoning utilized by Unsworth’s study. Additionally, I was unsure of how to separately conduct a thematic analysis of the “narrative” – identifying the types of clinical reasoning in TRPG therapist “chart talk” – and then separately conduct a “narrative analysis” in which I might understand the narrative structure of this chart talk. This reflected another choice point in my analysis, by which I had to understand how my approach to data analysis figured into the larger literature on clinical reasoning and narrative analysis.

“Narrative research” is the overall umbrella term for research that either attends to narrative structure or utilizes narrative analysis. Much in line with the qualitative methodology and non-positivist accounts of disability I employed in my approach to this study, Bager-Charleson et al. (2019) suggest that narrative research in its use of narrative “distances itself from objectifying, positivist accounts” (Chase, 2005; Riessman, 1993). Narrative research on the psychotherapy process often takes on two separate forms: research that utilizes narrative theory and narrative analysis to study the therapy process, versus research that studies client narratives using qualitative analysis (Avdi & Georgaca, 2007) . In this study, the identified “narrative” is the chart talk of the therapists, not the patients, and I sought to understand the narrative structure of clinical reasoning utilized by TRPG therapists. Mattingly suggested that clinical reasoning accesses the lived meanings of disability in that it is a “narrative”, rather than a scientific process: she referred to the “chart talk” or the clinical reasoning found in the everyday dialogue of clinicians. Mattingly’s (1998) statement that a therapist’s clinical reasoning reframes “a diagnostic mystery into a narrative ones” relates to the notion that clinical reasoning as a narrative is also influenced by cultural interpretation (Kleinman, 1988). This viewpoint combatted the traditional view of clinical reasoning as an applied natural science grounded in some sort of “biological universality”, such that scientific reasoning is restrictive to the clinical reasoning process (Plotkin Amrami, 2022). Instead, a narrative method to clinical reasoning would illuminate the ways in which “illness narratives” are co-constructed between therapist and patient, are derived from specific cultural and personal models (Crossley, 2000; Frank, 1995), and that symptoms are “standardized truths” in local cultural systems (Kleinman, 1988). Mattingly’s perspective on the cultural influence on chart talk contributed greatly to this

ethnography in that I aimed to understand how exactly TRPG therapists understood Autism as a diagnosis laden with specific, cultural meanings relevant to gaming and psychotherapy.

However, I wanted to be mindful of the difference between “narrative” and “narrative analysis”. Avdi and Georgaca warned that most psychotherapy research utilizing narrative analysis tended to only focus on the narratives of the patients and thus tended to ignore the social and cultural domains that result in pathology narratives of patients (McLeod, 2004; White and Epston, 1990). Avdi and Georgaca instead highlighted research in which both therapist and client narratives were analyzed, leading to contextualized and culturally laden analysis. However, in this study I was confronted with the issue of having to analyze multiple “narratives” – not only the narrative of one therapist or patient, but of multiple therapists regarding the same observed treatment. This posed another challenge to conducting both a thematic analysis – to discern types of clinical reasoning - and a narrative analysis to analyze the varying paradigms and dialectics at play in the interactions between these types of reasoning within each of the four therapist narratives.

I decided to follow the guidance of narrative analyst Riessman (1993) who suggested that when many narratives are analyzed and grouped thematically, like in this project, there is a high likelihood of ambiguities and “deviant responses” being lost. This issue got to the heart of my dilemma in wishing to conduct a thematic analysis that would provide a typology of clinical reasoning, but may not consider the emerging and potentially “deviant” aspects of clinical reasoning along the way. I decided that a sacrifice in the ambiguity that might enrich a narrative analysis felt necessary for this study in which there were multiple therapist narratives and a

primary goal of categorizing types of clinical reasoning within those narratives. In the end, I chose to use a “hybrid” method of narrative analysis called “Narrative Thematic Exploration”, also known as narrative thematic inquiry (Bager-Charleson et al., 2019). In a narrative thematic inquiry, the researcher highlights themes both within and across multiple narrative data sets. The themes selected are chosen to “push interpretation along” (Ricoeur, 1981), while simultaneously allowing the researcher to analyze the narrative structure of the participant interviews in a more efficient way than the lengthy method of traditional narrative analysis. While sacrificing ambiguity, narrative thematic inquiry as a form of data analysis “compromises” to combine breadth of narrative data with depth of analysis. This form of inquiry is both guided by a thematic approach (Riessman, 1993) to narrative analysis, while also looking for shared themes in the multiple narrative data sets (Braun & Clarke, 2006).

In summary, I relinquished the original structure of separate thematic and narrative analysis and instead chose a narrative thematic inquiry method. This method, while sacrificing some ambiguity, helped me to identify different aspects of clinical reasoning across multiple therapist narratives while also analyzing the narrative structure of the therapist “chart talk”. In this way, the process of analysis was simultaneous and depth-oriented in efficiently analyzing the twenty-four hours of interview data compiled from the TRPG therapists.

3.3C Types of Clinical Reasoning

The results of my narrative-thematic analysis helped me to identify several categories with which I could thematically code the interview data. Prior to conducting this study, I

experimented with data analysis of anecdotal clinical reasoning from TRPG therapists I had met and discussed their approach to treatment with. In this experimental narrative-thematic analysis, I identified several categories of clinical reasoning in TRPG therapist narratives: Case Conceptualization (i.e., diagnostic language, symptom, personality, player-specific experience), Intervention (i.e. therapeutic techniques and approaches to treatment), and Outcomes (i.e. therapeutic goals, results of treatment). I practiced coding with this experimental thematic system in the coding schema presented in Appendix E.

One of the subtle narrative aspects of this initial thematic analysis and coding was the sort of sequential nature of which clinical reasoning appeared to take shape: conceptualization of the player would next lead to interventions to support the player, which would then result in a therapeutic outcome. This sort of sequential flow in clinical reasoning mirrored the clinical reasoning process in existing psychotherapy literature by which conceptualization drives treatment (Betan & Binder, 2010). In this way, the narrative arc and sequencing of clinical reasoning played a large role in my narrative-thematic analysis.

On the MAXQDA data analysis platform, I first coded each interview for Conceptualization, Interventions, and Outcomes. With further meditation on these initial categories as “a priori” codes to use in my data analysis, I realized that I must consider the aspects of clinical reasoning that emerge through the clinical interaction as well as through the analysis itself. This tension between utilizing codes based upon pre-determined themes and the necessity to account for emerging themes in the analysis gets at the very heart of the decision between a thematic and a narrative approach to data analysis. The themes that emerged over the

course of my data analysis led to a breakdown in each of the previous thematic categories that will be summarized in the following paragraphs:

Conceptualization: I initially set out to use this thematic category as a code for diagnostic language, as well as beliefs and attitudes about Autism Spectrum conditions as the therapists discuss ways in which they conceptualized client symptoms and needs. The aim was to understand how the therapist would understand the client's experience of "misfit", and what factors contribute to their lived experience and diagnostic structure.

Through data analysis, this category split into separate types of conceptualization codes such as "Autism conceptualization" (i.e., Autism-specific symptomatology, DSM diagnostic criteria), "Gaming conceptualization" (i.e. player expertise level, player's character personality), and "Non-specific conceptualization". These separate categories accounted for the varying types of conceptualizations conducted by TRPG therapists as they observed and discussed the varying factors taken into account in their clinical reasoning about individual players.

My initial coding on the MAXQDA rendered different types of "conceptualization". For the purpose of this dissertation's main question regarding Autism conceptualization and treatment, I focused mainly on the data pertaining to Autism conceptualization transferring all of the coded data from this category to a spreadsheet in which I then was able to discern the many different ways TRPG therapists understand and conceptualize ASD as a diagnosis, a way of being in the world with others, or as a personality or type. The results of this section of analysis can be found in Chapter 6 of this study in an entire chapter devoted to unpacking the way in

which TRPG therapists conceptualize Autism Spectrum Diagnosis and represent the different dialectics that offer varying understanding of Autism as a medical entity or social identity, which gets to the heart of this study's use of critical disability theory.

Interventions: In my initial proposal for data analysis in this study, I hypothesized that the interventions discussed by TRPG therapists would inherently present two opposing dialectics in the context of a therapeutic game: the clinical interventions and the gaming interventions. As was discussed in my earlier literature review, there is a gap in the literature on therapeutic role-playing games in discerning the two different types of approaches to transformational interactional processes utilized in this approach: gaming and psychotherapy. This study aimed to distinguish how these two processes functioned at the level of TRPG treatment: how they were sometimes integrated, or were other times at odds with one another. Part of the narrative process of analyzing the intervention category of clinical reasoning data was paying close attention to the ways in which TRPG therapists narrate the interweaving, dichotomizing, or merging of these two different types of approaches to intervention. Thus, my initial coding scheme accounted for this by distinguishing these dialectics as separate codes in the data analysis. I split up coding and analysis into these two sections, teasing out the different dialectics of clinical and therapeutic gaming orientations that the therapists were drawing from while making decisions during each session as the GM.

I want to be intentional about discussing my own reflexive process as a clinical ethnographer while coding and analyzing this data. First, in using the methodology of clinical ethnography I utilized my own clinical training as a psychologist to distinguish the different

therapeutic orientations, schools of thought, and theoretical frameworks the TRPG therapists were discussing. My clinical training at Duquesne University consisted of an existential-phenomenological approach to psychotherapy, with training opportunities in Relational, Attachment-Focused, Psychoanalytic, Humanistic, and Gestalt psychotherapy. I primarily practice from a relational and psychodynamic background, but employ a variety of different therapeutic approaches in a client-centered manner (including Cognitive-Behavioral, Dialectical-Behavioral, etc.) Another psychologist, from another therapeutic background from my own, might have identified and discerned things that I may have not – and in this way, this research is absolutely situated within a specific clinical context, as is expected with a clinical ethnography methodology. I attempted, to the best of my ability, to learn from the TRPG therapists and tease out to what extent their clinical backgrounds were present in their work. I was also thinking about the influence of different cultural dialectics – not only of the dialectical frameworks of the clinical and gaming milieu but also the cultural influences embedded within each. By determining what frameworks are present in this study, and utilizing my own cultural positioning to do so, I am attempting to understand how different theoretical approaches and interventions operate at the level of culture. For example, psychodynamic approach as opposed to a behavioral approach has an entire set of cultural assumptions, attitudes, and histories associated, not only in the Autism community specifically, but more pervasively and globally.

Furthermore, my reflexive process as a clinical ethnographer was immensely helpful for parsing out how I might utilize my background as a psychologist to discern different types of clinical interventions. One likely result of this lens was my observation that TRPG therapists appeared to refer to the clinical and therapeutic aspects of their TRPG practice in either one of

two ways: either by a) reference to a specific clinical tradition or orientation (i.e., Jungian, CBT), or b) by referring to more general therapeutic techniques not aligned to any one specific orientation (i.e. suicide risk assessment, consultation). This emerging distinction led to further differentiation in my analysis: after coding for “Clinical Interventions”, I later analyzed the results of this coding by separating the data into separate spreadsheets for “Theoretical Orientation” or “Therapeutic Technique”. The results of this analysis can be found in the respective chapters in this dissertation, Chapter 7 on theoretical traditions discussed by TRPG therapists, and Chapter 8 on specific clinical interventions.

I would also like to acknowledge that my background is in clinical psychology, and I do not have a background in therapeutic gaming or gaming in general. Because of this, my discussion of gaming interventions was very much a learning process in which I was encountering many of the therapeutic and non-therapeutic gaming techniques for the first time. To the best of my ability, I attempted to account for this learning process by carefully coding the gaming interventions in my data analysis. The results of this section of the analysis can be found in Chapter 9 on gaming interventions.

Outcomes: The coding for outcomes initially sought to identify how therapists narrate the outcomes of treatment, such as the therapeutic goals that are planned and how they are met by clients over the course of therapy. The aim was to understand how the therapist narrates what “fit” would even look like for the client, if they were to experience it in session and in the outside world. Much of this designated coding came from the psychotherapy process research on

psychotherapy outcomes as well as clinical reasoning in delineating the purposes and goals of treatment – as well as if they were achieved by the treatment or not.

Upon further analysis, an emergent category of this coding accounted for “gaming outcomes”, such as the ways in which TRPG therapists aimed for players to grow in their expertise of the game or in their character’s growth arc. There were also some “non-clinical” types of outcomes defined by this coding. Once these emerging codes were utilized, I segregated the results into a separate spreadsheet and identified categories in this coded data as to the different outcomes TRPG therapists sought for players as well as felt were achieved in TRPG treatment. The results of this analysis can be found in Chapter 10.

3.3D Analyzing the Narrative

As was discussed earlier in this section, it felt important to the breadth and depth of this study to simultaneously thematically and narratively analyze the interview data as to account for the narrative structure of the therapist’s clinical reasoning as well as discern how the emergent types of clinical reasoning interacted with one another. Throughout the separate chapters on types of clinical reasoning in this study, my discussion of results describes the types of clinical reasoning as they narratively relate to one another. For example, in a discussion of Autism conceptualization, you will also find discussion of the interventions TRPG therapists described using as a result of that conceptualization. This narrative element speaks to the causal relationship between these types of clinical reasoning, and the sequential way in which this clinical reasoning is narrative in psychotherapy literature at large such that conceptualization

informs treatment. In sum, throughout these chapters that appear thematically organized there is an inherent narrative structure to the clinical reasoning discussed.

However, reminded by the ethnographic method and spirit of this project, I wanted to also create room in my discussion of results for a more in-depth narrative analysis of each TRPG therapist. My interviews with each TRPG therapist rendered an intimate portrayal of their clinical practice, their personal style, and their approach to TRPG treatment. I wanted the ethnographic material in these interviews to come alive, so that each TRPG therapist would feel familiar and distinct throughout my discussion of the results. For this reason, I chose to designate a specific chapter titled “Narrative Vignettes” to introduce each of the TRPG therapists in this study and paint a clearer picture of who they are and what their approach is.

The analysis required for writing this chapter included a more in-depth narrative analysis of each interview, treating each interview set as individual and separate from the others. After the coding had been conducted of the types of clinical reasoning, I reviewed each interview separately – pulling out “chunks” of data in which different codes appeared in relationship to one another and then visually mapped the clinical reasoning of each therapist (Miles & Huberman, 1994). An example of this type of visual mapping can be found in the Appendix F.

This individual narrative analysis of each three-hour interview provided a solution for the debate in my initial analysis dilemma between a strictly narrative approach versus a narrative-thematic inquiry that would allow me to observe and analyze the four distinct interviews together, as discussed earlier in this chapter. In the chapter with narrative vignettes, I describe

each TRPG therapist's distinct approach to TRPG therapy by utilizing their own language and the causal relationships in their specific clinical reasoning. This intimate introduction to each TRPG therapists and the results of this analysis can be found in the following chapter four, Narrative Vignettes.

Chapter 4: Narrative Vignettes

The first goal of this study was to understand the “clinical reasoning” of TRPG therapists. As was described in the Methods chapter, the way in which I analyzed the data aimed to discern thematic and narrative processes of analysis for the interview data. Thematic analysis would render the “what” of clinical reasoning: the conceptualizations, techniques, and approaches that are baked into the way TRPG therapists facilitate treatment. On the other hand, a narrative analysis gets at the “how”: the connections that exist between diagnosis, technique, and outcome – how these interplay in the minds of TRPG therapists as they are working with players. The purpose of interviewing multiple TRPG therapists was that there would inevitably be different clinical reasoning employed by each, by virtue of the fact that they were different clinicians with different backgrounds, experiences, identities, personalities etc.

This chapter is titled “Narrative Vignettes” in that it utilized my narrative analysis of the interview data, as well as my ethnographic field notes, to introduce to you the “key players” of this study: the TRPG therapists themselves. This chapter is meant to give the reader an introduction to each TRPG therapist: their background, their specific brand of clinical reasoning, and the way in which each therapist utilizes the thematic elements of clinical reasoning discerned in the thematic analysis. In the spirit of an ethnographic project, this section is meant to provide the reader with an in-depth feel for each interview and the culture of each TRPG therapist’s practice.

4.1 Beth

My observations of Beth's treatment took place over Google Hang on Wednesdays in the late afternoon. As the players would filter into the virtual therapy room, another box would pop up on the screen of a child's bedroom cluttered with colorful posters and objects, until six boxes (including Beth) appeared on the screen. The visual therapy room was a far cry from the "tabletop" nature of a table-top game: some children were lying with computers on beds, while others were at their desks, in swivel chairs with headsets and a notepad with a pen at their hands. Sometimes dogs or family members would appear visually or auditorily in the background of a screen, and once a pet was incorporated into the game play when Player J's dog appeared and became a "phantom steed". Players would experience technology issues, lags in audio, or sometimes a player would disappear off camera. There were sometimes long pauses in conversation, and other times everyone talking at once. Sometimes players would flash a meme on their screen or show a Youtube video to the group and see the faces in the box react with smiles and laughs. The group chat on the side of the screen would be active with links, jokes, and emojis.

My interviews with Beth looked much the same, two boxes on the screen instead of six, with two voices laughing and reflecting. On each warm summer day, Beth appeared for interview often with a coffee cup in hand in the same room in her home with a Japanese print in the background. Our interviews often followed the same structure of sessions, with a few minutes of "catching up" on each other's weeks and weekends, discussing the summer weather in our respective locations, and some shared sentiments about the state of the world during the

pandemic. Beth alternated seamlessly between playful and pensive, sharing enthusiastically about the players and giggling along the way in one moment and in the next delivering a deeply thoughtful, sophisticated, and impassioned account of how she practices and approaches treatment. Beth frequently provided examples from her personal life, her past experiences with gaming as well as anecdotes that beautifully illustrate aspects of her clinical approach. It was also clear from listening to Beth that a key ingredient to her clinical practice is humility: she refrains from overt interpretation often and appears comfortable with operating from a place of “not knowing” often. Both in her facilitation of treatment and in our interviews, Beth’s comportment was open, warm, and patient: shared silences are comfortable and she allows for moments of interaction to unfold.

As the facilitating therapist for the observed TRPG treatment, Beth had the largest amount of interview data to utilize for narrative analysis. For this reason, the analysis was the most thorough and richest in terms of discerning how Beth conceptualized TRPG treatment and her approach. First, I will provide an overview of how the narrative analysis revealed her approach and then I will offer specific vignettes that exemplify her clinical reasoning.

Beth had a clear line of thinking when it came to how TRPG addressed the “presenting problems” of the players and how these became therapeutic goals. First, she explained that she consults with the player’s individual therapists to understand what the player is coming to treatment for. When considering why the player is in treatment, she explained that the player “is not a problem to be solved” – as in, she does not think about the presenting problem in a way that treatment will “solve” or “fix”. She also referred to some of the individual patient’s

background, or more complex psychological processes as “darker stuff” – for example, one player’s traumatic friendship breakup. Beth explained that she would make note of the “darker stuff”, and felt it was “my job” to notice when a player inevitably brought it into the game play, and figure out ways to subtly weave it into the narrative.

Second, she explained that she does “interpret” some of the referral from the individual therapist in order to figure out how to weave these needs into the campaign story arc so that the player can work on these needs through experiential and narrative interventions later on. She elaborated that these individual client needs, or “goals” become “themes” in the campaign’s narrative. She also explained that she utilizes this information to come up with “overarching goals” for the entire group, and that these more group-specific goals are prioritized over more traditional therapeutic goals like “social skills”.

However, Beth clarified that often it takes getting to know the players well before she can inject their “darker stuff” into the therapeutic game. Before this can happen, she said that the “baseline” of the game is the problem-solving, collaboration and conflict among the players. She repeatedly emphasized problem-solving and group cohesion at the fore of the desired outcomes for the game, utilizing terms such as “co-creation of narrative” and “experiential relationship building” to explain how these relational outcomes are really at the heart of what is seen as individual outcomes for each player.

She elucidated that the player’s “presenting problems” and “long-term goals” are key to the treatment, and are embedded in the therapy and the campaign with an emphasis on

opportunities for experiential and narrative interventions. She described utilizing a combination of approaches to weave player individual goals into the story. In her descriptions, here were some of the ways the analysis revealed the ways she described these interventions.

First, she described experiential interventions as ways to weave in player's "dark stuff" into the campaign so that the player could experience difficult things in a safe, non-immediate with the facilitation of the game mechanics and rules. For example, one of the players had a history of migraines as described by the referral from the player's individual therapist and described that this history had led to the player's discussion in the individual therapy of "a fear of death". When the facilitating therapist noted the player-character's hesitancy to "jump from the tower" – she interpreted this moment as a "projective mechanism" and an opportunity for the player. Similarly, the facilitating therapist described using experiential interventions for players with phobias, such as a needle phobia for one player she worked with. Here is a narrative vignette of the therapist's clinical reasoning:

I think I approach it very much from my kind of child directed play therapy background, ... there's other styles and ways of doing this that has more process and maybe even more meta-process. and I do less of that because I do feel like there's – theoretically -- my play therapy is kids will bring their things and they're much more comfortable dealing with their darker stuff or the scary, you know if you're playing your tolerance for discomfort is so much higher...I do come to this with a very kind of child directed um, you know, approach of like you're gonna, they're gonna go where they need to go and I'm gonna, you know, it's my job to kind of hold the space and trust them. It's really hoping that they're going to bring stuff to the table that is stuff that it's important to them

and my job is to kind of notice it and try to track it and try to weave it in. Um, and for some kids they, that's more obvious than others on where that comes, uh but it's not I don't run it like "We're gonna sit down afterwards and then we're gonna talk about what was the goal, what was the themes?"

In the vignette, she detailed her aim that the players will bring in projected material from their own lives ("the darker stuff") and that her objective as the therapist is to "hold the space" – the therapeutic frame – so that when this projected material comes in, she can track it and weave it into the therapy. In this way, she highlighted that this is a child-directed approach: the player's contribution of projected material is directing the narrative and flow of the game. Another experiential focus of the facilitating therapist was using the TRPG treatment to provide relational experiences for the players. She described interventions tailored to foster "serves and returns", utilizing attachment theory and early childhood development frameworks, to offer the experience of being in relation to others. Beth also repeatedly highlighted the idea of "practice" with these things in the game.

Beth ultimately described the interplay between narrative and these previously mentioned experiential interventions. Her clinical reasoning for these interventions were thus: in TRPG treatment, the player can play in a fantasy world using their imagination, but also gets to co-create the narrative and the world of the game with the other players. The players can have the experience of danger or interactions with things that are difficult in real-life, while also being in a structured and rule-based environment. Her clinical reasoning also repeatedly prioritized a child-directed approach first, with a skills-based approach of modeling and teaching skills

second. She explained that using the campaign's story arc as a narrative tool, as well as the risks and rewards inherent to the game, would be best for teaching skills. She provided the example of how these interventions naturally teach executive functioning skills as "how I would totally market these groups".

Her approach also was repeatedly explained as non-process oriented. She refrained from "overt exploration" or overt processing of individual player difficulties or conflict with the group. She conceptualized the group cohesion as a tool in itself for encouraging this independent or group-directed process, and that when there is a lack of cohesion, the processing doesn't happen as much. For this reason, she continued to emphasize group cohesion and collaboration as the driver of the campaign narrative, likening the group working together to the "spokes on the wheel" with the larger narrative of the game being the wheel itself. When she did lean into a more process-oriented style, Beth emphasized tracking player discomfort and titrating the pressures in the group to support individual player emotional modulation. She explained using gaming interventions such as NPCs and externalizing statements ("What is your character feeling?" vs. "What are you feeling?") to support individual processing. However, she described "backing off" from processing when she could observe it being too much for players. Narrative analysis of Beth's clinical reasoning revealed several critical areas of focus in the way she understood TRPG treatment for children on the Spectrum. There are several areas that emerged in narrative analysis of her clinical reasoning, which correlated with three descriptive questions of why she focused on these aspects in her approach:

4.1A What role does the experience of threat and belonging play in this therapy?

Beth repeatedly emphasized providing experiences of managing threat both individually and as a group in the treatment. She provided these experiences through experiential interventions – such as Player S confronting her fear of death or the group banding together in the final fight. In general, threat – both the collective managing and resolving of it – appear to be a central aspect to role-playing games. In Beth’s perspective, the focus on threat has clear explanation: the experience of threat brings people together. She explained that this phenomenon lends to what she describes as a “macro-goal” for the players: “One of the things I had tagged as kind of the bigger overarching [goal] was promoting a sense of belonging and decreasing any sense of otherness, outsidership”. She explained that she based this goal on the “referral questions”, “diagnosis” and “backgrounds” of these specific player and that she identified a common experience for the group was feeling like “outsiders”: “That is a very common experience for them. Right? That look of like, what’s wrong with you? What’s your problem? And what’s your deal?”

She clarified that offering experiences for the players to feel banded together and on the inside – rather than the outside – of a social group often came through problem-solving as a team in high-risk moments of threat. One example of this was when one of the players was in danger after being attacked by a Cloaker. The facilitating therapist explained that she devised this narrative arc as a way to bring the players together, form group cohesion, and promote a sense of belonging for that particular player as his teammates attempted to save him. Ultimately, the goal of promoting a sense of “belonging” permeated much of the therapist’s interventions. She

explained that her goal “as much as possible” it to “make the game and the group a space where they don’t have as much of that, where they can find a place where it’s like, yeah there is a sense of belonging.”

Using early attachment language and a relational approach, she explained that experiencing a sense of belonging early in life can familiarize children so that they seek out and find belonging later on as adults. In her clinical reasoning, she suggested that providing this experience of belonging in the therapy directly prepares and positions the players to experience belonging elsewhere – which she described as especially important for this clinical population. Here is one sample of a narrative vignette in which the therapist’s clinical reasoning elucidates the previous narrative analysis:

When I wrote this campaign like I did do a page of like what are my big kind of macro themes that I want to think about and what are the kind of, some of the things that I’m trying to, you know tag for each kid and then what am I tagging for each character, and like the idea of character growth. Because like, even if, even if the thing that the character needs to grow isn’t exactly what the kid needs, therapeutic goal is, it’s still something though. Right? What, what is S working on as a human being? Or you know, yeah, he is a human... What is E working on as a character, not as, not as his actual real-life self? Umm, but one of the things that I had tagged as kind of the bigger, overarching part was just, also just, promoting a sense of belonging and a sense of decreasing any sense of otherness, or outsidersness, Umm, and I think of, you know, kind of based on kind of the referral questions, you know and the diagnosis and backgrounds for some of these kids, you know, that is, that is a very common experience for them. Right? That look of like,

what's wrong with you? What's your problem? Umm, what's your deal? And, and, and just so it be just trying as much as possible to make the game and the, the group a space where they don't have to have as much of that. Where there's, where they can find a place where it's like yeah, there's this sense of belonging... cause if you can experience it and you know how it feels then, then, you're going to find it outside in other places. Like, right? You have to know, know how it feels to recognize it when you are in it in other places, and I think that that's also, like an important and important piece of like you can get a felt sense of like this because you are doing this group, you're gonna recognize it later when you're finding a good healthy relationship with someone else hopefully.

Which is, you know, I think throughs back if you know you're just talking about therapy in generally, and the way I work kind of connects to attachment theory. Right? Which is like, your attachment relationships can, can role with you your whole life. Umm, but the experience of one healthy attachment in a life, an early childhood event can make all the difference as to whether you end up sinking or swimming, so.. So, I think that's umm, that's another real important therapeutic value of like if you, if the kids can get that cohesion. Umm, which, you know, you get from learning serves and returns. Right?

Serve and return I think is like an early childhood attachment language actually, I think I stole it from like Harvard Center for the Developing Child had a big, you know, splashy campaign on that last year and I've, I've continued to use that, cause I think it's super useful... That's how they've been seen by other people. So, for them to be able to feel seen by each other, I think that that's important, and yeah.

4.1B Why is fantasy important to this treatment?

“Imaginal experience is important, is related to real experience. Right?

Like I think that yeah, that is the other piece of like it may be a fantasy,

but you watch a movie and your heart beats faster. right?

And like that piece of like experiencing it does something for you

and teaches you things about yourself...” (Beth)

When describing the developmental aims and clinical importance of TRPG treatment, the element of fantasy was often discussed as critical to Beth’s approach. Fantasy was a sustained focus in her clinical reasoning of why the treatment “worked” for these patients, and how she saw it working. She stated that “imaginal experience is important”, as she explained why she uses experiential and somatic interventions that encourage players to use their imagination and observe the experiences they feel in their bodies as to make it feel more real. Part of doing this helps players utilize their imagination to access elements of the “fantasy” of the gaming world. One example she offered to players was the experience of watching a movie as a way of understanding entering the fantasy space: even though one is not actually experiencing what is happening in the movie, we can use our imaginations to feel as if we are and we can notice our bodies responding with accelerated heartbeat. Ultimately, she explains that this experience has direct outcomes: we can learn about ourselves, and how we experience things. This was one of the ways in which she connected the importance of experiencing fantasy to the therapeutic outcomes of the TRPG treatment.

Additionally, the therapist expounded on why fantasy-based therapy might be supportive for players on the Spectrum in particular. One aspect of TRPG play that the therapist repeatedly noticed in the observations was when players would engage in “meta-gaming”: a phrase common in the TRPG community for when players break out of character to discuss game mechanics (i.e., rules), or talk about aspects of the gaming world or things outside of the gaming world in a way that their character would not know about. Meta-gaming, and how much to allow or discourage it, is a hot topic in the TRPG community both in therapeutic and non-therapeutic settings. Breaking character means breaking immersion in the game – and immersion has significant implications for both gaming and therapeutic outcomes. By temporarily exiting the fantasy world and space, players risk losing opportunities for role-play, group cohesion, and may jeopardize other players’ immersion.

Each of the TRPG therapists spoke about reasons to encourage or limit meta-gaming with players on the Spectrum in particular. Mark mentioned that encouraging it could be helpful for players who are overwhelmed and need a moment to break character, while Jared and Louis explained that limiting meta-gaming would be important for players who struggle with self-awareness and might hog the microphone from other players.

Beth had a different approach to meta-gaming: instead of describing how this might negatively affect players on the Spectrum with their immersion in the fantasy world, she explained that she understood meta-gaming as a way of differently engaging with the fantasy space. One example of this was in response to a clip from the TRPG treatment in which one player, Player S, is “lecturing” to the other players about the Cloakers (i.e., monsters) that they

just encountered. While in character, he refers to his memories of learning about the Cloakers from another player in a previous TRPG campaign. However, while doing this he is also referencing knowledge from the Dungeons & Dragons Monster Manual – the player handbook with rules of the game. Beth noticed that while S was attempting to do so in character, he was still technically “meta-gaming”. However, Beth explained her approach to letting him do so by saying, “I let them run with their [fantasy-based] knowledge.” She further elaborated her clinical reasoning for this intervention by explaining why it is beneficial for children on the Spectrum to “run with” the knowledge they have:

Children on the Spectrum are literally shut down constantly for talking about the things that they’re interested in... because it bores adults, or its not on topic, or its you’re doing that too much, we can’t talk about Pokemon for twenty-five minutes straight without letting someone else say something. And yes, there are certain, there’s places there, but then there’s also like imagine going through life not being able to talk about the things that really get you excited, because every time you do, someone is trying to teach you how to be a more, like how to be a better speaker, a better communicator, or a better listener. And I think that, you know when I work with kids on the spectrum, if there’s a perseverative interest, I’m there. I’m not, you know, like I will talk to you... You’re like stuffing it all day long no wonder you’re like putting your head on the desk and not talking to people and when you get frustrated, you’ve got no room and you never get a chance, so. Yeah, we will talk about this thing that you love.

Umm, and so that's I think also a place where I don't shut down metagaming necessarily, the way a regular DM might, is also because I know that these kids really, really get, they're proud of what they know about this, whether it's, whether it is a Spectrum-y made perseverance, which I'm not, I don't know if that's really what it is for them, but there is also something about, you have pride that you have read this and that you know this information, and that like, and it excites you. So, who am I to like tell you, "No, don't use that, don't talk about that. We're not doing that." Like, so, you know, they can do both, I think. And that I think, it really important. Therapy GM hat, kind of meta-comment too.

Here Beth explained that whether it is talking about Pokemon or animals, children on the Spectrum often "get shut down" for talking about the things they are interested in. She explained that whether or not these interests, or S's meta-gaming, are "perseverative interests" – she approaches the TRPG treatment as a way to encourage players to talk about things they have knowledge about and feel proud of. She also acknowledged that this approach is in direct conflict with much of the approach that can be found in classrooms or at home, where many children on the Spectrum are counseled to "be a better speaker, a better communicator or a better listener" by not discussing these interests in a way that might be deemed impolite or non-self aware. In this way, Beth made the choice to encourage meta-gaming and discussion of fantasy-based knowledge, as a way of supporting players with engaging in the fantasy space.

4.1C Why use a non-directive and humanistic child-therapy approach
for children on the Spectrum?

Throughout the treatment, Beth extolled a non-directive approach to TRPG therapy – and many of the interviewed TRPG therapists commented on this unique aspect of her work as a facilitator. Specifically, Beth discussed non-directive play therapy – a play therapy tradition that prioritizes child preferences for play over therapist selection of toys, guidance of play, or explicit interpretation of the play. Many of the interviewed therapists especially noted Beth’s “hands-off” way of navigating conflict among the players. However, part of the reason why this theme was such a critical aspect of her clinical reasoning has to do with the nature of TRPG itself. In its most basic format, TRPG is a game with a group of players and a Game Master, in this case a therapist. By the very nature of its design, a TRPG has some direction from the Game Master who creates the campaign’s story arc and directs the players’ use of game mechanics. In its essence, TRPG players have a lot of direction and guidance. So for this reason alone, it is interesting to discuss ways in which any TRPG – including TRPG as therapy and treatment – could be “non-directive”.

In utilizing a non-directive play therapy approach to the TRPG treatment, Beth explained that “a certain amount of faith in the process” is foundational to non-directive therapy. One example of relying on faith in the process occurred when the therapist was responding to moments of conflict between players in the therapy and, specifically, the players’ ambivalence to take up opportunities to process the conflict with each other despite multiple gentle and semi-directive interventions from Beth to do so. She explained that she had faith that over time the

players would find their own ways to address the conflict: “I do have faith that when you do it for enough times over a certain amount of time the stuff that they need to get out, either between each other or with me will come into it and they'll bring it, and they'll show it to you, and they'll work on it.” She elaborated that sometimes when she tries to direct players too intently, whether towards processing conflict or otherwise, she notes that it doesn't work. This observation, she explained, has led her to adopt a more non-directive approach – which she likened not only to non-directive play therapy, but also to the Humanistic therapy tradition. She explained that by engaging in non-direction and allowing the players to independently direct the play and conflict processes on their own terms, she felt this was facilitating “an innate drive to self-actualization”. She defined this concept as “People, given the space and acceptance and the safety, will find their way into the space that they need to be their best person.”

Beth further described in her clinical reasoning why this non-directive and humanistic approach would be useful for the players on the Spectrum and in her TRPG treatment. She explained that a humanistic approach is key to her practice in her general, but for children on the Spectrum it was particularly crucial because of their experience in the world outside of therapy:

A lot of these kids get told how they should be and what they should think and what they should, or how they should, deal with their feelings. They get a lot of, ‘Don't do that, don't do it this way, don't, don't,’ you know? And they don't know who they are yet, you know, they know who they are but they don't, right? And so there's that space of like, you like this, you wanna do this, you wanna play that... what is the world telling you about who you are and to have a space where you can just try something on and see how

it fits and then discard it if it doesn't. I think that, you know, that's part of that finding it and having it be – no one's going to necessarily peg you in this certain way. It doesn't, you know, it doesn't have to be permanent. And I think the capacity for kids to just be who they are, is so limited in so many environments that they are in all the time.

This statement is similar to the above section in which Beth encouraged meta-gaming and fantasy engagement as a way of combatting the “limited” environments and the ways within them in which children on the Spectrum are “shut down” for having perseverative interests or acting in non-neurotypical ways. Here Beth expands this contrast such that the therapy is a space that not only encourages neurodiverse expression but also exploration outside of instruction of “what they should think” and “how they should deal with their feelings”. In her clinical reasoning, a non-directive approach – non-direction of how players should think, act or feel, is a humanistic approach in that it is aimed at player “self-actualization, in this case in that it allows neurodivergent players to be self-directed towards their interests and identity, rather than directed by others. This reasoning also leads to an expansion of identity, as it appears that Beth argues that this encouragement enables players to find their own identity and not be “pegged” in a certain way.

Furthermore, Beth contrasted her humanistic approach with more classically behavioral approaches that are upheld in the “public service” and “public health” approaches, which she describes as mainly oriented towards treatment of early symptoms during childhood. In these approaches, she describes that clinicians are “wrapped up in how do I order this sequence of approaches” rather than “responding to the child as who they are”. Paired with her clinical

reasoning around encouraging identity exploration for children on the Spectrum, this notion that clinicians must prioritize responding to the unique nature and identities of each player – rather than merely on symptom treatment or behavioral modification – is a hallmark of her approach to TRPG treatment and therapy in general. She further explained that a humanistic approach provides children the space “where they can just feel seen and heard and safe to talk about their own experience because it makes life less stressful right now”, as opposed to the position that therapy must treat symptoms early so that adult life can be less stressful. She explained that she saw this as the primary goal of treatment, regardless of whether symptoms persist or worsen, because “children deserve a good life while they’re children too”. She provided the example of when she has worked with children struggling with behavioral outbursts, or fits, and describing her approach to working with these children and their parents:

When I work with parents and their kids are having a fit or they’re acting out, the first thing I often say is like, ‘In that moment, yeah, your brain is like, what’s he going to be like when he’s 12? What’s he going to be like when he’s 20? But that’s not going to help you respond to him right now, and what he needs is you to respond to him right now.

She emphasized the importance of responding to children as they are in the present moment: prioritizing their present needs and their present identity versus fixating on symptom persistence, diagnostic categories, or difficulties that may arise later in life. This approach is specifically beneficial, she explains, for children on the Spectrum whose difficulties are often categorized symptomatically and diagnostically as neurodiverse and thus treatment fixates on these aspects

too – rather than on what Beth deems as more important: who the player is, their interests, and their unique experience.

4.2 Jared

At our interview, Jared appeared on screen looking ready for a game: with his headset on, sitting in his swivel gaming chair in his home office. Boxed games and toys were on shelves in the background, and he was wearing a colorful shirt that lightens up the shade-dimmed room as he pulls several bright sports drinks out of a plastic bag. With his boyish enthusiasm and the melodic voice of a cartoon character, Jared’s comportment and the scene of his office gave the impression that he simultaneously role-plays as adult TRPG therapist and kid player. He appeared excited to discuss the recent developments in his therapeutic gaming organization in the first few minutes of our interview before getting started. Yet as soon as it was time to start reviewing the clinical tape, Jared put on a laser-like focus – setting up his desk intentionally so that he could diligently note-take as he viewed the multi-vocal text.

Jared speaks with authoritative presence, with the clarity of clinical practice evident of a seasoned therapist. He referred to his notes often, and catches micro-moments of player’s non-verbal gestures which he describes as he refers to each one by name. It was clear that he was not only deeply attuned to the players in the observed treatment – referring to each of their “behavioral markers”, but he was also very focused on Beth’s every move. With his hands folded in front of him like the Buddha statue on a shelf behind him, Jared embodied the stance of a TRPG elder as he discusses his perspective of the treatment and Beth’s interventions with an eye

for supervision and feedback for Beth. His responses to the clinical tape showed an almost mechanical, calculated method of clinical reasoning – if X happens in the treatment, do Y. He was extremely observant of Beth’s stylistic choices in treatment, and noted the various ways her “non-directive” approach differed from his own – holding the various moments of tension in Beth’s choices versus what Jared would do in his own treatment. Jared’s austere expert-level feedback is balanced with his immense sense of humor, as he narrates and intuits player’s internal worlds (“[Player R] didn’t want to process, he was like, get me the f*ck out!”) and shares therapist jokes (“The artist formerly known as Asperger’s”).

Overall, Jared’s approach to TRPG treatment focused specifically on directive, skills-based approaches for Autistic players. Like Beth, much of his clinical reasoning for interventions centered specifically on how the modality worked for players on the Spectrum – specifically mentioning the directive nature of the intervention as particularly supportive. He referred to this tension in many ways: non-process vs. process, reflective vs. descriptive, guided vs. non-guided. He also referred to the “intentionality” of the facilitating therapist, as a way of denoting more directive interventions. However, he was extremely adept at interweaving many different clinical frameworks, despite primarily identifying as a CBT therapist. Much of his observations about the TRPG treatment were concerned with weighing the benefits of Beth’s more non-directive stance against his own preference for directive interventions. Ultimately, as this section will show, Jared’s weighing of these two approaches lent to masterful explanations of how to balance and integrate these two perspectives – and the pros and cons of each.

“Again, that’s probably one of the biggest questions about the whole [TRPG] process because you never want to force it, because then again you’re dominating” (Jared)

Jared’ statement, above, encapsulates the major tension described by each of the TRPG therapists. While Jared repeatedly noted the “hands-off” approach of Beth, Jared’s statement that “you never want to force it” directly contrasts Louis’s approach of “forcing a narrative” or “forcing a conversation”. These conflicting ways of supporting players through interpersonal conflict or difficult moments in the therapy point to the varying ways that TRPG therapists view their role as game master – with Jared here, explaining his wish to refrain from “dominating” the game. Jared repeatedly referred to his interventions as “gentle”, such as “the art of gentle confrontation”, and described the delicate practice of performing interventions in the game space with finesse.

One of the subtle dichotomies between non-directive and directive approaches that he presented in his clinical reasoning was the difference between what he called “descriptive” and “reflective” interventions:

Basically descriptive is when you set the stage and describes player actions and the results from rolls. Reflective is when you have the players describe it. Reflective means that the description is reflective of viewpoints, issues and essentially projections from the player, giving you insight into the player's mind and experience via their engagement. Descriptive is typically for players who might be new to role-playing or

players that have difficulty with more abstract thinking. They need it. You can and should switch between both.

The above quote reveals the way in which conceptualization of players – both his conceptualization of the players’ gaming expertise as well as diagnostic conceptualization – fuel his clinical reasoning as to use descriptive or reflective interventions, as well as his suggestion that a therapist “can and should” utilize both in order to encourage therapeutic engagement as well as player engagement – interweaving these two dialects of game and therapy. Whereas descriptive interventions serve as a more therapist-directed intervention for guiding and directing players’ responses especially in the case of players’ emotional recognition and emotional management, Jared explains that reflective interventions such as open-ended question help elicit player feedback that drives the game in a client-directed form. Jared further explained that this dialectical weaving of descriptive and reflective, as well as non-directive and directive, is “not a tension, it’s a constant concert between the two: you are getting information, you are getting therapeutic narrative, you’re getting stuff to go into the game.” Again, Jared describes using his conceptualization of the player’s needs to drive which intervention is used and when: “How much help the player needs determines whether you need reflective or descriptive [interventions]”. This approach mirrored the developmental interventions used by Louis, and the focus on a client-centered approach used by Mark, in order to meet the player where they are at and present scaffolds accordingly.

“You stretch the game to fit the therapy. You don’t stretch the therapy to fit the game” (Jared)

The above quote of Jared’s clinical reasoning will reappear throughout this study many times, as it so aptly describes the way in which therapeutic gaming works. Jared explained time

and time again the way in which the therapeutic game works to account for the client's goals and is tailored to the specific player's experience, rather than the clients having to stretch themselves to make the game work. With one of the focuses of this study being the critical disability methodology of Rosemarie Garland-Thomson's idea of "fit" – it is remarkable that this quote from Jared appears to respond exactly to this concept. Instead of the Autistic player being "stretched" or pushed to fit the therapy or the environment, much like in the way that mainstream Autism psychotherapy encourages neurotypicality – the game of the TRPG treatment is "stretched" to "fit" the therapy and the client by accounting for the individual experience and history of each player. As will be discussed in the Discussion chapter, this quote accounts for the emerging shift in the field of Autism psychotherapy in which therapeutic modalities are being more and more tailored towards individual clients and matched developmental interventions.

Like Beth, Jared described clinical interventions that would acknowledge and highlight the growth of individual players – such as private one-on-one check-ins as well as public praise. His clinical reasoning for this also mirrored Beth's in describing the importance of "feeling seen" especially for players on the Autism Spectrum who often do not feel seen in a positive light.

However, there were ways in which Jared's clinical reasoning utilized the language of more mainstream Autism psychotherapy, such as "behavior" or "skills", but ultimately used in very different ways. One of the ways that Jared focused on player experience was an extreme attention to player comportment, non-verbal gestures, embodiment, eye contact, and micro moments of interactions. He frequently called upon his behavioral background in noting "behavioral markers" of the players, such as a marker of distress or anxiety, and used these to calibrate his suggestion of interventions. This approach signified the way in which he used a client-centered and developmental method of using conceptualization to drive scaffolding

interventions to meet the players where they were at. Additionally, these “behavioral markers” were not always diagnostic or symptomological – they were more attuned to the specific player’s personality and tendencies. In this way, what he referred to as “behavior” really encapsulated far more than just that.

Additionally, though he repeatedly discussed “skills” and identified moments in the observed treatment where the game could be paused for “skill instruction” – such as coping skills or social skills – there were also many instances in which Jared seemed to point to the organic skill-building process that would occur experientially in the treatment. While in some moments there was advocacy for skill instruction, in others he seemed to note the self-generated skill building that players would autonomously acquire through interaction with others.

Jared frequently postulated interventions as specific to Autistic players, focusing heavily on the clinical and symptom-related outcomes of TRPG treatment. He spoke about the importance of the treatment in “increasing” emotional expression, communication, and social skills as well as improving critical thinking and reflective capacity. Yet he also spoke about much of these “improvements” happening organically through the development of group interactions and cohesion among players. He explained that by being a part of the group and collectively building the group’s “norms” and culture, players would learn naturally how to “rely on each other”. In this way, part of what he credits the TRPG treatment with doing is helping the players feel a reliable sense of belonging - which Beth also advocates for in treatment.

4.3 Mark

Mark appeared on screen wearing a Batman t-shirt and emanating the calm, quiet presence of an eager and open young therapist. He speaks with a low and slow cadence and in our interview he waited patiently for each clip of the observed treatment to be come to completion before gingerly chiming in with his thoughts. He often spoke in the second voice while recalling aspects of his own experiences as a player in games (“you have to respect your fellow players”). During our interview, he was in a room with boxes overflowing with books and shelves piled high with large textbooks: his environment mirroring what appears to be his stage of professional development. He humbly referred to his own work-in-progress as a TRPG therapist, discussing his own studies of particular theoretical frameworks and denoting specific clinical terminology as if to “back up” his thoughts. Perhaps due to his young age or his earlier stage of training as a therapist, Mark appeared to be deeply attuned with the internal worlds of the players as he intimated what each might be experiencing in their own development as novice D&D players. Much of his clinical reasoning, both conceptualization and intervention, attended to the players’ experience as players – how they are navigating the game’s world and mechanics, as well as what gaming interventions might support them. He also reacted to interactions between the players, the ways in which the players respond – or sometimes don’t respond – to each other. This focus was reflected in his emphasis on the relational aspects of the clinical work, as he repeatedly noticed moments of collaboration, learning, or peer modeling.

“A moment to shine... that’s what makes [TRPG] fun!” (Mark)

As a CBT therapist, Mark explained that many of his interventions in TRPG therapy rely on a behavioral approach but that he often thinks about real-life applications of the therapeutic space. He spoke often in his interview about building “life skills” in the treatment, and repeatedly notes his “client-centered” approach in wanting what happens for each player in the treatment to have positive effects on that player’s life outside of the treatment. Mark did not focus as much as the other TRPG therapists on Autistic symptoms or clinical definitions of Autism, and instead his conceptualizations appeared to be far more driven by individual player’s experiences. This client-centered approach resounds through his discussion of “strength-based” interventions that aim to promote players’ self-advocacy, confidence, and sense of self. He repeatedly described his goal of fostering a sense of “pride” and “ability” in players, reasoning that this was extremely important for players on the Autism Spectrum to feel while in treatment. Much of the interventions he proposed that accomplish this included “spotlighting” certain players by giving each a chance to shine in the treatment. His clinical reasoning here was that by focusing on individual players in the group treatment, interventions can be tailored to foster individual growth. To me, Mark’s approach appeared to be focused on de-pathologizing the experience of Autistic players, with a psychotherapeutic lens that resembles disability-affirming psychotherapy.

One example of how he does this, he explained, is by building very intentional moments of client-specific challenges in the game by using his conceptualization of the players. For example, for a player with “impulse control issues”, Mark had the player encounter a whirlpool in the game in which the player had to learn how to “act instead of react”. Pulling from behavioral psychotherapy, Mark described the cultivation of behavioral skills through experience

in the gaming world. This example also reflected Mark's strong emphasis on gaming interventions in his clinical reasoning. He frequently referred to his GM-ing techniques as the main method for garnering player engagement, and explains the priority on first engaging players before providing the therapeutic experience. The notion of engagement repeatedly came up in Mark's clinical reasoning, and appeared to be a hallmark of his approach to TRPG treatment in that he explained engagement was the primary ingredient for the shared fantasy space of the game. Mark repeatedly stressed the importance of players' immersion in the story and in the game, and paired this with the notion of "little wins" and successes in that these opportunities for "a win" are only made meaningful if the players are fully immersed in the game.

Another example was Mark's "dirty little GM secret", in which he used the first moments of each session to ask players about the previous week and garner implicit feedback about the aspects of the game that they liked that he should implement more of. By eliciting player feedback in this way, Mark explained that he as the therapist could then utilize player's input for the world-building in the game. He elaborated that this was a critical outcome for players, especially players on the Spectrum, in that it gives players a "sense of ownership of the world".

"Fellow players were trying to encourage her through it, not saying, oh that's stupid, and it's the whole, yeah, it's scary but it will be okay." (Mark)

However despite the focus on individual players, Mark also was the TRPG therapist who most privileged relational outcomes of the TRPG treatment. In addition to players' feeling an individual sense of ownership in the gaming world, he also repeatedly referred to "collaborative

world building” as a way for players to build connection between each other, share the spotlight, and build comfort with one another. Mark stated that his primary goal of the treatment was to help players build trust, rapport, and collaboration with one another. He was especially observant of moments in the taped clinical treatment where players encouraged one another, noting these as relational “successes” especially for players on the Autism Spectrum who may not experience those successes outside of the game. One of the ways Mark described interventions in the game tailored towards relational outcomes was providing players with the “experiences of failure and collaboration”. He explained that it was through these experiences that the players would come to understand what it is like to be in relation to others – experiencing both the success of a full circle of communication in which there is reciprocated rapport, as well as the failure of what happens when the rapport is not complete. Ultimately, Mark commented on aspects of the observed treatment where players were able to problem-solve, collaboratively plan together, and have strong moments of teamwork. He also pointed to the relational gains made by players in advocating for each other and helping each other – relating these to the individual moments of self-growth, in which players not only learned how to build themselves up, but build up others as well.

4.4 Louis

In his first few moments on screen, it was abundantly clear how energetic, enthusiastic, and engaged Louis is while he sat in what is clearly a professional office with both degrees and certificates on the walls as well as gaming posters (including one large World of Warcraft one visible in the background). He passionately shared with me about a new training program for therapeutic DMs that he is running, and the atmosphere in his office was one of a clinical

practice that is booming and buzzing – with our interview being interrupted with exciting phone calls and emails from players. With the comfort of a seasoned therapist, Louis managed to both appear deeply intellectual as well as emotionally transparent – offering a self-disclosure in our first few moments that he hoped to “do a good job” in our interview by offering diverse clinical perspectives on TRPG treatment. He did not disappoint his goal, as our interview is spent with Louis often waxing poetic with the seasoned lecturing of a doctoral professor on everything from Jungian psychotherapy to the backstory of Wilfred Bion during World War II. Balanced with his deep discussion of psychodynamic theory was Louis’s references to his own experiences as a gamer, providing lengthy descriptions of the DM in his own non-therapeutic game in which he was a player and how this influenced his practice as a TRPG therapist.

In his clinical reasoning for treatment, Louis specifically pulled from his primary orientation as a psychodynamic and depth-oriented therapist. He spoke at length about psychodynamic aspects to TRPG treatment, such as Jungian archetypes, metaphors, projection, and unconscious supervision. Louis was the only therapist to mention the word “healing”, in noting that “shadow work” and working with unconscious material would help TRPG players access healing in the therapeutic modality. His favorite psychodynamic concept which he repeatedly discussed was the “subjective third” – borrowing from Bion, he explained that the unconscious of the players and therapists would merge in the game space in the creation of the fantasy game. This co-created and shared world not only would help the players solve problems together, but also contributed to a sense of group cohesion. Group cohesion, Louis repeatedly stated, was his primary goal of the TRPG treatment.

However, in addition to psychodynamic concepts, Louis also described specific clinical interventions aimed at providing development scaffolding for players in treatment. In his gaming intervention, however, Louis highlighted the importance of the game's narrative as the primary mechanism for therapeutic change. He explained that in any RPG game, therapeutic or non-therapeutic, he believed that the narrative is what keeps players engaged:

The whole idea behind any sort of RPG system is the narrative is what keeps us there. And if we can bring that narrative into a life into a feel like I am invested in this narrative then it changes the way we're going to interact with the way we're going to have that interaction with other people in that as well. the narrative journey—and this goes into when I worked with video-gamers as well—that narrative aspect is what keeps the person engaged in the therapeutic treatment. And if we can force a narrative that we think needs to happen and see how it plays out we don't have to be like, "This is the only way I want it to play out." We can just force a certain conclusion to occur and see what happens.

Like Beth, he describes using the narrative as the method of driving the story of the game towards the therapeutic benefits of the players. Many of the interventions he described were explained as ways to use the narrative as an engagement and investment tool for the players. However, many of these interventions were of a directive nature – as he repeatedly used the word "force" to describe his role as TRPG therapist in getting the players invested and engaged: "force a choice scenario", "force a narrative", "force a conversation", "force communication". This notion of "force" built upon Louis' conceptualization that players often would not engage or invest independently, and would need developmental supports in doing so. One of the gaming

interventions Louis repeatedly mentioned as narrative tool was the use of non-player characters (“NPCs”) as a way for the therapist to role-play as another character and re-engage players in the narrative. Just as Jared described “stretching the game to fit the therapy”, Louis also highlighted this hallmark trait of a therapeutic game. He repeatedly describes the ways in which he as the game master would “break the rules of the game” which he also referred to as the “imaginative breaking of the game”. This was one of the ways he explained the liberties of a directive GM approach in that choosing to stretch the gaming interventions and structure, such as providing the players with more time or switching the turn order, allows players to feel creative in the structure of the game without it being de-stabilizing for them.

“If we problem solve it that we figure out the solution ourselves it makes it much more likely to stay in our mind rather than if someone gives us a solution.” (Louis)

However, Louis also repeatedly mentioned an opposing notion of “flow” – his term for a non-directive approach – in which the players can organically come together, collaborate, and find group cohesion themselves. Louis suggests “holding back” and using therapeutic restraint at times, especially in terms of group problem solving. Problem-solving, Louis argued, was the key ingredient to building the group cohesion in the TRPG treatment – and part of doing so was for the TRPG therapist to stay out of these moments as much as possible. Much like his notion of the “subjective third”, Louis explained that the players had to work together to find resolution – even of conflict management – and that the therapist could provide gentle scaffolding while ultimately not giving too many answers to the group. Louis focused far more on collective goals than he did on individual conceptualization, and despite his degree as a clinical psychologist – Louis did not

focus on Autism symptomatology and conceptualization. His focus relied much more on building the sort of skills that come through collective problem-solving, such as critical thinking skills, planning, and organization: “critical thought is what we are aiming for”. Like Mark, Louis repeatedly emphasized the treatment as an empowerment tool and that by players collaborating and world-building with one another, they had the “ability to feel powerful” and agentic. Also like Mark, Louis argued that social engagement was the primary method of building social skills and he explained that this was the way in which he marketed these groups to patients, families, and insurance companies as a psychotherapy tool.

Summary

The narrative vignettes in this chapter illuminated the individual voices of each of the TRPG therapists, yet also highlighted the multiplicity in their individual approach: the diverse, sometimes contradicting, methods encapsulated in their individual clinical reasoning and the integration of various theoretical orientations as well as gaming experiences. They each describe different ways of using conceptualization, intervention, and outcomes in their clinical reasoning – with the narrative and causal structure of these thematic elements of clinical reasoning operating in divergent ways. Each of the TRPG therapists also privileged different elements of their clinical reasoning in terms of TRPG treatment for Autism, with some therapists emphasizing Autistic symptoms while others way less so. Ultimately these vignettes also show the variance and tension between “non-directive” and “directive” approaches to treatment – and the way in which TRPG therapists interweave as well as dichotomize these two approaches in their clinical reasoning. Ultimately, these vignettes will serve as a reference point for the

identities and backgrounds of the TRPG therapists, to be utilized throughout the rest of the dissertation.

Chapter 5: The Multi-Vocal Text

As described in my Methods chapter, the creation of the “Multi-Vocal Text” – the primary document of this study – required compiling the video data from both the observed TRPG treatment and the initial interview with the facilitating TRPG therapist, Beth. The initial creation of this compilation required the selection of specific themes from the observed treatment that I felt would be universal and applicable to discussion with TRPG therapists about the core aspects of TRPG treatment. These initial themes that formed the analysis behind the Multivocal text were:

- A) Opening Space
- B) Circles of Communication
- C) Collaboration
- D) Emotional Attunement
- E) Experience-Based

I will review each of these components of the TRPG treatment here as a sort of “introduction” for my readers of the resulting data in the following chapters. These initial themes selected from the observed treatment are the foundation upon which the multi-vocal text was created, and upon which all of the other interviewed TRPG therapists meditated in their interviews. These themes will also reappear in future chapters as they are elaborated upon with input by the other interviewed TRPG therapists.

First, a key component to each observed session included what the therapist described as “Opening Space” – the first ten to fifteen minutes of each therapy session. The repeated designation of this opening time appeared to be a valuable therapeutic technique to the TRPG therapy, in that the therapist described it as an intentional way of allowing the players to “warm up” before game play. These early moments of each session included observing attendance of which players had arrived, events in the lives of players from the previous week, or – most often – the sharing of funny memes or videos by the players. What was most remarkable about this time each session was that it appeared to be an encouragement of player-led interaction and an opportunity for the therapist to facilitate casual conversation outside of the gaming space. That it was a repeated amount of time each week made it feel more like a ritual, and lent to a sense that this specific TRPG treatment had its own culture: a culture in which we perform certain rituals, like the Opening Space, each week. There were some times that the “Opening Space” was shorter or longer, depending on the flow of conversation between the players. The “Opening Space” will also be discussed further in the chapter on Gaming Intervention as a key aspect of the TRPG treatment from the perspectives of other TRPG therapists.

This notion of the “opening space” as an intentional and ritualized way of initiating communication between players related to the second identified theme, “Circles of Communication”. There were many times throughout the treatment where this concept, and its associated therapeutic strategies, would be discussed and implemented by the facilitating therapist. The therapist explained that the concept of “circles of communication” was borrowed from communication theory and DIR Floortime – a type of play-based therapy for children on the Autism Spectrum – where one of the expressed goals of treatment is to facilitate and support

complete circles of communication between therapist and patient, and patients with others. One example of a “circle of communication” would be what the therapist described as a “serve and return” – borrowing also from tennis imagery, the notion that one player will serve up a comment or statement, and a return would be a response from the therapist or another player. This serve and return would be a complete circle of communication, rather than if no “return” occurred and a response never came – which the therapist, again using a tennis metaphor, described as “when things fall flat” or when “the ball is dropped”. When using a narrative analysis to discern why this theme was so elemental to the treatment, I found that the therapist repeatedly described the utility of this type of lens and intervention for people on the Autism Spectrum – reasoning that a closed circle of communication is often more difficult for those who feel challenged by social and conversational clues. There were many moments throughout the treatment of closed circles, as well as circles left open – in which the therapist would attempt to help close the circle. The theme of “Circles of Communication” will also be found in the chapter on clinical interventions, with further explanation of its origins in developmental, relational, and play-based approaches to Autism treatment as well as further discussion by TRPG therapists on the importance of this theory to the treatment.

Another related component of treatment was “Collaboration” – which in some ways built upon the theme of opening space and circles of communication as ways to scaffold player collaboration through casual and therapeutic dialogue. However, the theme of “collaboration” echoed throughout the treatment more explicitly as Beth repeatedly emphasized players working together within the story arc. The therapist emphasized that the TRPG game and treatment requires collaboration: character must work through their independent preferences and strategize

with the group in order to make progress on their journey, solve challenging situations, and survive difficult battles together. The game, and the dungeon master, explicitly encourages collective problem-solving and consultation with the team. One example of this in a clip selected for the multi-vocal text was when the players had to collaborate with one another in order to strategize during a battle scene. The therapist explained that in this clip, and in many other moments in the treatment, the players had to contend with the core dilemma of risk versus reward – a predominant dilemma in many TRPG campaigns and a gaming intervention designed to encourage player strategy and collaboration. In this specific clip in the last session of the treatment, the players finally had discovered the crystal that they had searched for all campaign – and when the players are in proximity to the crystal’s light, they experience the huge reward of having “bonus 2” points to all of their characters’ strengths and weaknesses. The therapist explained that the crystal’s purpose was a gaming intervention and served as a “carrot to dangle in front of the players”, for if they had increased strengths in every area – they could also take greater risks by trying new strategies for obtaining the crystal that were not typically in their character’s wheelhouse. The therapist described that these newfound powers were in the face of great risk, as the players were in an intense final battle for the crystal and up against many challenging forces. For this reason, the players would have to work together, take chances, “step outside their comfort zone”, and utilize the rewarding boost from the crystal for the collective management of danger. The theme of collaboration will be discussed in future chapters with the accompaniment of the other TRPG therapist perspectives. Collaboration, as in group problem-solving and group cohesion, will especially highlighted as a primary “relational outcome” of TRPG treatment that TRPG therapists sought for players in the Outcomes chapter of this study.

The fourth component of treatment from the first stage of analysis was “Emotional Attunement”: there were many instances in which the therapist described interventions designed to facilitate players having greater attunement with their own feelings and the feelings of others (both players and NPCs). One example of this theme was in clips where the therapist would directly label and narrate the emotional experience of players (“Sounds like Player E is feeling curious... his knowledge seeking has been activated, and also may be overwhelmed by the situation”) and NPCs, which the therapist later explained was an intentional way of supporting players with being able to one day do this independently. Another example was the use of sensorimotor interventions, in which the therapist would describe or try to elicit player experiences using sensory and motor descriptions in order to help the players access what their characters would feel in a given situation. A clip in which this occurred was when the therapist narrated each player getting a “fuzzy head feeling” – which she later in interviews correlated to the experience of anxiety and self-doubt. She explained, “You all getting this fuzzy head feeling and that you know what that feels like in real life. And if you can interject a you know a memory of a somatic sensation, you know you can you can you can experience it better... if you can relate to an experience and feel it then you’re gonna have a better sense of what I’m trying to say here.” The therapist would also facilitate the emotional attunement of players with each other by explicitly trying to elicit player attunement with themselves. An example of this was when she asked a player (“Player R”), who was in danger, how he was feeling in front of the group as a way of modeling how to “check-in” with one another: “I’m gonna check in with R, I want him to role play how he is feeling because they care about him, and I want them to know that he is in danger and suffering, and that creates like the emotional investment in his experience too.” The theme of “emotional attunement” will be further discussed with the accompanied TRPG therapist

perspectives in the Conceptualization chapter of this study. My participants will discuss the importance of this being a particular aspect of TRPG treatment for Autism in that it helps to facilitate a sense of emotional attunement for the players with themselves and with others.

The final component from the observed treatment was the emphasis on “Experience”, in that the facilitating therapist repeatedly mentioned the importance of providing the players with an experience in which they could feel and learn. This focus on experience will be discussed further in the next section, especially as it pertains to the differences between the TRPG therapists: some were like the facilitating therapist in that they too saw experience as being a key intervention in the therapy for outcomes such as learning social skills. This theme emerged in the initial coding and thematic analysis in a few different ways. First, the therapist repeatedly mentioned the importance of providing players with the experience of relationships such as going through conflict with peers, and building relationships. The therapist explained that this experience in the therapeutic setting would serve as a sort of practice for relating to others in the outside world. In addition to this aspect of experience, the therapist also tried to provide another opposite relational experience: the experience of not being prompted or encouraged to process conflict with others. For example, when during one conflict among players, the therapist explained that she could sense that they were not ready yet to think about the conflict or reconcile with one another – and instead of directing the players to do so, she explained the importance of players having the option and the experience of what happens when conflict remains. Similarly, the therapist also encouraged the players to have the experience of risk and danger – explaining that this experience was critical for the players to have in the safety of the gaming and therapeutic space, so that they might know how to manage and deal with this experience in other settings.

Finally, the therapist continued to draw on sensorimotor examples to provide players with the experience of negative self-talk. This occurred repeatedly in the campaign when the therapist had the players encounter the Nothic – an NPC character who would subtly infiltrate each player’s minds and implant negative thoughts about themselves. The therapist explained that by having the players experience this in the therapeutic game, they might have practice with learning how to manage and talk about self-doubt and negative perceptions of themselves. The theme of “experience” will continue to resound throughout this study, especially in the chapter on Theoretical Traditions in which TRPG therapists discuss the importance of experiential interventions to the TRPG treatment as well as tensions between experiential and skills-based approaches.

Summary

The results presented in this chapter represent the product of the first stage of data collection, and the thematic analysis of the observed TRPG treatment and Beth’s interviews regarding the TRPG treatment. This thematic analysis rendered several themes that aligned with an overall narrative structure of the treatment, which Beth described in her interview as one session built off of the next. The identified themes in this section laid the foundation for which clips would ultimately be selected for the multi-vocal text that would be shown to the other TRPG therapist, preserving the narrative of the game’s story arc as well as Beth’s narrative of how the players grew each session. These identified themes continue to play a prominent role throughout the rest of this study, in that they appeared to reoccur and resound through the other TRPG therapist interviews. Many of the themes will re-emerge in the following results, as they

highlighted some of the key aspects of not only the observed treatment – but pointed to some of the core components of TRPG treatment as a modality, as described by the TRPG therapists.

Chapter 6: Autism Conceptualization

The category of clinical reasoning labeled “Conceptualization” was applied to statements made by TRPG therapists when describing how they utilized a formulation of a player’s behavior, personality, gaming character, diagnosis, or gaming experience in their clinical reasoning for interventions and outcomes. Research on clinical reasoning suggests that conceptualization plays a large role in how therapists make treatment decisions during the therapy session as well as in the treatment as a whole. This section aims to answer the first question of my study, which is:

“How are TRPG therapists conceptualizing this therapy as a treatment for Autistic clients? In other words, what does the facilitation of TRPG therapy reveal about how clinicians understand the lived experiences (i.e. symptoms, challenges, sociality) of their Autistic clients – and how the TRPG therapy supports this lived experience?”

In a typical clinical setting, a therapist’s conceptualization of a patient might attend to the patient’s symptoms, life context and stressors, and ultimately formulate a diagnosis. For the purposes of this study, I was especially interested to understand how TRPG therapists in particular understood the Autism diagnosis and thus rationalized TRPG interventions as a treatment of Autism. Thus, this section will focus largely on how TRPG therapists discussed Autism symptomatology, and how – if at all – this “conceptualization” featured in their clinical reasoning during the TRPG session.

However, one key component of TRPG therapy is the patient's creation of a character – a character with perhaps a completely different set of personality traits, difficulties, and experiences than the player himself. Thus, TRPG therapists are taking into account not only their conceptualization of the player, but also the character that the player utilizes. This was especially evident in this study when I observed TRPG therapists considering the experience level and gaming expertise of players, and using this information to conceptualize how the player was role-playing, understanding game mechanics, and experiencing the TRPG overall. Some of these considerations by way of therapist conceptualization will be observed in the following chapter, although the primary focus of this study was on the conceptualizations TRPG therapists were making regarding Autism as a diagnosis.

There were several emerging areas by which TRPG therapists considered aspects of TRPG player conceptualization:

6.1 Clinical Symptoms and Challenges: language specifically related to a more medical or diagnostic explanation of ASD and ASD language framed in the context of challenges or difficulties

6.2 Sociality: language related to ASD social demeanor and experience

6.3 Theory of Mind

6.4 Personality or Style: language that referred to ASD as a personality type or style (i.e., way of being)

6.5 Interests

6.1 Clinical Symptoms and Challenges

In this study, it was observed that TRPG therapists utilized some classic clinical terminology for ASD symptoms and challenges while also utilizing language that falls outside of the traditional DSM criteria. In the introductory chapters of this dissertation, I reviewed the specific DSM criteria for Autism Spectrum diagnosis and hypothesized the limited ways in which these criteria fell short of accounting for a broader understanding of Autistic symptoms and diagnosis. Clinical definitions of Autism Spectrum Disorder and its symptomology have been in flux over the past twenty years, with diagnostic criteria changing between DSM-IV and DSM-V especially in the emergence and then disappearance of Asperger's Disorder. What has been left is a dizzying sense among some psychologists as to how to classify Autism, especially with less guidance on the varying types of "functioning". This has resulted in the creation of non-DSM criteria for Autistic symptomatology (Attwood, 2007; Bromfield, 2010; Gillberg, 1991) that utilize less pathological and value-laden terminology in exchange for language that further attends to the child's experience: such as Bromfield's observation that Gillberg's criteria for Asperger's swaps words like "restricted and abnormal" to describe Autistic interests to "narrow" and "exclusion of other activities". This is just one of many examples in which the field of Autism studies and the clinical field of diagnosis appear to be searching for more experience-near language to describe Autistic symptoms and comporment in a way that diverges from what many see as the rigid and non-descriptive criteria of the recent DSM. In this way, the results in this section add an additional dimension to the clinical literature: the perspective of Autism symptomatology as described by TRPG therapists. As will be discussed further in the Discussion chapter, the TRPG therapist conceptualization of Autism lends itself to a larger

conversation in the field of clinical anthropology on culturally derived definitions and interpretations of diagnosis and pertains to the critical disability methodology of this dissertation.

Here I will provide a brief overview of the ways in which the TRPG therapists relied on symptomatic language that is associated with ASD diagnosis, divided between the emergent categories of Self-Regulation (i.e., self-modulation of emotion and sensory needs, impulse control), Executive Functioning (i.e. organization, attention, problem-solving), Mood (i.e. co-occurring anxiety).

6.1 A Self-Regulation

TRPG therapists spoke about several different aspects of self-regulation, as it pertains to self-regulation of impulses, sensory needs, as well as emotional self-regulation. Several of the TRPG therapists highlighted the importance of being aware of the “sensory needs” of children on the Autism Spectrum as well as with co-occurring ADHD diagnoses – describing these sensory needs as “constantly struggling to kind of be in a calm, alert state”. Several of the TRPG therapists described interventions aimed at supporting the players with nervous system regulation, including sensorimotor interventions.

One result from the data analysis was a distinct dialectic about self-soothing techniques perceived by TRPG therapists of the players on the Spectrum. Two of the TRPG therapists pointed to the same moment in the clinical tape in which a player on the Spectrum, Player R, was loudly humming the Spider Man Theme song during an uncomfortable moment of disagreement

between two of the other players. Jared interpreted this behavior as “a self-soothe song”, and attributed this interpretation of Player R’s distress to his conceptualization of the player as previously wanting to get out of uncomfortable situations: “That’s an interesting self-soothe song there ah, cause that was the same player that was like...’I just like go over to the door over there and just like got the f*ck out. Kind of just ‘check please’.”_In this way, Jared was both identifying the cause of player distress as uncomfortable moments in the game play – and adding to his diagnostic conceptualization of this player that he utilizes a song to self-soothe from this distress.

Beth had a similar interpretation of Player R’s behavior as an attempt at “self-regulation” for the purposes of staying present in the game.

I didn’t notice the spider man theme song. No. I did notice, and I actually did notice while I was doing it when I went back and reviewed, I did notice Player R humming almost the entire time.... I wonder about self-regulation um you know was it a way that helped him stay present when he was not sure where he wanted to jump in or what he wanted to do. Um, cause he’s also sometimes on and sometimes off in terms of taking the initiative to dive in or being a little lost.

On a separate occasion, Beth also identified Player R’s frequent echolalia with the terminology “scripty” and attributed this behavior to an attempt to express his experience when language is challenging:

Yeah, Player R is scripty... I mean I always, whenever I think about scripting with um kids on the spectrum, I'm always thinking that there, it's a short-cut to like to express things you can't because language is hard... And those scripts that are actually a tool of like, "Well this line from this movie is a good way to talk about, ya know, that I don't like what's happening right now".

Here Beth was providing a strength-based perspective on echolalia, a common ASD behavior, as a "tool" for self-expression – much like Jared's strength-based understanding of the Spiderman song as a method for "self-soothing".

Another example of self-regulation was described in regard to "impulse control", with Mark designating this as a goal of TRPG therapy. He responded to moments in the game where the therapist had to support players with "impulse control issues". The framing of this is as a sort of challenge of ASD, which the TRGP therapy and the therapist can directly intervene on and support by helping the player to slow down and acknowledge the given consequences or additional information like input from other players.

Similarly, Jared referred to "emotion management" as being an "issue" for players with ASD. He linked "emotional recognition" to an issue of "emotional management" in one particular moment from the treatment where one player angrily responded to another player by casting a thundershock spell that affected the entire party. He related this "issue" to a moment from his own TRPG therapy work – an example from the use of the game system Kids on Bikes, where a player in his treatment angrily responded to a situation in the game and it ended up

having unforeseen consequences for him. In this way, Jared appeared to be making an argument for why emotion recognition as a skill – one that is often associated as a deficit with ASD, as will be discussed in the next section – is intimately linked to the ability to emotionally manage or self-regulate in response to negative consequences of one’s own actions.

6.1B Executive Functioning

Executive functioning describes the way in which an individual can attend to and organize external and internal information efficiently. Tasks of executive functioning require attention, organization and problem-solving capacities. The facilitating TRPG therapist, Beth, mentioned that children on the spectrum often have difficulties with executive functioning, as observed during the TRPG game: “I think that thinking of kids with executive functioning issues and thinking with the spectrum stuff with not knowing what to do and not having the clearer parameters, um they struggled with it.”

Beth explained that she noted these “executive functioning issues” come out more when the switch to virtual led to their switch to the Monsters of the Week gaming system, and that this game has less structure. She noted that the switch back to D&D – even in the virtual space – was supportive for executive functioning issues because it had more structure, and engaged the players more because Beth said she thought the players felt more confident and knew the rules better. This is an example of tailoring the gaming system, and the intervention, to the players – leading to more organization, confidence, and engagement. This clinical reasoning also reflected some of Beth’s child-directed play background, in taking account player preference of the preferred toy object, as well as letting her diagnostic conceptualization of executive functioning

help her to guide the selection of the play tool. The result of matching gaming system to players is an experience of “fit” – the players felt more confident and executive functioning issues were resolved with more structure and knowledge of the game.

One area of executive functioning skills that the facilitating therapist repeatedly discussed in conceptualizing her players was their ability to organize their thoughts. The therapist attributed an appearance of “rigidity” – a common Autistic trait discussed in clinical presentations of Autism – as having to do with a difficulty with organization. The therapist described her understanding of rigidity and Autism as such: “[Player S] has had a lifelong rigidity and like so kind of Spectrum-y”. In attempting to provide a differential diagnosis for a player with a suspected Autism diagnosis, the therapist specifically referred to how the player’s rigidity did not appear to fit with a typical Autism spectrum:

If you think about the different ways that these kids present,yeah that's [Autism] not been her. She is not the kid whose kind of rigid because she's having struggling organizing her thoughts, there is something else of discomfort and that is kind of preoccupying her and it's a different kind of presentation [than Autism].

Like rigidity, the notion of “flexibility issues” also repeatedly came up in the therapist’s Autism-related conceptualizations. She described these flexibility issues as: “[The idea that] there’s maybe no good option here is a thing that like, for kids with flexibility issues... especially often with kids on the Spectrum... [the idea that] ‘if it’s not the way I want it to be, then I can’t do anything’”. The therapist also described trying to encourage flexibility with children on the Spectrum, linking this conceptualization to intervention and outcome.

One explanation for executive functioning issues was offered with the language of “coherence”, as one therapist suggested that kids on the Autism Spectrum “don’t always feel coherent. They don’t always feel like they have a clear ability to, even in the game, look at the story, beginning, middle, and end.” She related this “not always feeling coherent” to the player’s capacity to organize aspects of the gaming story in a chronological manner, as well as account for certain sequential aspects of the game. This observation occurred following a moment in the final session of the treatment in which the players came upon the magic crystal that they are been aiming to find throughout their quest. Beth noted that the finding of the magic crystal did not appear to “land” with the players, which she interpreted as a function of “coherence” in that the players had been focusing more on the details than the big picture of the quest. While not named explicitly by the therapist, the term “coherence” has particular significance to the field of Autism studies and diagnosis in the “central coherence theory” of Autism (Jarrold & Russell, 1997; Happe, 1996) that postulated that the key deficit in Autism was the lack of “central coherence” – or an ability to complete perceptual tasks that require the coherent organization of information in a non-fragmented way. While this has since been contested by shifting perspectives in the Autism research community (Mottron et al., 1999; Lopez & Leekam, 2003) and the therapist is not explicitly naming this theory, her observation and conceptualization perhaps suggest something about the way in which players on the Autism Spectrum interact with the overall narrative of the TRPG quest. Beth states her observation that Autistic players focus more on the present situation at hand than the overall context, leading to perhaps a differently organized narrative of the game.

Another area of executive functioning repeatedly brought up as linked to neurodivergence was the topic of attention. One TRPG therapist explained that when working

with children with ADHD diagnoses, he will use this conceptualization to guide specific interventions tailored towards ensuring the players are attending to gameplay. He described using a “re-engagement” intervention when noticing a player was distracted, such as directly asking the player, “What do you think of what just happened?” He also described using a gaming intervention of asking if the player was distracted “in real life” or if the player’s character was distracted, as a way of re-engaging the player in their role-play.

The facilitating therapist would often note the player’s level of attention in a strength-based way. Her conceptualization of player attention was transparent about her own process as the therapist: she repeatedly mentioned that it was sometimes hard to identify whether players were paying attention, or looking at other things on the screen – and that sometimes she was pleasantly surprised when a player was attending to the game more than she had initially thought.

6.1C Mood

A lesser discussed conceptualization category was the topic of mood as it relates to a diagnosis of Autism. Specifically, the concepts of emotion identification and effects of Autism on mood came up several times. Beth noted excitedly when one of the players, who has a formal Autism diagnosis, responded to the gaming therapy and her use of sensorimotor interventions that encouraged him to recognize bodily sensations and identify emotions accordingly. As she guided the player to recognize his bodily movements, at that moment tightened fists, the therapist witnessed the player discussing feeling angry and frustrated for the first time. “This kid is [on the] Spectrum, right? But now he is talking about anger and frustration!” Her enthusiasm and use

of conceptualization seemed to point to one of the common conceptualizations of people on the Spectrum as having difficulties with noting and discussing their emotional experience. Yet her conceptualization here is also strength-based, as in it does not utilize a deficit-based conceptualization of Autism – she observes that through the gaming intervention, the patient can perhaps access something that is commonly thought as inaccessible for people with his diagnosis.

A common part of this discussion was noting how the therapists understood the notion of “anxiety” as part of this conceptualization. Beth first discussed how a patient’s “rigidity” and “anxiety” can sometimes mimic or resemble one another, and as discussed in an earlier section – “rigidity” was a common conceptualization word used by the therapist in relation to Autism. In one section, she describes a player who has a suspected diagnosis of Autism (but no formal diagnosis despite repeated evaluations) as having “a lifelong rigidity, so kind of Spectrum-y but not really”. Within this narrative, the therapist also offered other aspects of clinical reasoning as she discusses her conceptualization of the player: “some language delays”, “tantrums”, “struggle with friends”, “very smart”. However, she went on to explain that she rather conceptualizes this player’s behavior as “anxious, but like [the player] denies it all the time”.

This is the first of several instances in which the therapist’s clinical reasoning described a process of “differential diagnosis”. This process, often times also known as differential diagnosis procedure in the clinical community, is the process by which a clinician proposes a variety of possible conditions that share the same symptoms a patient presents with (Matson, & Williams, 2013). However, many researchers have noted the complex process of differential diagnosis

procedure for Autism Spectrum diagnosis given both the prevalence of co-occurring diagnoses (i.e., depression, anxiety, ADHD, PTSD) as well as the historically tense and values-laden debate around what constitutes as “neurotypicality” (Frigaux et al., 2021; Matson & Williams, 2013). In the case of this player, the therapist appears to be noting the ways in which an “anxious” presentation – such as how anxiety contributes to social challenges and tantrums – could also overlap with Autism diagnosis (“language delays”, “rigidity”).

Jared also provided a type of “differential diagnosis” statement about how anxiety presents and manifests for people on the Autism Spectrum, stating that he felt the experience of players was more akin to “I’m anxious not because of my Autism, [but] I’m socially anxious because of how other people might respond to my Autism”. In his clinical reasoning, he explained that the narrative structure of the game and the mechanics of the rules allowed for a safe, predictable environment for players on the Spectrum to engage with others – and thus, social anxiety would dissipate because of how others responded to the players’ behaviors. He also credited the directive nature of the game in helping players with social skill acquisition and engagement – which he explained was a key feature of the TRPG modality in that it “uses social engagement as a resolution, not chance”. This resolution, or outcome, of social engagement – he explained – was what allowed for the conceptualization of social anxiety as produced through interaction with the other to resolve through game play.

Another example of a differential diagnosis process when considering both Autism and anxiety also accounted for the aspect of social challenges. Here she discussed another patient with a suspected Autism diagnosis, who was referred to the TRPG treatment by an individual

therapist for diagnostic clarification. In the following excerpt from the interview, the therapist presented a dichotomy, explaining why she felt that this patient's "internal experience" is likely more aligned with an anxiety presentation than Autism:

People can have social skills issues, right? But they can have them because they have Autism and they can have them because they're anxious. And that can look very much the same in the moment but the internal experience is really different. You know, like I think if she is struggling socially to come away and to like respond to peers and...if she is coming off as dismissive to other kids, she doesn't come off as dismissive in the way that a kid on the spectrum comes off as dismissive because they just don't get the tone of voice thing.

There are many components to the above therapist's conceptualization: first she is identifying that "issues" with social skills is, in her opinion, contributed to Autism or anxiety. More about the conceptualization of social skills will be discussed in the next section. Second, the therapist explains that in her conceptualization, Autism and anxiety can "look very much the same in the moment, but the internal experience is really different". The therapist, both in this statement and in other interviews about this specific patient, appeared to designate this patient as "anxious" and attributes her issues with socializing to this anxiety. Last, the therapist seemed to be making a connection between the patient's internal experience of anxiety and the patient's tendency to come off as "dismissive". Here she noted another conceptualization of Autism, in that she described people on the Spectrum as coming off as dismissive to others "because they don't get the tone of voice". This sets up another differential diagnosis: the same symptom of appearing

dismissive may either be attributable to anxiety, or to Autism. In this way, the therapist appeared to be referencing clinical conceptualizations of Autistic challenges, such as difficulties with emotion recognition in others, or difficulty with understanding things like sarcasm or tone of voice, such that this experience leads to genuine misunderstanding and the appearance of indifference.

In the next section, I will further discuss this particular player again in regard to differential diagnosis and the conceptualization of the player's sociality as key to that process. However, before moving on, there was one final and crucial reference to the topic of mood as it pertains to conceptualization and Autism. One therapist described the Autistic population he has worked with as having "co-occurring mental health disorders", especially when discussing the challenges that these individuals would face when also experiencing trauma and in the criminal justice system. Despite mentions of "anxiety", "depression", and "trauma", this was the only reference in the interviews by any therapist to the term "co-occurring" diagnoses, which in the clinical field this phrase has typically pointed to the "co-occurring" experiences of anxiety, depression, and mood disturbance that often appear for people with developmental disabilities. This reference is note-worthy for several reasons: first, it acknowledges the presence of dual diagnoses – a contested topic in the field of mental health, especially at the level of medicalized insurance companies and the field of psychoeducation as the previous DSM-IV-TR explicitly forbid dual diagnosis (Leitner, 2014). This speaks to tension in the field about diagnostic clarity and the process of arriving at diagnosis just as I observed in the therapist's differential diagnosis process in discerning Autism vs. Anxiety. To acknowledge "co-occurring mental health diagnoses" is to acknowledge that it can be both Autism and Anxiety. This recognition

represents a burgeoning area of interest in our field today and will be discussed further in the Discussion section later on.

6.1E Embodiment

There were several references to Autistic embodiment, such as the reference to children as “fidgety”, “wandering”, or “stimming” behaviors as well as ways in which embodied behaviors signaled a type of “distraction”. Beth noted that many of the players in this observed group were “fidgety” and provided the example of watching the players in this group wandering around the therapy room – back when the group was in person – and would that they would often get up from the game and pick up toys like action figures in the room. Beth framed this behavior as a “need for sensorimotor stimulation” and explained that many of the players did not actually realize that they needed sensorimotor stimulation in order to remain engaged in the game. Beth’s intervention for these players was to bring this to their awareness, by providing them the opportunity to use the action figures and other sensorimotor toys from the room and touch, hold, and play with them during the TRPG game play. She narrated the outcome of this intervention was that players came to understand their sensorimotor needs, and the importance of having sensorimotor stimulation during the therapy as a way of staying engaged. Beth also gave the example of having an “exercise peanut ball” in the therapy room which would rotate among the players with sensorimotor needs, as well as a hassock seat and a trampoline. This conceptualization driving intervention reflects the way in which Beth understood this ASD symptom as needing self-awareness and body-awareness: the intervention provided the players with this recognition that this was a sensorimotor need – and the TRPG therapy allowed for

additional interventions, such as toy and sensorimotor object use, in order for the players to “stay immersed”. Rather than viewing wandering or fidgeting behaviors as disruptive and needing to be corrected, Beth frames these behaviors as players “not realizing” their own sensorimotor needs. The provision of objects and encouraged use of methods for meeting these sensorimotor needs, will be discussed further in the discussion of fit.

Beth explained her own personal history as relating to this approach: not only her background as a play therapist, who has play objects and toys in the room for early childhood intervention, but also her own background as a gamer. She described her own experience with playing video games, such as Twilight Princess, which had a large physical component (i.e., sword fighting, swinging your arm, doing the actual physical movements even while sitting down) and that she would track her own arousal and stress levels from before playing to after playing. She likened the video game to “LARP-ing” (i.e., live-action role-playing”) and that “putting your body into it” makes a difference in a player’s immersion in the game. She also noted that she could feel herself getting tense and would regulate the stress by taking a break. Beth explained that she used this example in her sessions with the players as a way of a) noting the physical experience of role-playing as a stress reliever as well as b) promoting a sense of self-regulation through physical play. Again, Beth appeared to explain here how physical engagement promotes a sense of immersion: thus, the players with the toy figures, and the exercise ball, while those are not formal components of a TRPG, were given physical ways of engaging in the role-playing game. Additionally, this context provides some context for her clinical reasoning of why TRPG game play might be a “stress relief” for players on the

Spectrum: the physical engagement with their bodies allows them to stay immersed and simultaneously meet their sensorimotor needs.

Furthermore, Beth referred to the “sensory needs” of players on the Autism Spectrum and with ADHD as a “struggle to be in a calm-alert state” and a struggle to be present in the room. She explained that this is what she saw as the origin of fidgeting and off-task behaviors. Beth’s clinical approach to this conceptualization was “a pretty wide allowance for like, get what you need, as long as it’s not disruptive” – such as Player E moving his legs around, or players going to the toy shelf. When sensorimotor needs do get disruptive to the game, Beth reported that she uses a re-direction intervention to get the player back in the game such as, “you’ve missed a couple of turns”. If a player was off-task or fidgeting and was not immersed in the game, she also might use a gaming intervention she called the “murky mirror model” which Beth said she stole from other GMs. She tells the players, “What your character is doing in the game is not exactly what you’re doing in the room at the table, but it’s kind of like it. It’s through a foggy mirror of a translation of what you’re doing as your human actual self”. This gaming intervention reminded me of a reflective statement in an individual therapy (i.e., “I see your hands are folded”) or a process comment in a group therapy in which the therapist comments on what they are seeing in the room.

An example of the murky mirror model occurred in the observed TRPG treatment where Player S rolled a “hide roll” and was completely hidden but then got distracted and started talking to other players. Beth then reminded the player of the murky mirror model and that his character was supposed to be hidden, and the player was immediately reminded that how he was

acting was how his character would be acting, and re-engaged in the game. This gentle re-direction, using the gaming interventions as a support, led to the outcome of body and self-awareness – as Beth noted that many of the players have “come a long way” with “being aware of what your body is doing in the moment”. This narrative vignette of Beth’s clinical reasoning highlights the way in which sensorimotor interventions, which are built into the gaming intervention of the murky mirror, helped players develop not only body but self-awareness. Beth also explained that she felt that the switch to virtual helped with body awareness, as the switch to virtual meant that the distractions were different – players were no longer picking up toys, but instead going on Youtube.

Beth and Louis viewed “stimming” behaviors of the players somewhat differently. While Beth viewed “stimming” as a way of engaging in the physical environment, Louis commented on Player E’s stimming as “distracted behavior”. Yet, both Beth and Louis agreed on the interventions for this conceptualization which was to first appropriately ignore the player’s behavior and then try to re-engage them with reflective statements and re-direction back to the game. Louis suggested an intervention similar to the murky mirror model, which was “Oh, were you distracted in real life or your character” – which he explained would “force” the player back into the storyline, leading them to be re-focused and-reinvested in the game. Both Beth and Louis advocate for the use of gaming interventions for “distracted” behavior – such as relying on re-directing the player back to their turn in the game, or as Louis suggested – even completely changing the turn order to surprise the players and re-engage them if they were distracted. He explained that this breaking the mechanics of the game was crucial for a therapeutic game, especially with players on the Spectrum who might rely on their knowledge of the mechanics

and rules for a sense of structure and predictability. However, Louis explained that playing with this structure could also be helpful for players with distraction and re-engagement. These comments reflected Jared's assertion that "we stretch the game to fit the therapy".

6.2 Autistic Sociality

One of the key aspects of conceptualization pertaining to Autism diagnosis was described by the TRPG therapists as sociality – social skills, communication, reciprocity with others. This is an important area of consideration in regard to Autism treatment, as much of the treatment for this population is expressly aimed at improving social skills as previously discussed in the literature review. The facilitating therapist noted the way in which this specific area of conceptualization can figure largely in the presenting problem, or the reason for why a patient will come to TRPG treatment. She gave the example of one player in the group whose "referral" – meaning the referral made by his individual therapist for the group treatment – was "very strictly around increasing flexibility and social skills." One of the interviewed therapists explained that a key component to his approach to treatment was "social skill development". Conceptualization of player sociality was the most frequent aspect of TRPG therapy conceptualization, and encompasses critical aspects of discussion around Autism diagnosis such as Theory of Mind.

First, I would like to start where the last section left off: with the concept of differential diagnosis as it pertains to sociality. In the previous section, I provided the example of "Player J" being referred to the TRPG treatment for diagnostic clarification and a suspected Autism

diagnosis. The facilitating therapist identified the source of the player's social difficulties as rooted in anxiety, rather than an Autistic presentation. In this section, I will elaborate on further examples of the therapist's differential diagnostic process with this specific player in regard to her sociality. First, the therapist noted that this specific patient "presented with some atypical behavior as she struggles socially". This conceptualization appears to be an extension to the therapist's thoughts in the previous section, in connecting social difficulties to a more "atypical" presentation. She has also remarked on this conceptualization of social difficulties as a means for differential diagnosis amongst the players in the group, both with and without formal Autism diagnoses:

This group is particular, they are not the best socially. You know, they struggle. There's a couple [with a formal] Autism diagnosis. There's a couple that just have "the quirky diagnosis" and you know sometimes the pieces just don't click.

The facilitating therapist, Beth, also noted that these social struggles were common for other players on the Spectrum whom she had encountered in treatment: "when you have a kid who is on the Spectrum who doesn't make friends easily". One way the therapist noted this conceptualization of social struggle as appearing in the TRPG treatment space is that the players will talk to the therapist and role-play with her – but that they struggle to initiate this with one another.

However, Beth also described the Player J upon observation in the therapy setting as "being possibly more neurotypical" than the other players in the group with Autism diagnoses.

She specified this observation by explaining that the player “was tracking better” and that the player was able to “read cues better”, “read the scene and read the situation” and “had a lot more emotional language”.

In this conceptualization, the therapist identified several aspects of sociality – attending to social cues, understanding a social situation, and using language that conveys this understanding of others – as key to differentiating between “neurotypical” and neurodiverse presentation. In other interviews, the therapist highlighted these aspects as key “social skills” that, in her conceptualization, patients on the Spectrum often have trouble with. In another interview she noted that her patients on the Spectrum often struggle with reading social cues, and that this is especially difficult while using tele-health. She elaborated that this difficulty often lends to players struggling with knowing when to talk, resulting in “they talk all over each other, and there’s some time it is like nobody knows when to talk so they all just kind of freeze.”

This example speaks to another area of sociality that multiple therapists pointed to: communication skills. Louis explained that TRPG treatment would facilitate “good social skills development” by increasing communication – and that this was “specifically because of the diagnosis [of Autism] or suspected diagnoses.” Beth also discussed communication skills in her conceptualization of differential diagnosis when discussing the communication skills of the players. The facilitating therapist noted that Player J had “stronger” conversational skills than the other players – and appeared to utilize this rationale when explaining why she did not believe that Player J was on the Autism Spectrum. She also explained that Player J had more “capacity” for continuing conversations amongst players. While she described Player J as having “strong

pragmatic language”, she referred to Player R – a patient with a formal diagnosis – as “getting the pragmatic language elements of conversation, in terms of how you use language to communicate, but he’s not actually getting the content of the conversation, not responding to content.” In this way, the facilitating therapist conceptualized one of the communication challenges for a player on the Spectrum as related to difficulties with responding appropriately to others – not in the words being said, but in responding to the meaning of what is being said to them. This communication skill lends to the notion of “reciprocity” that will be discussed in future paragraphs.

With these conceptualization elements in mind of reading social cues and communication skills, the facilitating therapist provided another example of differential diagnosis by comparing Player J and two other players (“Player E” and “Player R”) in the group who have formal Autism diagnoses: “I am also just very aware of how Player J attunes to the screen in the way that maybe, especially you know... like Player E and Player R are not always attuned to the screen when you are looking at them.” Here the therapist seems to be asserting a critical aspect to her conceptualization of Autistic sociality: the consistency of attunement to others and to the therapy space that is partially what she means by attuning to the “screen”.

However, Beth may have also been referring to the player’s ability to attune to the screen as well – the camera, the tele-health platform. She explicitly discussed this aspect of “awareness” in another interview, in response to a moment in the therapy where one of the players with a formal Autism diagnosis asks the group if they can see him on the screen. Player E was consistently off-camera throughout treatment, whether exhibiting physical stimming or bodily

contortions – all while still playing the game. Yet the therapist enthusiastically noted that this moment signified E’s self-awareness of his body in space and on the screen:

[For] a kid with Autism, what does it mean for him to actually ask ‘Am I in the right? Am I doing the right thing like socially? Can you see me?’ You know, because that is again, that is the awareness of the other. And the interaction and the need to see each other in order to interact well.

Here she was conceptualizing an aspect of Autism by noting a common clinical observation and experience – in that people on the Spectrum may not often or easily access an awareness of the other. For this player in particular, for much of the TRPG treatment in most sessions he did not appear to have this access – as he would often be off camera and the therapist would frequently remind him in a gentle manner to shift the camera or his body. In this statement however, the therapist used a strength-based perspective to highlight the way in which the therapeutic gaming space has helped foster an awareness for this player: an awareness of what others might be seeing, and how this might support his interactions with others. In this statement she was also linking a self-awareness – an awareness of the self in space – to an awareness of other.

6.3 Theory of Mind

In this section, I will review several different ways that TRPG therapists differently referred to “Theory of Mind” (ToM)– one of the core deficit theories of Autism Spectrum diagnosis, which holds a contested position in the field of Autism and posits that people on the

Autism Spectrum struggle with empathy, awareness of other, and “mindblindness”. As was discussed in the Introduction to this dissertation, anecdotal evidence from TRPG therapists regarding the “disappearance” of ToM deficits was part of the inspiration for this study in encouraging the exploration of this phenomena of how TRPG therapists might understand Autism and Theory of Mind in particular. Overall, their perspectives reveal that they view ToM as an issue with engagement and knowledge gap – which the game then supports through scaffolding and communication-based interventions – rather than a lack of empathy. This section will include more explicit narrative analysis, linking this conceptualization of ToM to interventions and outcomes.

A conceptualization of a player’s awareness of self and other leads to one of the key concepts that this study was designed to understand: how TRPG therapists understand Theory of Mind as it pertains to their players on the Autism Spectrum. Theory of Mind is the ability to understand the beliefs and experiences of others. In the previous example of Player E, he exhibited the ability to mentalize others by asking the other players if they could see him on the screen. For one of the interviewed TRPG therapists, the recognition of others’ feelings or thoughts was in his perspective a “deficit qualities with ASD”, as well as an “issue” tied to “emotion management”. In this way, the therapist is directly tying together one’s ability to recognize others’ emotions as well as recognize and manage one’s own emotions.

The facilitating therapist used different language to describe this phenomenon, describing this ability to “empathy build” and “read others” as “emotional reciprocity”. Calling this a “social engagement skill”, the therapist explained that this would help players in the game: “[if] I

can read that this guy's freaking out, then that might influence how I interact with him depending on the outcome that I want." In another instance of differential diagnosis between Player J and the other players in the treatment, the therapist explained that for most of the players in the game it was "tough" for them to have emotional reciprocity with others. She noted that for one of the players, Player S, she has noticed his emotional reciprocity grow in the last couple months of treatment and that he had made significant progress in this area over the last year. As will be discussed in the chapter on Outcomes, Beth explained that a direct outcome of the TRPG treatment and game play was a change in Player S's emotional reciprocity, not only a difference in how he carried himself with self-awareness but also grew an awareness of others. However, of the two players diagnosed on the Autism Spectrum, Player E and Player R, the therapist explained that this was far less accessible for them.

The main way in which Theory of Mind was discussed in interviews was by Jared, who specifically noted a difference in awareness of others in the specific gaming space. Jared said that in the gaming space, he sees the "opposite" of what is typically thought of with ToM: "self-centered" and "lack of empathy" being some of the classical definitions. Instead, he reported that he sees Autistic players "dive into" the dramatic portrayal of their characters, and that when in character he finds that players are able to "self-gauge" and really get into the "mind" of their character.

When watching one of the clips in the TRPG treatment in the first session in the moment that the players introduce their characters to one another, Jared identified that one of the players

appeared “checked out” while others were talking about their characters despite appearing more engaged while discussing his own:

It might be correlated to the ASD, but in the last clip [when] it was all about his character, he was all over it! But now, talking about bringing someone else in, you know Theory of Mind and ASD works well with that, he was checked out. He was like, “I don’t know what to do”.

Here, Jared appeared to be explaining Theory of Mind difficulty with sustaining interest and/or awareness in the other, which he conceptualized as specifically related to Autism and this player’s behavior in the game. Even more relevant is that he is framing this conceptualization of the player as “checked out” as a result of him “not knowing” what to do when an other is present – leading to a non-engaged compartment, labeled here as ToM. However, this poses a ToM deficit as actually a matter of engagement and skill (i.e. knowing what to do) rather than lack of empathy. When boiling this deficit down to an “engagement” issue, there was a similar flavor to this discussion of ToM as there was to discussing another clinical aspect of ASD, “stimming”, in which TRPG therapists viewed this classic Autism symptom as a different way of engaging different with the space – through toys like a peanut ball or figurines. In a narrative analysis of Jared’s clinical reasoning, he suggested that an intervention for this player might be to “let that player space [out]” – referring to a non-directive approach of allowing the player who “doesn’t know what to do” to have that experience rather than be corrected. Jared also weighed a non-directive versus a directive approach for a therapist knowing when to “jump in” to help support kids who have difficulty with checking out – referring to Beth’s “intentionality” of either “letting

the player space out” or “jumping in” with an intervention to help the players “focus”. Again, here ToM is being framed as an engagement, perception, and attentional issue – with the intervention being a support with “focusing”.

Furthermore, the notion of “not knowing what to do” came up repeatedly in Jared’s conceptualization of ASD – framing ToM as a knowledge gap in which players are uncertain about how to conduct and sustain emotional engagement. He noted that Beth’s style was more “reflective” than his own, in that she asked questions of the players to encourage emotional expression such as “What is your character feeling?” He explained that not all children have the skill set to know how to engage with reflective style questions, such as “What do you think?” and that some children could feel “pushed too far” and “get frustrated” by this sort of intervention. He explained that some children who “does not have the skills” or “doesn’t get it”, such as how to reflect on how they are feeling, would have difficulty engaging with a reflective style question – and thus the aimed outcome of emotional expression would be foiled. Instead, Jared explained that he would use a “descriptive” (i.e. “What do you see in the cave?”) style intervention rather than “reflective” (“What are you feeling?”) one in order to scaffold their experience in the game, and “give the kids more to go on” by encouraging them to first engage with the content of the game world before reflecting on their character’s feelings. This sort of intervention of scaffolding mirrored Louis’ developmental approach of helping to meet the players where they are at. Again, Jared emphasized ToM as a skills-gap issue, with the intervention being to scaffold so that they could eventually access emotional self-awareness.

Later, Jared also referred to “emotional recognition” as a “kind of known deficit qualities with ASD” –referring to the larger literature (“kind of known”) on this deficit. Yet, for this conceptualization, he comments on Beth’s more directive intervention, which he calls, “Social Skills Relationship Dynamic Instruction”, of narrating the positive nature of the players’ relationships with one another in the first session and “putting a value to the relationship”. Beth did this in the introduction portion of the characters by feeding the players context for their relationship like “he helped you” and naming the “emotional contents” or the implications of the relationship. Jared noted that an outcome of this intervention is that once the players understand that there is a relationship established between their characters, they can “perceive” that there is a relationship. Thus, this intervention is to support the “recognition” aspect of ToM, with perception being narrated as the key issue: change the players’ perception of the relationship and provide the context – and then the players can emotionally connect with one another. Thus is it not a lack of empathy or “the ability to have an emotional connection” – again, Jared frames ToM as an engagement or perception issue rather than an issue with empathy or mindblindness.

Jared also referred to Theory of Mind when discussing other aspects of Autistic behavior. In another clip, he responded to the intervention of “The Travel Montage” – in which the facilitating therapist encourages each player to individually discuss one thing that happened to them on their previous journey. He noted that he likes this Travel Montage intervention, because the technique allows for “one short blip about you”: each players can have their own speaking time while also providing the therapist with insight about what each player found to be important in their character’s past journeys in the campaign. He contrasted this intervention with another popular intervention that often occurs in the first session of a campaign, a technique which the

TRPG therapists referred to as “Previously On,” an allusion to the recaps that often occur at the beginning of television episodes to review the events of the previous episode. He explained that unlike the “Travel Montage” intervention, the danger of the “Previously On” intervention is that it might lead to one player hogging the airwaves – a danger which the therapist refers to as “one of the risks of theory of mind”:

I like the montage technique... I think it’s especially good for work with ASD youths because one of the risks of Theory of Mind is you’ll get a ‘What happened to the party previously,’ but you’re gonna get nothing but a one-man show where you know, the person is just gonna talk about themselves.

Again, here the therapist discussed a conceptualization pertaining to Autism, and directly explained how this presentation emerges or does not emerge as a function of the gaming situation. As a narrative analysis of this discussion revealed, Jared suggested that a TRPG intervention that would help this player sustain interest in the others would be the Travel Montage intervention but with a time limit on how much one person can share – so that it would limit the “one-man show” aspect of Theory of Mind, and support this experience rather than aim to correct it. He also explained that this gaming intervention would allow the player to share what he found was valuable in the previous session so that the therapist can learn from his perspective – as to allow the player space to share, but support the player in awareness of others. This sort of intervention marks me as supportive, rather than corrective – encouraging, rather than limiting. In the previous example, the therapist identified that the player was “checked out” as a function of being unable to attend to the other players. In this example, the therapist

explained that the Travel Montage alleviates the potential for a “Theory of Mind” presentation to emerge – in this case, it would be a function of the player being unable to recognize the presence of others, and then talk over others – a phenomenon similar to the point made by the facilitating therapist about the way in which lack of emotional recognition can lead to breakdowns in communication in the group.

While not an explicit reference to Theory of Mind, an extension of Jared’s conceptualization of players on the Spectrum occurred at a later point in the interview. The observation was a product of the therapist watching a specific clip in the first session in which the facilitating therapist utilizes the gaming technique of “The Nothic” – an NPC that extracts the private information of the characters and will later exploit them with it. Beth, role-playing as the Nothic, asks each player to disclose one secret about themselves to the group. In response to this intervention, Jared explained that he at first interpreted this technique as “an activity that was trying to encourage at least the concept of, maybe there’s things that you don’t talk about with other people...that’s where I thought that the intervention was going.” He elaborated that he thought this activity would be a useful intervention for people on the Spectrum because: “A lot of people [in TRPG treatment] who are on the Spectrum... very often there’s not really a filter of who I am and what I’m about. Like usually folks on the Spectrum, especially like Asperger’s range and things like that, will blurt ‘I am who I am’ and ‘I’m just going to tell you everything about me in like eight seconds’. The conceptualization of people on the Spectrum as “having no filter” appeared related to his earlier conceptualization of a player who was “hogging the airwaves”. Jared explained that with this conceptualization in hand, the gaming intervention of the “deception check” (in which the TRPG therapist has each player “roll for deception” and

share a secret about their character with the group) would be a way to encourage player emotional and verbal expression of secrets as a way of also helping to teach in a more skills-based way about privacy and how to engage with others in a way that allows shared airtime. Like the discussion in the previous paragraph about the Travel Montage intervention, Jared framed these gaming interventions as a way to encourage player expression while teaching awareness of others – rather than shutting down or completely correcting ToM behavior.

Conversely, Beth had a quite different conceptualizing in response to this same moment in the treatment. She explained that the technique of the Nothic was “you get the secret and then twist it into something worse... and then it’s gonna feed them back the worst interpretation of that.” She explained that by encouraging disclosure of the secret, and the eventual challenge of responding to that secret being brought up by the Nothic later on in the game, she was trying to encourage the players to become aware of their own thoughts – another aspect of mentalizing and Theory of Mind. However, in this case, the facilitating therapist remarked that she felt that this was actually a strength of the players in the game:

It’s cultivating that relationship to our own thinking too. And I think for some kids, those are kids who can’t...but this is, they can do this. I’ve seen that, you know, they can do this kind of thing with these characters better than they can when they talk about themselves as their human selves – as I call them.

Here, Beth diverged from Jared on the value of players talking about their characters. In this statement, Beth seems to acknowledge this capacity to identify and communicate their thoughts

as a strength – something that would otherwise be challenging outside of the game, but in the gaming space is far more accessible. In this way, she conceptualizes this as both a challenge for people on the Spectrum as well as a potential for this population while in the gaming space. By framing this as an engagement issue, the TRPG therapists described interventions that help the players engage and attune with one another – referencing developmental interventions, such as scaffolding and bridging player interactions, aimed at making this engagement and attunement more accessible.

Another area in which TRPG therapists appeared to conceptualize player capacity for self and other awareness occurred in the different uses of the term “consequence” by Beth and Jared. Similar to the prior discussion about “having a filter” and having a “relationship to one’s own thoughts” in the public arena of the game, Beth noted when one of the players, Player E, struggled with sharing the airwaves with other players while consumed in his own thoughts. She attributed his lack of awareness to “you know him, on the Spectrum” and described this as a “Spectrum- way of ‘I am staying with this though and this idea for a very long time and it is a completely irrelevant thought’”. Beth elaborated further that this conceptualization of the player had negative “consequence” on his interactions with the other players in the game. She also noted that Player E had “come a long way” with this specific struggle.

On the other hand, Mark similarly discussed the difficulty as well as strengths of players on the Spectrum in their acknowledgement of social consequences for their actions. He specifically noted this conceptualization while watching a clip from the treatment in which

Player S performs a spell that negatively impacts Player J and that he wanted the facilitating therapist to actively narrate the effects of this action so that the player could become aware:

I think one thing [the facilitating therapist] can do is [say] like, ‘Oh man, it really seems like, Player S, you don’t that really irritated this other character so she is responding to you,’ and it kind of lays those types of things out if they are on the Spectrum to be like ‘Oh my actions had a consequence and also I’m recognizing that because I can see her agitated.

Here, Mark tailored an intervention that is correlated with a conceptualization of a player on the Spectrum as needing explicit support with recognizing not only the emotions of others, but the way in which those emotions are a direct result – or consequence – of the player’s actions.

Louis also discussed other ways in which he conceptualized Autistic sociality in situations of conflict, like the one described amongst the players above. In response to the same conflict between Player S and Player J, Louis noticed that the players did not seem to want to process or confront their conflict and stated, “ Kids on the Spectrum will just ignore [conflict] completely. They’ll never come back to it”. He related this conceptualization to a proposed intervention, explaining that for this reason he felt that the facilitating therapist should explicitly encourage the players to process what had just happened. Louis elaborated further to refer to the type of interventions he has found useful in his own gaming group where he participates in D&D games as a player: he explained in the interview that “the best DM he ever played with” would frequently invite the players to confront conflict with one another. While explaining this

technique, he expressed that the reason this intervention would work well in his gaming group is because “obviously none of us have Autism or Asperger’s, so we don’t have to worry about certain things.” In this way, he appears to be noting that interventions that directly encourage confrontation of conflict may prove difficult for players on the Spectrum given his conceptualization that a unique presentation of this population is their adversity to discussing conflict.

He echoed a similar sentiment in response to a later clip from treatment in which the Player S appeared to playfully reconcile with Player J by pulling her down the staircase away from danger. However, Louis reflected here that this would have been another opportunity for explicit processing between these players – specifically in regards to the topic of consent. The therapist explains that he would have wanted the facilitating therapist to encourage Player S to ask permission of Player J to pull her down the stairs, especially given the conflict that just occurred between them in which Player S negatively impacted player S with his previous actions. Louis elaborates that, similar to having difficult conversations about conflict, he conceptualizes players on the Spectrum as hesitant about conversations about consent:

That’s a possible potential for a consent conversation which is very important because consent isn’t just sexual consent. It’s, ‘Can I get your backpack? Can I put this spell on you? Can I do this type of thing?’ It’s asking for those types of aspects [of consent] which is very important for working with those on the Spectrum and also those who might now wanna talk about other aspects of [consent].

Louis concluded his conceptualizing remarks on Autistic sociality by responding to situations where the players might have difficulty asking for help. In response to a clip from the last session in which a player struggled to respond to the negative self-thoughts from the Nothic, Louis expressed that he would have encouraged the other players to respond to the situation: “How do you guys respond to this?... It seems like she’s beckoning for some help.” He explains that by providing this intervention, he would be able to intervene on what he conceptualizes in Autism as a difficulty asking for help: “This would be another kind of technique because it then allows them to ask for help, which is another big thing with those on the Spectrum of, how do they ask for help?” Here he seems to be promoting an intervention designed to encourage self-advocacy, while directly relating it to a perceived difficulty specific related to players on the Spectrum in this very capacity.

6.4 Autism as Personality or Style

“[Autism] as a personality, like a piece of who someone is and not a disability really, or not a problem to be solved” (Beth)

As opposed to the conceptualizations described in previous sections that directly pointed to clinical terminology or symptoms of Autism Spectrum Disorders, an emergent aspect of conceptualization denoted the way in which TRPG therapists discussed player behavior and experience as more akin to a “presentation” or “style”. This conceptualization speaks to one of the pervasive aspects of the modern Neurodiversity paradigm (Walker, 2012) and recent research in the field of Autism studies, in which Autism is discussed as a personality type, or a style,

versus a diagnosis (Baron-Cohen, 2002; Costa & Grinker, 2018; Straus, 2011; Valtellina, 2018).

The facilitating therapist spoke to this sort of movement in the field when describing her own approach to working with children on the Spectrum:

I think working with kids on the Spectrum has always been kind of like a trajectory that I picked pretty early on... [I've always] kind of wanted to know more about, learn more about what, what does [Autism] really mean... I've loved all of the movement around that as a personality, like a piece of who someone is and not a disability really, or not a problem to be solved.

Beth repeated this sentiment many times throughout interviews – highlighting her expressed goal of not wanting the players to feel pathologized, or like a “problem to be solved”. She also utilized language typical of this movement in the field, such as “neurodiverse”. She reported that she felt like she was “a little neurodiverse herself” and that for this reason, she “related to how these kids’ brains are working”. These statements emphasize the conceptualization of Autism as somewhat personality-oriented, describing herself as having “a little” of the traits she is identifying. Her language also highlighted another meaning, in that she sees neurodiversity as having to do with how brains “work”. The “how” here feels important as it points to process and style, rather than label and diagnosis.

One way in which therapists utilized the terminology of “presentation” gave the impression that their conceptualization was really rooted in just that – the presenting appearance of the patient in the social arena. An example of this was when the facilitating therapist discussed

the referral for Player J – whose individual therapist referred her for diagnostic clarification of an Autism diagnosis:

[Player J's] therapist had said something about like in peer supervision, people have asked if there is an Autism presentation. And I haven't felt that, and her therapist kind of didn't feel that.... And I think this group has, you know, they all kind of do lend to that presentation.

Another way of describing the “presentation” was utilizing language such as “Spectrum” as in “A group of people who are much more presenting with like some kind of social spectrum presentation”, or “direction” (“he also kind of leans towards that direction”). Conceptualizing Autism as a presentation that has a spectrum or direction offered a different approach to more diagnostic terms. However, the notion of “presentation” did not remove the discussion of conceptualization entirely from more classic symptoms of Autism. For example, the therapist explained that a need to be in control did function as a “kind of Spectrum presentation” – calling upon the player in the group who she conceptualized as “single-minded” and “I need to be in control, you know [Player S] is like ‘It's on my terms... if it's not the way I think about it, I'm not doing it...no one is making me do anything that I don't want to do.’”

In addition to the notion of “presentation”, another common way of discussing Autism conceptualization was in reference to “style”. The facilitating therapist repeatedly used the word “style”, as in “different style” or “cognitive processing style” to describe the TRPG players.

Another therapist explained this “processing style” as he saw it in one of his TRPG players and utilized this conceptualization for describing players in the TRPG clips:

I have a player in my one game who will get shy. And I have learned to just give him space and time. He is on the Spectrum. He just needs some time to process things...but that player needs some silence. And I think from that one clip I have seen, [Player J] might be like that a little bit as well, might need a little silence here and there to process...

In this conceptualization, the therapist noted some of the characterological aspects, such as shyness, but he also described the way in which he observes these players’ “process” that might be similar or specific to the processing style of a person with Autism.

A prominent example of “style” was in the Beth’s differential diagnosis of Player J – whose individual therapist and the TRPG therapist both felt unsure of Autism diagnosis for. Beth explained that in considering a diagnosis of Autism, Player J’s individual therapist thought of Player J’s social interactions as more attributable to “family style quirks of being a little bit more direct”. For this reason, Player J’s individual therapist was also reported saying that it was difficult working with an “insight-focus”. This conceptualization, and its implications for intervention approach seem to suggest that this “direct style” clashed with prompting more of a depth approach.

This “direct” style was referenced multiple times in describing other players in the TRPG treatment. In some cases the “direct” style referred to players, like J, who would speak to others in a way that possibly denoted lack of awareness of how others perceived their speech or speaking to others without polite pretense. In the Autism literature, such a style is often referred to as “mindblindness”. One example of this was in discussing two players with formal Autism diagnoses, Player E and Player R, whom the Beth referred to as using a lot of “non-sequiturs” in speech. In the case of Player E, Beth conceptualized these “non-sequiturs” as a way of engaging with others:

Player E has been assessed and has an Autism diagnosis...the way Player E presents is that he has a lot of non-sequiturs. I think he says things for reaction and not so much for content. Like I think that is his way of engaging, it is provocative and if he can get a response, if he can get people to laugh he’s being ridiculous and that I think is very edifying to him.

In other cases, a direct style referred to players who had a “literal” or “matter of fact” way of interacting either with others in conversation or with the game rules. The facilitating therapist described one player with a formal Autism diagnosis, Player R, as “practical, like matter of fact, very in the surface level space”. An example of this was when she noted that the player made a “classic” statement of theirs, of “just name what’s happening” – literally noting the surface-level action of a situation. At one point later in the treatment, Beth utilized this conceptualization of only “surface level” engagement to address treatment implications for Player J – whom she said this conceptualization had made more “depth” work difficult in individual treatment with her

outside therapist. This interaction between a conceptualization of “surface level” engagement versus “depth” oriented therapy has strong connections to the field of Autism psychotherapy. The therapist is suggesting here that this “surface level” aspect of Autism, which many TRPG therapists noted as a difficulty with engaging with “depth”-level content such as interpersonal conflict or “darker unconscious” material, might be a contraindicator for traditional forms of depth-oriented (i.e. psychodynamic) therapies. This statement is not new to the field of Autism psychotherapy: Richard Bromfield, in his case study on psychodynamic play therapy with a high-functioning autistic child, noted the way in which “depth” material did not feel accessible for the patient unless it was through the play. In the interview with Beth, she further explains that Player J was explicitly referred to TRPG treatment by her individual therapist for the purpose of exploring “depth”-level content that felt inaccessible in the individual therapy: such as her history with migraines and fear of death. In this way, the TRPG treatment was framed by Beth in her interview and by the individual therapist as a sort of accessible therapy for “depth” material to be explored.

The facilitating therapist noted that the group of players in the TRPG treatment often liked to engage in “healthy poking” or ribbing of one another, but she explained that this was a prior challenge for one of her players on the Spectrum who would often take statements she made too literally. With this player she encouraged a sort of practicing of healthy ribbing in their individual therapy, leading to his having a greater understanding of sarcasm, dead-pan humor and play joking with one another. However, the therapist describes when the player’s practice in the individual work then gets translated to the group therapy setting:

You know, he was on the Spectrum, and we would talk about playful joking with one another... and like that idea of sometimes I would say something and he would be like, 'What?' And I would be like, 'I'm just poking you! Just doing a little poke and I'm trying to be funny' ... And then we had this interaction in an individual session... we talked about what kind of sandwiches [we like] and I was like, 'I like salami,' and he looked at me dead in the [eye] and he says, 'I don't think we can be friends anymore.' And I was like, 'Whoa whoa!' And he was like, 'I'm poking you.' And like he got it right? And it was this moment...

And then he came to group later that week and walked in and looked at one of the other kids and looked at them and goes, 'What kind of sandwiches do you like?' And the kid was like, 'I like this,' and he's like, 'I don't think I can ever speak to you again,' And the other kid was like, 'What the hell?' And he's like, 'Why didn't the joke work?' and I was like, 'Because you and him don't have the relationship that you and I have.' And we got to like actually talk with these other kids about like, why that didn't feel funny... and he had no idea of the context of what was happening. I knew the context... but just those moments to be silly and poke and learn how to.

This example illustrates a common perception of people on the Spectrum experiencing difficulties with sarcasm, as a result of a very literal and matter of fact style. Beth described using the conceptualization to drive an intervention in the individual therapy of practicing healthy ribbing, and then conducts an intervention in the group setting to help the players process and discuss healthy ribbing when it is misunderstood by others (presumably players also on the

Spectrum, struggling with this same style). This vignette also highlighted this therapist's style, and the way in which she created space in the TRPG treatment for these "silly" moments that are not specific to game-play but appear to build the rapport and bond of the players. Ultimately her interventions proved fruitful for this conceptualization, as the player "got it" – he was able to comprehend and understand the therapist's sarcasm in the individual setting, given the interventions of practice and – what the therapist describes as "the relationship" between them.

The TRPG therapists also spoke about the way in which this "literal" and direct style influenced the way in which they conceptualized players on the Spectrum in regards to the game rules. The facilitating therapist made this connection in explaining a moment in which one of the players, Player R, has a very literal approach when reading a magic sign that instructs the players that they cannot take their magic items with them:

These kids... on the Spectrum have that kind of like, you know, Player R is very specific and [he's like], "If [the sign] says don't take [the magic items], don't take em!" And that like rule-following... like that's the rule, that's the structure of it.

The other TRPG therapists acknowledged this same sort of conceptualization as being specific to Autism. Jared responded to this same clip of Player R saying:

Like man! How ASD can you get? 'Well the sign clearly says that this is what we need to do,' Well okay, so we're talking about routine, we're talking about you know, fixation upon what the letter of the law says.

In this statement, Jared appeared to connect his conceptualization of this type of style, as related to a possible intervention of “routine”. Mark similarly responded to this same clip:

[Player R is] very literal, very wanting to know the rules and wanting to follow the rules. In a way that I know, my player [on the Spectrum] is like that with, not rules necessarily as in mechanics, but rules as in what you can expect...It’s just that was his almost like a safety net for him, wanting to know the world that they’re in... but he feels much safer, I think, as a player knowing the rules.

In the above statement, Mark was associating this “literal” style of the player with the conceptualization that he wants to follow the rules. He also explained that this player reminded him of one of his own players on the Spectrum from his TRPG treatment, who is not as interested in the rules of the game (“the mechanics”) but that this literal style lends to wanting to know “what to expect” in the game, and that he believes this provides a sense of “safety” for the player.

6.5 Interests

“When I work with kids on the Spectrum, if there’s a perseverative interest, I’m there.” (Beth)

The TRPG therapists reported some tensions in how they conceptualized players on the Spectrum in regards to their interests and imagination. Mark referred to the “schizoid effective

scale” when conceptualizing a player’s difficulty in distinguishing fantasy and reality. Louis actually shared another perspective, which is that fantasy – or “imagination” in his words – is actually something he has found in his own treatments so be difficult for players on the Spectrum to access. Some researchers have noted that difficulties with visualizing imaginary situations or environments may be related to the observed “resistance to change” as well as repetitive behaviors symptomatic of ASD (Morsanyi & Handley, 2012). A narrative analysis of Louis’s clinical reasoning revealed that he felt this difficulty with imagination was actually a function of a knowledge and engagement gap, in that these players might not know how to engage with the imaginative elements of the story. His suggested intervention was to utilize a narrative intervention of a “built narrative”, providing the players with a narrative with “focused ideas” so that the players can know how to go with it. He explained that this built narrative also provides a Vygotskian developmental intervention of a scaffold, to help the players “build the story themselves” by giving them just enough imaginative material to build off of. He also explained that by stimulating player imagination in this way, the end result is actually more group cohesion by helping the group focus on what they need to add to the story and how they need to work together to build the narrative as a sort of group imaginative task.

Another way in which the TRPG therapists conceptualizes Autistic players was noting their specific interests, such as reading. Several therapists described a player as “a reader”. The facilitating therapist described one of her players this way and explained how she sees this in the TRPG therapy: “He’s a reader. He will actually often sit there and read when we play in person.” One of the interviewed therapists similarly described a player in his own treatment this way, and also observed that this player would bring in a book to read during the therapeutic game. The

therapist explained that at first he thought this behavior was “counterproductive”, but explained that after a few months of working with the player the therapist realized “that this was a tool he uses to help stay immersed”. In this way, the therapist’s conceptualization of the player (“a reader”) directly influenced the therapist’s approach in session, and the passive intervention of allowing the player to read. This also added an interesting component to this conceptualization, that the reading actually led to the player being more engaged – or immersed – in the game than otherwise.

The question of accessibility to fantasy, imagination, individual interests – while not all synonymous with one another – suggests a conceptualization of players on the Spectrum that feels quite particular to the TRPG therapist perspective. In an impassioned explanation of her approach, the facilitating therapist memorably described working with a player on the Spectrum and conceptualizing his “perseverative interest” in cetaceans: “I had one kid I remember, who used to be really into cetaceans which are whales and porpoises and dolphins and things and then he was into cephalopods which are like octopus and squids and cuttlefish... but now he’s just really into anteaters. And this kid you know, like for him to come to me, you could see it in his face, like... yeah we are going to talk about every type of anteater.”

The therapist elaborated to describe how she understood this interest as specific to his Autism diagnosis and how she conceptualized the experience of having these interest in a broader context. As discussed in the quote from Beth on pg. 75 of this dissertation, she explained why “we are going to talk about every type of anteater” is because she felt children on the Spectrum are “literally shut down constantly for talking about perseverative interests. In this

quote she also explained that she chooses in her own practice to engage this particular player on his perseverative interest in treatment as a way of showing the patient that his interests, and the information he knows about his interests, matter to her.

Beth invited the player to utilize toy objects representing his interests in the therapy and further elaborates on why this approach is elemental to her overall conceptualization of the experience of players on the Spectrum: she is using this intervention to counteract the way in which these players often feel shut down and frustrated by not having space to discuss these interests elsewhere – she references the classroom specifically. Additionally, the therapist appeared to be careful about the conceptualization of “perseveration” – remarking that she is unsure of whether to classify these interests this way, as if to refrain from pathologizing their “pride” in these interests. This offers a very balanced, non-clinical perspective to this conceptualization and how the TRPG treatment directly interacts with this conceptualization of players on the Spectrum to encourage, invite, and celebrate these interests through play engagement and discussion.

Summary

Overall, this chapter reviewed the varying ways that TRPG therapists described their conceptualization of Autism Spectrum Disorders. The results reveal the way in which Autistic symptomatology and diagnostic criteria is described as emerging through and within the game space, as well as the ways in which TRPG therapists aim to scaffold and support this emergence through both clinical and gaming interventions. TRPG therapists looked beyond diagnostic

conceptualizations as they described Autism as a personality or style, as well as utilized client-centered perspective and de-pathologized language to describe Autistic players. Ultimately, Autism figured heavily in the conceptualization of most TRPG therapists in their practice of TRPG therapy and as a driver of interventions in treatment that amplified, encouraged, and supported Autistic comportment and expression.

Chapter 7: Theoretical Orientations

Introduction

With each of the interviewed TRPG therapists coming to this modality from different settings, backgrounds, education and degrees, and specialty areas, it is understandable that each drew from a diverse range of theoretical orientations when discussing how they work as TRPG therapists. As TRPG therapists Josue Cardona and Dr. Janina Scarlet state of TRPG therapy, “theoretical orientation is your superpower” (TAGG Summit, 2021). Many therapists utilized and integrated a number of theoretical frameworks, some which at times were vastly different from their primary orientation and training background. In this chapter, I will analyze the multiplicity of viewpoints that these therapists hold, and the way that these viewpoints sometimes diverge from what the TRPG therapists identify as their primary orientation and training. Ultimately, each of the TRPG therapists described the varying ways that they utilized multiple traditions – sometimes simultaneously – and how they at times would integrate various clinical perspectives.

One of the aspects of each participants’ approach that I was trying to understand in each interview was how each TRPG therapist viewed each of the mentioned theoretical frameworks as a tool in their facilitation of TRPG therapy. I will briefly discuss each of the major theoretical orientations mentioned with specific examples of how and when these frameworks were brought up by the TRPG therapists. Doing so will allow this study to reflect the varying ways that TRPG

therapists approach this modality, with the hope that others may better understand the direct influences to this modality.

7.1 Psychodynamic and Psychoanalytic Therapy

As was discussed in the literature review, psychodynamic and psychoanalytic theory has a contested role in the history of Autism treatment and thus I was unsure of how much of these theoretical frameworks might be discussed by TRPG therapists working with this population. However, two of the four interviewed TRPG therapists described their theoretical approach to treatment as having a psychodynamic or psychoanalytic influence and I was surprised when all of the TRPG therapists referred to several psychodynamic concepts mentioned as a theoretical framework for clinical interventions in TRPG therapy including Projection, Interpretation, Archetype, Metaphor, and Subjective Third. I will define each of these terms and couch them in the greater theoretical tradition before describing the various ways TRPG therapists discussed using them in the treatment.

While only two of the four interviewed therapists identified as having a psychodynamic theoretical orientation, all of the participants mentioned the psychodynamic concept of Projection within their discussion of clinical interventions. Projection is a term first deployed by psychoanalyst Sigmund Freud (1911/1958) as a psychological defense mechanism by which a person deals with undesirable thoughts or emotions by projecting it onto others or outward experience. TRPG therapists used the term to describe the phenomena less as an operation of “defensiveness”, but rather as a function of the player’s engagement with their characters and the

gaming world when players projected elements of their own internal experience onto their characters in the gaming world. There is also evidence from the field of role-playing game studies that projection is a naturally occurring product of “character attachment”, or psychological identification with one’s character (Griebel, 2006; Lewis et al., 2008; Reardon & Wright, 2022).

Each therapist referenced projection to suggest that the players were imbuing aspects of their characters and their game play with elements of their real-life personality and experience. The two therapists who did not identify as psychodynamic in their orientation explicitly pointed to the possibility that players “fill the space with something that’s on your mind”, and suggested following-up with players after the game to discuss if elements of the session were “reflective of something in real life”:

There's no way you're not putting your stuff out there, and, and I think that that is kind of true, especially with kids and roleplaying and play therapy in general. Um, the choices that you make to not go to this direction still mean something.

On the other hand, the facilitating therapist Beth mentioned that she explicitly encouraged and assumed that the characters of players were projections of themselves – referring to the characters as a sort of “Thematic Apperception Test” in which the patient players would reference parts of their personality and history. She said that character building was a “projective mechanism” and spoke of “planting projective material” from the players’ real lives into the game so that projection could occur naturally: “I was thinking about the Nothic which is like

here I am injecting all of these fears for you, that's an externalizing something and there's a bit of a projective piece to that.” Beth explained that her approach to the game relied heavily on the notion of projection, sharing that her goal was to utilize patient history and presenting problem within her creation of the campaign narrative, with the intention that the players will experience projection in an experiential way. Beth also repeatedly mentioned the possibility of her own projection in her facilitation of the game – a form of projection known in psychodynamic orientation as “counter-transference”.

While not only utilized in psychodynamic camps, the concept of Interpretation was discussed as a technique by TRPG therapists. Derived from Freudian psychoanalysis and his interpretation of dreams, interpretation as a technique in psychotherapy is the formation and communication of a therapist’s hypothesis for the patient’s unconscious conflict and the symbolism communicated to the therapist through the patient’s discussed content in session (Kernberg, 2016). While each therapist mentioned the concept of projection, there was a bit of a tension in terms of how the therapists wanted to take up the assumedly projected or unconscious material provided by the patients and form clinical interpretations based off of this material. On the one hand, therapists described leaning into their interpretations for better understanding the players through their characters: for example, when Player J shared the backstory of her character to the group and said “[my character] really misses the rock gnomes he grew up with even though they did not treat him well” – Beth shared later her interpretation that this was Player J’s direct reference to personal content, and related to things that Player J’s individual therapist had shared with Beth in her referral. On the other hand, TRPG therapists also described some hesitancy with using interpretation – in that it could lead to incorrect assumptions about

what aspects of a player's character or character actions is necessarily derivative from personal experience. Beth repeatedly mentioned times where she would "refrain" from interpretation in order to "stay close" to the play in the moment, explaining that this was more aligned with a play therapy approach.

One example of interpretation was both the therapist use of metaphor, as one therapist discussed metaphors as a psychodynamic concept and experiential tool in treatment. When TRPG therapists described the use of metaphor in TRPG treatment, they referenced moments in which players engaged with symbolic content – or what Freudian psychoanalysis would suggest is unconscious content that requires interpretation (Freud, 1900; Lakoff & Johnson, 1999). For example, Beth spoke about "engagement in metaphor" as crucial to the therapy, with one example being the Nothic: "The technique of the Nothic is you get the secret and then twist it into something worse or secret, and then it's gonna feed them back the worst interpretation of that". Operating as the Nothic, the therapist openly used interpretation of the client presenting problems and growth areas.

Metaphor was also a psychodynamic concept that the therapists discussed in terms of interpreting what might be considered metaphorical in the actions and responses of the players. A case vignette from the observation displayed the latter. In one session, the therapist prompted a dyadic role play between two of the patient players, during which one player ("Player E") began a long soliloquy discussing the cultural concept of "Karens" – "You know, privileged white lady". He then continued to discuss the experience of racism, comparing it to the experience of "having glasses". Beth encouraged E to continue sharing, even though she expressed in the later

interview that she was unsure of how to understand what he was bringing into session – whether he was role-playing and using these concepts as metaphors, or whether he was trying to have a discussion about culture and race given the political climate at the time. Beth questioned whether this was a use of metaphor and as a potential projective statement of transference, whether perhaps E was referring to her as the “white woman”:

I was like, I’m not, what, what, what are, is this, is this just the experience of having glasses, or are you using this as a metaphor or...? and I said do you want to talk about this some more, and he was like no, and then he was like I’m just bored... And so, I took that as the first vote for like, ‘can we please move on’ is my other interpretation of kind of, of what was happening there.... It was, I got two votes that were bored and therefore, that message, yeah, it was very much like, message received. Like you are also allowed to tell me when to shove it, you know, but in a very appropriate and polite way, like when you’re done, you’re totally fine.

While watching this clip, Louis similarly leaned towards interpreting this interaction with a psychodynamic sensibility – sharing his interpretation that perhaps this was a moment of “unconscious supervision” from Player E. The term “unconscious supervision” is a psychoanalytic term coined by analyst Patrick Casement (2002) that describes the unconscious motivations of the patient to indirectly supervise the therapist. Louis described this unconscious supervision taking place in the therapy as follows:

It's an interesting thing for [the facilitating therapist] because on some level her how they perceive her --which is beneficial but also not always beneficial. I love it when [Player E] was saying, "Well we're just gonna talk about some metaphorical stuff." And then it's like someone says, "Yeah it's like old white woman stuff." [chuckles] And I'm like, oh my God. They're like telling you, "I don't wanna talk about this. I don't wanna deal with this."... they're aware of that we're gonna get some metaphorical bullshit going on here. He's like, "I know where this is going. Let's just get it out of the way. I'm done with this." This is the fourth time you brought it up. Let's just do this. Okay you're gonna do some metaphors.

Examples from the therapy such as the Karen discussion or the Nothic also brought up the discussion of the psychoanalytic concept of archetypes most well-known within the Jungian psychoanalytic school. The concept of archetypes derives from theoretical framework of Carl Jung, who proposed that within our "collective unconscious" as a society there are archetypal figures (The Mother, The Warrior, The Orphan) who appear both in our dream states as well as manifest in cultural representations and symbolic rituals (Jung, 1968/2014). The notion that Jungian archetypes appear in both therapeutic and non-therapeutic gaming spaces has been argued by several prominent role-playing theorists (Beltran, 2012; Bowman, 2012; Bowman & Liebenroth, 2018; Burns, 2014; Larsen, 1996; Page, 2014).

Louis, who described himself as hailing from a Jungian background, repeatedly used the term archetype to describe to NPCs in the therapy. Both Beth and Louis acknowledged the discussion of Karen with the concept of social constructs and archetypes in society. Louis also

explained why archetypes can play a healing role in TRPG therapy, by explaining why the Monsters or NPCs played by the therapist can support the players:

Villains are a way of bringing an archetypal shadow into physical existence and physical existence can be healing on a lot of different levels um where it hopes to bring out the things they don't want to see but sometimes that we have to be able to go forward and focus in on and to be able to actually see what happens.

The psychoanalytically-derived notion of “insight” and TRPG as an “insight-oriented” therapy also came up during interviews. While “insight” is a term utilized in various theoretical traditions of talk therapy, the term insight was first utilized by Freud (1900) in describing psychoanalytic psychotherapy as an “insight-oriented” psychotherapy and then taken up by ego psychologists as a “process of looking inward and the content of what one discovers there” (Frank, 1993; Messer and McWilliams, 2007). The cultivation of insight, or deeply rooted knowledge about one’s own psychological experience and process, is thought to be the goal of most dynamically-informed psychotherapies.

Beth spoke of trying to foster insight and a pursuit of self-knowledge in one of her players: “Not a lot of like insight...but that’s kind of my goal was you know personally with him...I know you have a true self in there. I know you have thoughts and feelings about things, I know you’re a thinker and I can tell that there’s something about it that you just won’t go that next step and say it”. She also mentioned that one player had been referred to TRPG therapy by their individual therapist, with the explanation that the player struggled with “insight-focused

work”. Beth explained that this was a common referral for clients suspected of an Autism diagnosis, and repeatedly discussed the ways that she planted projective material from the player’s real-life – her fear of death, her experience of social rejection – into the game in order to provide an indirect line of access to her insight.

The last psychodynamic terminology that will be discussed is the notion of “subjective third”, a psychoanalytic concept that Louis repeatedly utilized. While Louis explained that this notion of the “subjective third” came from his use of Jungian and Bionian schools of psychoanalysis in his TRPG practice, the terminology more broadly refers to the psychoanalytic concept of the “analytic third” from the psychoanalyst Thomas Ogden (1994) and the taking up of Wilfred Bion’s (1962) term of the “analytic object” by intersubjective psychoanalysts. This idea of the “third” is an entity that is created by both the unconscious individual processes of the patient and the analyst, and it is produced through the dynamics of the therapeutic relationship. In his utility of the concept in TRPG treatment, Louis also applied the concept not only to the therapist-patient production of a “third” but also the “third” that is produced through the patients amongst each other in the group therapy. This concept will be explored further in the following section on Group Therapy as a theoretical framework, but here the idea of a “subjective third” relies on unconscious group processes. Louis described this below:

I’m bringing in psychoanalytic, Jungian, and Bionian, ideas because working as that group cohesion creates that subjective third. And when we focus in on that and we allow our minds to mix and merge and stuff like that, then it becomes a thing that we can rely on. And that subjective third is when we—if you ever have a group of friends and you’re all

like-minded, you're not like-minded because of your individual personalities. You're like-minded because of that subjective third that you guys created and that creation itself does not have to be done in a physical room. It can be done over text messages. It can be done over phone calls. It can be done over anything.

Louis repeatedly expressed his primary goal in TRPG treatment was to create group cohesion, and doing so relied heavily on the creation of a subjective third – a sense of a shared reality, a shared culture, and a shared game space that could be the foundation for meaningful relational experiences among the players. Without using the terminology of subjective third, Beth appeared to echo this importance when discussing the tension between process-oriented and non-process oriented therapy. She explained that when the group achieves what Louis describes as the “subjective third”, there is less of a need for therapist direction in the TRPG modality – and that the players, with a group self-reliance on their shared goals and reality, can then independently support each other in processing both individual and shared experiences. Again, this will be discussed further in the following Group Therapy section.

7.2 Group Therapy

The topic of group therapy and group interventions was a frequent clinical orientation and tradition discussed by TRPG therapists. Like I will share in the later section about play therapy, I was actually surprised by the frequent inclusion of group psychotherapy frameworks in TRPG treatment because in much of the existing literature on TRPG treatment it was not discussed. This is, of course, fascinating because TRPG is a group treatment (Ascherman, 1993;

Lewis & Zayas, 1986)– as well as a form of individual treatment used in individual sessions with patients (Blackmon, 1994). Much of the existing literature thoroughly investigated the merits and supports of utilizing TRPG in an individual therapy, such as fantasy work, skills-building, and identity work. However, it felt more rare to hear about specific group therapy approaches – although these were certainly addressed in the TRPG interviews in this study. I also want to admit that prior to starting this study, group modalities were not in my own clinical wheelhouse, and perhaps this was a limitation. In the following section, I will review the varied ways in which TRPG therapists discussed utilizing their group therapy backgrounds – whether in the form of specific theoretical frameworks of experts (Bion, 1961;Tuckman, 1965) or by identifying certain group dynamics and forms of group processing.

First, several of the TRPG therapists referred to the work of psychologist Bruce Tuckman and his theoretical framework for group formation. Based on his observations of group behavior, Tuckman (1965) theorized five sequential stages of group formation: Forming (identifying purpose, little agreement), Storming, (conflict, clarity of purpose, power struggles), Norming (consensus, clear roles), Performing (focus on goal achievement and delegation), and Adjourning (task completion, recognition of others). While observing the clips of the TRPG treatment in its initial sessions, Mark repeatedly commented on how he saw the group’s formation and referred explicitly to Tuckman (“I was pulling from Tuckman for that”). He even stated that he believed Tuckman’s theory was a clear demonstration of how TRPG group treatment works: “If you look at Tuckman’s stages of development, it is a gaming group coming together. If you understand Tuckman, then you can run a game – it’s kind of that easy, or at least helps manage the table.”

Mark mentioned Tuckman when describing an intervention he uses at the beginning of running his own TRPG treatment group each week. He notes that, like the facilitating therapist does, he starts each group with “Opening Space” – leaving ten minutes or so for checking in on how everybody’s weeks went. He says that this intervention is “open-ended”, and that he will often ask specific players about things they had mentioned might be going on during the week. For this intervention, he referred to Tuckman’s stages and the notion of “re-forming” the group after seven days apart between sessions. He suggests that this intervention helps the “reforming” of the group because it acknowledges that “life has happened and to process that before moving on into the group space or the story space of the game”. Beth, while not explicitly referencing Tuckman in this intervention, also acknowledged the importance of the “Opening Space” in the group’s weekly development and dynamics. Jared noted when players were beginning to develop group roles, such as one player taking on a leadership role in the second session – a sign of group dynamics and development occurring.

One example of how Mark discussed using Tuckman’s theory within TRPG treatment was when he described how he used the NPC of the Nothic in his own TRPG treatment. After noting how he saw each of the players responding to the Nothic, Mark explained that he – like the facilitating therapist – likes to use Nothics when he has a “relatively new party” of players, especially “where the trust [between players] might not be fully up yet.” He explained that measuring the level of trust between players while using the Nothic can help test what Tuckman stage of formation the group is at – whether they are at the “Storming” stage or “Norming” stage. These stages refer to Tuckman’s theory that storming is the second stage in which power

struggles and leadership emerges as a means to the third norming stage where the group has problem-solved through these struggles and started to build cohesion.

The facilitating therapist, Beth, also referred to the “Storming” phase of group development when reflecting on the group’s dynamics in the second session of the treatment. She noted that she felt that the group had entered more of a “storming phase” as evidenced by the conflict that happened between two of the players. During the fourth session, she referenced the Tuckman stage of “Performing” when noting that it was “the phase of the group where they find each other in a flow” – noting that she observed the players seeing each other, and experiencing excitement and enjoyment with one another in the game. She made note of this during a moment in the therapy when the players had successfully defeated a Cloaker, and humorously decided to throw a celebration of their triumph by eating the Cloaker. Beth highlighted moments like this, at this stage of group development, as some of her favorite of her job.

This notion of the group “flowing” was repeatedly brought up even outside of a reference to Tuckman’s “performing” stage. Louis emphasized the importance of the group “flowing” with one another, and identified that this was a sign of “cohesion”. He explicitly stated the importance of cohesion to TRPG therapy as a whole in stating, “group cohesion is the whole point of us running these groups”, and that the main objective was to get to a point in the treatment where the players could “flow”. This term cohesion came up a number of times among the TRPG therapists and appeared to be an important concept to the group approach. The facilitating therapist explained that “cohesion” was the only way for the group to survive the campaign, and that the treatment would only work if the players worked together through the challenges. She

referred to this cohesion as the group coming to “gel” with one another, which she identified as the players being able to read one another and collaborate together. The moment described previously in which the players were “flowing” by eating the Cloaker together, was identified as a moment of the players experiencing “cultural gelling”: by virtue of the group processing their triumph and reflecting on past campaigns in this scene, the players were experiencing a type of cohesion based off of shared experiences and almost creating their own culture as a group. The facilitating therapist identified that learning how to “gel” as a group is one of the first skills she feels players need to be able to learn in order to be in TRPG treatment. One aspect of group cohesion that the facilitating therapist identified as a goal for this specific group was encouraging the players to collaborate with one another.

With this group cohesion being an expressed goal for this TRPG treatment, the TRPG therapist described how they differently used group interventions towards this aim. There was a tension between more the therapist taking on a more active, or directive role in encouraging group cohesion. The facilitating therapist noted times when she might “scaffold” this through intervention, for example by telling the players to pause and strategize as a group out of character in order to slow down their thinking and encourage collaborative problem solving. These more directive interventions were noted by the other TRPG therapists as “intentional”, whether intentional encouragement for the players learning how to support one another, or intentional pauses in which the therapist encouraged group collaboration. Mark stressed the importance of directive interventions that encouraged peer modeling and peer learning.

However, the facilitating therapist noted that in her experiences as a TRPG therapist and in using a more non-directional approach in general, there were many moments in this treatment where she reflected that she could have done more scaffolding or intervention for the purpose of group cohesion. Yet, she explained that when the group does “gel” – or when the therapist “can get the group to gel”, the players will eventually find ways to pause, collaborate, and process situations as a group and independently of therapist direction.

On the other hand, Louis expressed that more therapist direction is needed to encourage group cohesion – and often times commented on ways in which he felt that the facilitating therapist could have intervened more. One example of this was in encouraging the group to confront and process prior conflict as a group, which he referred to as “forcing the conversation”. He explained that he would direct the group to do this, and frame it within the context of the game as that failing to process could lead to the players “having disadvantage on your next role” – providing gaming context in addition to the relational context that conflict can damage relationships. Louis explained that a directive approach, such as forcing hard conversations between players, was at the bedrock of his approach to group therapy: “In order to make it a therapeutic group, a therapeutic nature... we have to sometimes force those hard conversations”.

However, in contrast Louis variably responded to some of the facilitating therapist’s directive interventions – where she seems to “force” processing about conflict. He noted four different moments in which he felt Beth’s interventions were attempting to encourage conflict processing, and explained that he felt her interventions may have “inadvertently” created a “lack of cohesion” among players. He even suggested that this divide between players may have been

“unconscious” on the therapist’s part. In this case, he suggests a more non-directive approach to letting the conflict play out between the players in order for them to independently find cohesion.

These moments of lack of cohesion were one aspect of how the TRPG therapists observed this specific group of players was in the lack of cohesion, or lack of “gelling”. The facilitating therapist at one point noted that one of the players, Player J, had not exactly “gelled” as a new player with the existing group. The TRPG therapists commented on the ways in which facilitator intervention directly contributed to group dynamics. One example was when Jared praised the facilitating therapist for not interrupting a process of peer interaction, which he explained “allow[ed] the group to police the group”. He explained that a non-directive approach of “just kind of let them go” and “allowing the group to police the group” would eventually lead to more support for one another, increased social skill development, and increased communication.

This debate of directive or non-directive approaches specifically became relevant following the major moment of conflict in the TRPG treatment, after Player S had “shock and grasped” the phantom horse of Player J – leading Player J to retaliate with a thunder clap spell that damaged the health points of the entire group. When weighing the different types of group interventions she could utilize to help the group process the conflict between players, the facilitating therapist explicitly referred to “traditional” group therapy models as “let’s only process group together”. She explained that she leaned on this more traditional model when debating whether to continue (after several previous attempts) to encourage the two players in conflict towards “overt exploration” of the what happened between them outside of the general

group space – specifically, in the “Opening Space” of the first five minutes of the group. The therapist explained that both of these players happened to show up early for the session following their conflict, prior to all of the other players, and that she did not feel that it “made sense” to explicitly talk about what had happened outside of group without the others. She explained that this particular group was not exactly a “process space” – referring specifically to a “process group” style of group therapy, which she defined as a type of therapy group where patients are explicitly required to discuss conflict:

I also don't want this group to be a place where I'm gonna look at you and say, 'Listen, we need to talk about how so and so is always doing this,' unless it's really disruptive and the other kids have clearly said it versus kind of an aside...

She further explained that she wanted to give the players the “an out” if they didn't feel ready yet to process their feelings about the conflict, describing this as a deliberate choice to preserve player autonomy. She explained that some topics are difficult for players to explore through explicit conversation, and that allowing exploration to be done through game play was better. She gave the example of one player who struggles with “rigidity”, such as doing things he did not want to do, and that she felt she could not “overtly discuss” this with him. Instead, the therapist explained that she was using the technique of the Nothic to help the player explore this aspect of himself through play rather than processing out loud. In this way, it seemed like the therapist was trying to preserve the group space from forced exploration of disruptive individual behaviors, such as rigidity, or disruptive group behaviors (“so and so is always doing this”) so that it could remain a safe space for the players. Beth also explained that she felt that the players

were independently processing their feelings about the conflict and that she felt that some group processing of the conflict would inevitably happen through the game play. In this way, she relied on more experiential group interventions rather than the more traditional “group process” model in the TRPG treatment.

One example of the facilitating therapist’s more “experiential” techniques for group process was her intervention of “dyadic pairing”. “Dyadic” psychotherapy has origins in both child psychotherapy and group psychotherapy. Dyadic psychotherapy may refer to the parent-child dyad, mirrored in therapy through the therapist-patient dyad, found in developmental and child approaches for developmental disabilities such as Parent-Child Interaction Therapy. Beth explained that her approach of “dyadic work” was something she often used in therapy with younger patients as a way of encouraging relationship building in a hyper-specific way.

However, the “dyad” may also refer to the peer dyad of two patients within a group therapy setting – also known as “pair counseling”, “dyadic developmental psychotherapy” and in play therapy traditions as “dyadic play therapy” (Karcher & Lewis, 2002; Selman & Schultz, 1990). In the TRPG treatment on several occasions, Beth split the larger group of five players into pairs to encourage more localized relationship building in addition to larger group building. She explained that these dyadic pairs were sometimes a more effective way of inspiring group process and stimulating the group dynamics in an experiential way – especially when there were groups where players may not easily get along with one another. In action, the intervention is actually highly structured and directional – as the facilitating therapist set up specific moments in the treatment for pairs to role play with one another as a dyad. One example of the dyadic role

plays was used as a way for Player S and Player J to have a chance to process their conflict while in character:

I wanted to tag that [Player S and Player J were] a developing relationship, and I wanted to give one more chance... to see if they wanted to play around in that space together and as soon as they, you know, they, they, really did. And you know, I think they were really not comfortable with it, and there was this point of, I'm gonna just leave it. And then I said, you know, I started prepping of like, here's what I want to do, and here's what I thought we could do as these two dyad role plays, and then I, you know, in terms of the way that I presented it.

She describes offering the dyadic role play intervention to the players in a structured and optional way, and recognizing when the intervention worked for some of the players but not all. She also later explained that part of the goal of this intervention was to give the players the time and space to strategize and plan with one another in smaller pairs, as a way of promoting group problem-solving.

Ultimately, there was some debate about how TRPG treatment figured into traditional group models. Some TRPG therapists utilized more of a "process group" style (Yalom & Leszcz, 2008) where the focus was placed on interpersonal processes among group members and in which directive interventions would be used to stop game play and discuss and process conflict or tension among players. Whereas others explicitly refrained from a process model, explaining that while there was some room for processing conflict – there was instead an encouragement to

“play it out” in the game and a preservation of player autonomy to make the choice not to process. Part of the tension in these choices has to do with the game play itself: for example, pausing the game play to process group dynamics was seen as some therapists as prioritizing the therapy over the game. Another example was Louis’s intervention of encouraging players to process conflict, or else it may lead to disadvantage on a roll. He was aware of the tension this created, “If it affects the gaming... then it can then force... that need to change how we do this and force a conversation.” This example paired onto Jared’s memorable statement, “We don’t stretch the therapy to fit the game, we stretch the game to fit the therapy”. In Louis’s example, the game is being stretched to fit the therapy: the players might roll a disadvantage and so the priority is that they process conflict. However, in Beth’s approach of not encouraging conflict processing and allowing the players to “play it out” – she is not prioritizing game over therapy either, although it may appear that way without hearing her explanation. Instead, she is making the choice against a process group – for reasons of prioritizing player autonomy about how and when to process conflict, unconscious independent processes of exploring conflict on their own, and also preserving the group space so that it remains safe for players.

As mentioned previously, one of the TRPG therapists utilized the group theoretical framework of Wilfred Bion (1961) in his TRPG treatment. Louis identified ways in which the facilitating therapist might be using certain elements of a “Bionic” style, and described this group approach as: “[The Bionic method] is that the group itself is gonna solve its problems on its own.... And the administrator of the group, whether she intentionally did it or not, was kind of running this as a “Bion style” where the group is solving it’s own problems”. Throughout his interviews, Louis identified these sorts of “Bionic” moments in which the group had to solve its

own problems. He stated that he specifically liked the Bionic group style because of the way the interventions can “frustrate” the players by withholding solutions, which ultimately brings about better problem solving.

He explained that the role of the group therapist in a Bionic tradition is to observe the group’s dialogue and “interject” a sentence or question, such as “I really wonder what this person is thinking in this moment”, as to create a “slight problem or concern” for the group to then solve together. Louis highlighted the term “I wonder” both in the facilitating therapist’s style and as an intervention he likes to use in TRPG treatment, describing this intervention as a sort of therapist role-play in and of itself: in addition to stoking problem-solving, an intervention like this encourages the players to get in touch with their feelings and their character’s emotional content by stating what they are experiencing. He explained that the Bionic group method often had a two-facilitator role, much like many TRPG treatments, and that the therapists would often take on “good cop, bad cop” roles in order to stir the pot among the players. He described this role in Bionic terms, but also in TRPG treatment through the use of NPCs like the Nothic as, “How do I stir something up so that the other person can problem solve but not stir it up so much that it’s not going to be able to be finalized?”

Louis also explained that the Bionic interventions could encourage the group to re-engage with each other, (“I really wonder what the rest of the group wants to do here”) especially in moments where players might be distracted. He also explained that this intervention could acknowledge player actions aloud. In response to one moment in the therapy where he observed the facilitating therapist praising a player for helping the group, Louis stated that he would

actually have “taken this one step further” by not only acknowledging player actions but narrating their purpose in the group: “I probably would have taken it one step further even, in being like “Oh it’s almost as if [Player S] is helping out the group as a response to this previous thing,’ and just seeing where they would go with it...Sometimes it helps to give those words, sometimes it can help bring in the things that are still unspoken.” Another way in which he used the Bionic “I wonder” intervention was as a technique at the start of each TRPG session, by asking players “I really wonder where you guys are gonna go today...”. He explained that following this question, he would encourage players to answer this question both in and out of character, to help the players “merge” as well as “differentiate” the two. In this way, the Bionic method can help engage players with each other and in the game in a way that facilitates immersion through feeling better connected with their characters, and in the game’s problem solving processes.

7.3 Behavioral Therapy

Behavioral therapies are a widely utilized form of Autism treatment with what many clinicians consider a vast evidence-base in clinical research. Behavioral therapies are also a hotly contested clinical tradition with Autism populations. As Jared, who aligned himself with the CBT tradition, said, “FBA [Functional Behavioral Analysis] and ABA [Applied Behavioral Analysis] are barbaric. We are not machines. Can we get away from Autism as a superpower? We are not machines. This is a person exploring possibilities, there is a better way to explore”. Here he referred to literature previously discussed in my literature review (see pg. 24) regarding the debate on ABA and behavioral therapies, and how many in the broader Autism advocacy

community view these treatments as forcing neurotypicality on neurodiverse patients through the use of negative reinforcement practices. Instead, Jared distanced his approach as a cognitive-behavioral therapist with players on the Autism Spectrum from these other types of controversial behavioral approaches to Autism treatment.

With two of the interviewed TRPG therapists hailing from a Cognitive-Behavioral Therapy background, there were many tenants of both behavioral and cognitive-behavioral therapeutic approaches discussed in the interviews. I will briefly review the behavioral, cognitive, and cognitive-behavioral theoretical approaches and interventions mentioned amongst all the TRPG therapists.

The most frequently discussed concept from this theoretical framework was the notion of consequences: one of the participants explained that consequences are both a therapeutic cornerstone of the TRPG modality and a derivative of the Antecedent, Behavior, Consequence (ABC) model in Cognitive Behavioral Therapy (Beck, 1976/2011) :“Gaming and antecedent, behavior, consequence – that is gaming. The DM tells you to do a thing, and the DM explains to you how your thing – [and] the reaction to that thing. That is CBT.” In this way, therapists were explicit about the notion of consequences being linked to a cognitive-behavioral approach as well as a gaming tool – as one therapist explained, consequences are a natural part of the gaming experience. However, the emphasis remained on the therapeutic implications of using the game to identify and analyze player behaviors and the consequences of those behaviors on others in the group. Another therapist also referred to the CBT framework of behavioral analysis when

explaining the importance of consequences, while emphasizing the importance of positive consequences as well as negative:

I think that consequences are, they very often get a bad rap. People think consequences are entirely negative. They're all negative. Well, no. The antecedent behavior consequences, the consequences reaction that happens from an action. So I think the reason why it's integral to therapeutic gaming is that if I'm gonna do a thing, that action does not exist in a vacuum because none of our actions exist in a vacuum. So, I think it's a great way to teach you know cognitive behavioral chain analysis through the game. Ah, I think it's also a way to show the impact of someone's behavior so it can also develop forethought.

The CBT-oriented participants stressed the use of this theoretical framework in TRPG modality as a way for players to understand the impact of their actions on others, observe the interactions that led up to this consequence, and discover alternate ways to operate.

However, TRPG therapists differed in how they imagined applying this theoretical framework as a therapeutic tool in session with clients. An example of this tension occurred when two TRPG therapists were analyzing the same clip from the observation. In the clip, Player S acts impulsively by “shocking and grasping” the phantom steed of Player J. Effectively, this means that Player S attacked the pet horse of Player J – after which, Player J becomes very angry with Player S and casts the spell “Thunderclap” – sending a shock wave that de-stabilizes all of the players in the group. After watching this clip, Jared – a more CBT-oriented therapist – shared

his perspective that the moment in the session was a good opportunity to analyze consequences and initiate a therapeutic discussion about behavior, consequences, and impact on others. He explained that he appreciated how the facilitating therapist called attention to the consequences of the situation, and even imagined that the facilitating therapist was likely sharing his approach about what to do next in session:

A lot GMs even in session like private friendly sessions, consequences are nowhere to be found in role playing games traditionally...this whole thing that [the facilitating therapist] is building, I mean I can almost see the wheels turning inside of Beth's head to be like, "Ok this is a great way for us to now discuss the effects of anger, the impact and the consequences of displaying anger, especially if it's someone that is our friend or our comrade like sometimes emotions get out of hand". And sometimes people do things we don't like so we may respond, "Look at how that escalated". All from a horse when maybe it will lead the way for a conversation of, "Ah, yo, my man [Player S], could you have done that differently? Like what was up with that?"

Here the therapist explained that, in his practice, using a CBT-based approach with a focus on consequences would lead to a therapist-led conversation about the consequences of anger. He proposed using an explicit conversation about impacts and consequences, whereas the facilitating therapist, Beth, ended up having a very different theoretical approach.

In response to the same clip, Beth also emphasized the importance of consequences but explains that she approached the therapeutic moment with a more non-directive approach: "I'm

thinking about um how do I let it play out? Right, there's there's also a place of like... I'm gonna give you the chance to back out of that one. But then you know the dice are gonna roll and the consequences are gonna happen. And what we do matters in this game right. You have taken action. Consequences occur." Instead of considering a directive conversation about consequences with a pause in the game play, as Jared suggested, Beth explained that she draws from her play therapy orientation as she wants to let the situation to "play out" and for the consequences to naturally occur as a result of player actions. However, at the end of the clip – in a similar vein to Jared's thinking – Beth does ask the group if they would like to discuss the conflict that just occurred – to which the players respond no. Beth explained that because the group did not take up the invitation to have a directive conversation about the situation, she planned to structure a group opportunity to converse in character about what had happened:

When it was kind of all over you know opening up like you guys just had a thing. You need to talk. And of course, no right? Everyone was kind of like mmm no we don't. Um but I do plan on actually going back and having a little bit of more of a structure. Like I actually think what happened last week was important. I wanna say is there was this other really important thing that happened between these two characters and I think if if these were this was move right, like the characters in the movie wouldn't just like pick up and move on to the next thing right? They would have to figure something out because something happened between them. Um I you know my thoughts are like I wanna externalize it because I feel like it's gonna be safer.

As we see in these two differing applications of the theoretical framework of consequences, TRPG therapists of different orientations apply similar theoretical principles, but they do so in different ways. This observation points to not only a possible integration of theoretical traditions by TRPG therapists, but also a multiplicity of viewpoints that has profound implications for the field of Autism psychotherapy as will be discussed later in the Discussion chapter of this study.

Another example of TRPG therapists of different orientations applying similar theoretical principles is the concept of “cognition” and the mention of cognitive theoretical frameworks amongst all of the TRPG therapists. In particular, each of the therapists discussed “negative cognition” such as negative self-talk and negative thoughts that was first popularized by CBT therapist Aaron Beck (1976). One therapist discussed the importance of cognitively labeling emotions, such as fear, as “irrational” and encouraging players to distinguish between rational, reasonable thinking and irrational emotions. The facilitating therapist, Beth, explained the use of a therapeutic gaming technique, an NPC monster called the Nothic, as both an archetype and a manifestation of the negative thoughts that players have about themselves. By including the Nothic in the game, the players had to both repeatedly encounter and respond to negative thoughts about themselves in the game.

Negative internal narratives are like. They’re like a creeping little critter that’s just trying to beat you down and trying and to kind of like throw you off your game. And but they are still a part of you. And they, you know, you have to build a relationship with them in some way... theoretically in some way in order to be able to stand up to them or at least make space and, you know find counter arguments with your own self.

Two of the TRPG therapists spoke about the importance of exposing players to negative internal narratives and negative thoughts within the therapeutic game, as well as the technique of preparing both personal narratives related to the player's specific circumstance and more general and pervasive negative cognitions like "I'm not good enough". The facilitating therapist, Beth, explained that her inclusion of these negative cognitions were to support the players in how they might respond to and self-regulate during these "introjective" thoughts that might make them angry or frustrated. In the case of the Nothic, Beth referenced her utility of Acceptance and Commitment Therapy (ACT) as a way of encouraging the players to form a relationship with these negative thoughts, and learn how to respond to them:

My approach to using it this way it really comes from also I have some background um, in Acceptance and Commitment Therapy so like there is a solid, you know that place of what they would call getting hooked, right by the thought, and you're in it and that thought is traverses having a thought. And the concept that I have thoughts and they happen, but I don't have to buy into them. I don't have to get hooked. They don't have to, you know, you don't eat every time you're hungry. You can walk by a bakery and look at the cookies and go those look good and you don't go in and buy it. Sometimes you do. And you do, sometimes you choose to do, and sometimes you don't. And we can look at the thought of nobody will ever love me, I'm useless. And we can say I don't have to buy that cookie. I can walk by. I can see it happen, and I don't have to internalize as true. I can just say it's a thing that, it's an event that's happening in my

head. And it's a thought, and it's, that's all it is. It can't hurt you. Um, so that's what I think of like of it's the, it's cultivating that relationship to our own thinking too.

When one player responded to the Nothic's negative intrusions by suggesting that all of the players were "going cuckoo", Beth used the CBT technique of reframing (Beck, 1976) to encourage them to have a more "acceptance and commitment" attitude towards these thoughts as not pathologized, but rather natural: "it could be just a thought or something else, ya know.... Thoughts are just like thoughts. They're just internal events that happen". Beth repeatedly emphasized the universal importance of cultivating a relationship with one's own thoughts, with an expressed goal that through the Nothic the players may have the experience of realizing that "The world inside our heads is more similar with everybody else than it is difference... that is kind of an underlying theme I'm trying to pull here too, that's about as directive as I get." Beth appeared to integrate psychodynamic and behavioral frameworks when she expressed that Acceptance and Commitment Therapy (ACT) "relies heavily on metaphor", sharing her belief that the technique of the Nothic and the negative cognition worked so well because it utilized the "associations and sensations" that the players projected from their personal lives. This use of metaphor as both a psychodynamic concept with cognitive-behavioral applications in the therapy is one of the many examples discussed in this chapter in which TRPG therapists appear to integrate and interweave between various theoretical traditions.

Mark, a CBT therapist, also repeatedly mentioned the importance of interventions that support players with "acting instead of reacting", and helping players identify how to navigate their thoughts: "The separation between you, and what happened to you, to give that moment of

thought and that moment so that you can act instead of react”. He especially referenced this sort of approach when supporting clients with managing impulses and anger within the TRPG therapy, explaining that a major intervention would be supporting clients with “verbalizing” when they believe a specific choice may have negative consequences.

There were also several mentions of a more behavioral theoretical framework and behavioral interventions. Jared, a CBT oriented therapist, repeatedly brought up the notion of “behavioral markers” as he observed the players throughout the TRPG therapy sessions. He explained that he used the concept of behavioral markers to signify a manifestation of client experience, feeling, or thoughts: “I have a behavioral marker of when the person is feeling this, they do this. When the person is experiencing this, they do this.” Jared also appeared to explain behavior as a function of a client experience, “It’s not what the player does, it’s why they are doing it. What function is it serving?” By tracking and analyzing behavioral markers, Jared shared that this was the way in which he could assess the effectiveness of the TRPG therapy and player clinical growth.

Finally, it should be noted that it appeared at times that the TRPG therapists associated cognitive and behavioral theoretical frameworks with a more skills-based approach to treatment. I understood this to be because CBT and ACT therapies can often utilize skills modeling and teaching, and I will discuss this approach further in the next paragraph on Skill-Based Therapy. However, the pairing of these frameworks did appear to create some tension for Beth, the facilitating therapist. Although she fervently described the utility of ACT in her application of TRPG treatment, she was adamant that her approach was not about teaching or learning skills:

It's about them learning about themselves in a way, you know it's their, it yeah. And I think, I think that's also a therapeutic tenet that I hold is you know I can't, you can lead a horse to water, but you can't make them drink. And it's one of the reasons, I mean I appreciate CBT and cognitive techniques and I use them, it's, it's one of the reasons I'm not solutions focused therapist. You know I'm not a, I'm not a um...I'm not a like, let's build some skills, let's practice this, let's rehearse this, and you know because in some ways you also have to come to it and experience certain things in order to understand.

This statement set up one of the major theoretical clashes among the clinical traditions, as Beth describes an approach of “CBT and cognitive techniques” as related to building skills and then practicing and rehearsing sed skills. She contrasted this approach with her own – rather than having clients learn and practice skills, Beth proposed that their experience in the TRPG therapy is more at the center of the therapeutic experience. She explained that in her practice, she privileges clients “drinking the water” themselves, rather than being led and forced to drink. In this statement, she also echoed some of her more dynamic clinical leanings, towards an approach that fosters insight and clients “learning about themselves” through experience rather than skills.

7.4 Skills-Based Approach

When considering the various forms of Autism treatment, there are a number of traditions and settings that highlight the importance of skills building – whether this be social skills, executive functioning skills, or daily living skills. While this section will not be specific to one

form of “Skills-Based Therapy”, here I will share the different skill-sets that the TRPG therapists mentioned as being a major part of their TRPG treatments.

One of the major tensions I observed in discussion of a skill-based approach to treatment was contrasting opinions about how this work is done in TRPG modality. There was disagreement among the participants about whether skills were to be taught as a form of instruction or whether skills were to be indirectly learned experientially without explicit instruction – or both! This tension is important to this modality, and will repeatedly come up also in the section on Play Therapy, because of the unique TRPG setting.

One major place this tension came up was around the question of immersion: keeping the players in the game, or stopping the game to take them out of it. As will be discussed throughout this study in the following chapters on gaming interventions as well as in the final discussion chapter, TRPG therapists weighed heavily the stakes of pausing the game and breaking immersion as a dilemma between privileging the game structure or the therapeutic moment. In order to provide a therapist-directed, or directive, approach to skills instruction, the didactics of skills might necessitate stopping the game and taking the players out of their immersion. The TRPG therapists appeared to deliberate intentionally when making this choice, with Jared explaining that “you stretch the game to fit the therapy, not the other way around”. By pausing the game for directive interventions of skill instruction or for group process, the argument is that the therapeutic moment is privileged over the game structure. Jared continued to explain that in his facilitation of TRPG therapy, he wanted to encourage individual and group process as well as “skill teaching” but that he was careful of when to do which:

Ah, seems like you had a different idea. What were you hoping to accomplish' by you know maybe trying with that skill build to encourage the process of analyzing but you're just like, wait. "You have an idea. Do you want to talk a little about that" ...So there maybe could have been some further skill teaching --- you know. sometimes the moment presents itself and we want it to happen organically. Sometimes that moments does need to kind of be served on a platter... So, and again that's probably one of the biggest questions about the whole process because you never want to force it, because then it, again you're dominating.

The issue of "dominating" that Jared brings up is the fundamental tension between a non-directive or directive approach to the play or the skills-based therapy. His sentiments echo the same tension described in the previous section on Behavioral Therapies regarding consequences: does one stop the game to discuss consequences of actions, or as Beth does – "let them play it out"?

7.4A Executive Functioning Skills

One skillset that the facilitating therapist appeared to focus repeatedly on was within the area of executive functioning – which seemed to be related to metacognition, problem-solving skills, strategizing, and "thinking through" a complex situation. The facilitating therapist included several "exercises" within the campaign as built-in activities to work on executive functioning. One example of this was a brain-teaser – a word puzzle that the players needed to solve in order

to progress in the adventure. In explaining the purpose of this activity, the therapist both stressed the experiential value for the players as well as the “brain” benefits:

A little bit of like brain exercise those like something you can do to make your brain feel different, right? And that’s always a good thing to expose yourself to... I think it’s philosophical for me like it’s just the idea of like being able to know when something is to like put your brain into a into a um a different perspective... Um but just again a structured experience of doing something with your brain that is different.

Again, Beth continuously foregrounded the experiential benefits of skills-building, as opposed to the practice of a particular activity or skill. This observation marks a pattern in Beth’s TRPG approach, and distinguishes a difference from some of the TRPG therapists who might privilege certain discrete actions or activities over the experiential. While the exercise was experience-focused, it was also quite a structured and therapist-directed activity geared towards a specific skillset. However, Beth took an explicitly different approach to the area of social skills. When asked about why executive functioning skills were a component to the TRPG therapy, Beth continued to stress this skillset’s importance to her practice, even going so far as to say that she would “market” these groups by this skillset alone:

Exercising executive functioning skills which is another way that I would totally market these groups... Where you don't have to you know like I said that that on paper is fantastic those are, those are skills kids need to succeed in school, they are skills kids need put to navigate their friendships, they are skills they need to you know get their

chores done at home. And right and so if they are in the game and they're practicing just at that level alright this is a complex situation how do I break it down, how do I stop and see the pieces for the whole? Right that that's a skill, that's a skill building in a way that I think is working it in a creative way which is why literature and fiction is so great right....But having a complex story that you're literally engaged in and trying to kind of like do that, that actually does have a restorative kind of stress relief you know. There's like better benefits to that kind of brain activity and in relaxation or in recreation.

Here, Beth implied a number of valuable connections implicit in her approach to TRPG therapy: the players learn executive functioning skills, such as organization of tasks and problem-solving, through being engaged in a complex narrative that makes the acquisition and learning of these skills not only less stressful, but also a stress-relieving exercise. Additionally, she again appeared to link the “brain benefits” and neurological activity in executive functioning TRPG, but also connected it to the brain benefits of stress relief in recreation and gaming. As will be discussed in the sections on Narrative Therapy in regards to interpersonal neurobiology, here Beth linked “brain activity” to the engagement in a complex narrative or story in the TRPG treatment. This mirrored other ways in which Beth included discussion of the brain – such as “brain exercises” she would integrate in the TRPG treatment, like the word puzzle she included in the third session of the treatment. Other examples of implicating the “brain” in TRPG treatment were in the form of psychoeducation about the brain, such as in the first session when she described talking to players about negative cognition by saying “our brains are not always our friends, our brains are not always gonna tell us the right things” or in the final session of the observed treatment when

she noted that one of the non-player characters acted impulsively and without emotional input because he was “thinking without amygdala”.

Two of the study’s participants spoke about the importance of strategy and planning as “executive functioning skills”. Researchers have pointed out that the encouragement for players to rehearse adaptability and consider alternate options before committing to one course of action is a particular therapeutic strength of TRPG treatment as a clinical tool (Causo & Quinlan, 2021). This was especially spoken about in regards to the final session, a finale point in many campaigns in which there is usually a large battle that requires “great risk and great reward”. Both therapists stressed the importance of “information processing” and thinking through a complex situation as skillsets present in TRPG therapy. The facilitating therapist also referred to these skills as “metacognition skills” – what she described as problem-solving and working with others. These skillsets not only appear to be individual in nature – as in one player developing these skills within themselves as the more brain-focused dialectic would perhaps suggest. For example, one might consider this skillset – especially with an Autistic population – to be more related to independent functioning, such as making a decision or staying organized. Instead, these skills were narrated by these TRPG therapists as being developed through the other and with relational outcomes. Encouraging these skillsets in TRPG therapy appears to be geared towards beyond individual outcomes, and towards relational outcomes of collaboration with others, and navigating social situations like at school, their friendships and at home. In this way, the metacognition and executive functioning skills discussed were in some ways social skills as well.

7.4B Social Skills

It is noteworthy that all four of the TRPG therapists mentioned social skills in their discussion of their clinical interventions and theoretical frameworks. However, each of the therapists with their unique backgrounds and orientations, focused on different aspects of social skills and varying ways on which they believed the therapist would operate when interacting with a skills-based approach. Mark emphasized social skill “instruction”, for example – highlighting a moment in which he observed the facilitating therapist doing this:

I also really saw and loved how when a relationship was established, EB did some very good social skill relationship dynamic instruction of putting a value to the relationship. Because again emotional recognition things like that are kind of known deficit qualities with ASD. So that idea of giving them the context to the relationship, I think was a very good foundational step to them being able to perceive the relationship from that standpoint so she kind ah she set up the pins for, for hopefully for later bowl to have the ball hit the pins.

Here another major theme of the results, the tension between directive and non-directive approaches to treatment, can be seen in the participant’s interview. Mark acknowledged what he perceives as several moments of a more directive skills approach – both the “instruction” of labeling the relationship and the “set up of pins”. Another TRPG therapist, Louis, also appeared to take a more directive approach with what he called encouraging “social engagement” among

players. He explained that social skills and a more directive approach was at the core of his approach to therapeutic gaming, especially when conflict occurred between players:

We run a lot of social skills groups. [Conflict] happens 99% of the time. And in order to make it a therapeutic group, a therapeutic nature, or a social skills group, we have to sometimes force those hard conversations.

Louis continued to explain that in order for the group to be therapeutic, in his view it was the therapist's role to manage conflict and promote social skill development by encouraging process-oriented conversations among players. This approach differed from the way in which the facilitating therapist opted to handle conflict, in which she actually explicitly said the exact opposite of forcing hard conversations: ““I wanted to give an out if you don't wanna process. Like there's also a place where like you don't if you're not ready, you're not ready. And like that is the do you guys need to talk about this? And if they want to explore it, and maybe they'd rather not and that is all I think that's an important choice you should be able to have too.”

In contrast to a directive, instruction approach to skills, Beth promoted a more independent quality of social skill development that was being self-directed by the players rather than therapist. A repeated example she shared was the metaphor of “dropping”, “picking up”, and “passing the ball” – with the ball being the social conversation and engagement. She repeatedly spoke of wanting to refrain from “passing the ball” between players, as in initiating and carrying the conversation, and wanting them to have their own experiences with initiating and carrying on conversation, as well as ultimately responding when the conversation naturally

“drops”. She spoke here of the social skills as being a function of “rehearsal”, an experience rather than an instruction:

That idea of you get a turn, so here’s your next chance. Like, I’m gonna say the appropriate response when someone sends out an overture, but like you know, to be given the space to drop it and then a chance to to pick it up again. You know, the just the rehearsal of that... This, you know, this skill that is good, I think for them.

This was one of the many times she spoke of the more experiential elements to the therapy, using terms such as “rehearsal” and “practice” to denote the importance of a repeated, relational experience. Despite Louis’s more directive approach to social skills described earlier (i.e. “force a hard conversation”), he did appear to also promote language of “practice” pertaining to social skills while explaining how he justifies TRPG as a therapeutic modality for Autistic clients to insurance companies, like Medicaid. In this instance, he reported that it is useful to express the therapy as a means for “building” social skills and refers to his session notes as a tool:

And I can kind of tell you, insurance---cause we can actually kind of bill insurance to do these things the way that we would, which is fantastic cause these kids. We have a whole bunch of Medicaid kids who are like, “I don’t get anything” because Medicaid sucks on paying for anything. But we get them to pay for these groups and sometimes they come and audit us and they’re like, “Well what were you guys doing in this group?” We’re like, “We’re playing D&D.” And they’re like, “Well that’s not...uh...therapy.” And we’re like, “Well let’s hold on. Let’s go over the group notes. Let’s figure these things out.” And we’ll line it up and everything like that in order to show the insurance companies

that these things are important. These things happen. And that we are engaging in a social skills practice building.

Louis's stance on social skills stands in stark contrast to the discussion in the previous section in which Beth stakes a focus in executive functioning skills as her way to "market" the TRPG modality. In either case, it is interesting to explore the varying ways that the notion of "skill" as a theoretical framework, whether social skill or executive functioning skills, provides grounding for how this modality is marketed to others including the medical community.

Two therapists repeatedly emphasized social skills pertaining to empathy and perspective-taking. However, again, the way in which each therapist explained the development of these skills via the therapy was quite different: one emphasized skill-building through experience, the other through direct instruction. An example from the observations will help illustrate this difference: when Player R was stuck in the grasp of the Cloaker monster and the group struggled to deliberate on a rescue plan, as described before, the facilitating therapist verbally checked in with Player R in front of the group by asking he how he was doing in the arms of the Cloaker. Jared explained that he felt that this intervention was a way of promoting "perspective taking situational alliance" as a means for "social skills development", and that the therapist was adding an emotional "catalyst" to support this happening. In another instance, Jared also commented on the importance of supporting players with understanding how others think about situations differently, which he called a "great skill build moment".

On the other hand, Beth viewed "perspective taking skills" with a different approach. As has been described in other clinical examples, Beth again took a less directive and more

experiential approach to the notion of skills. While similarly commenting on there being an emotional component to this skill as Jared asserted, Beth stressed the experiences of “strength”, “confidence”, and “shame” over the idea of building of a skill:

Perspective taking skills. Impact. Understanding impact... you need the strength to be able to kind of fight back the shame of like when you know there's a breach in an interaction or there's a breach in a fight or you know like, “Yeah I didn't do that right. That was wrong.” You know you need strength and confidence. You need the skills that I think you know – talking back to these negative attacks from the Nothic or saving on a fear roll – you need those skills in order to be able to say “Oh yeah, maybe I did outshoot a little bit,” and to be able to come have that repair space happen.

This statement suggests that understanding impact, or the perspectives of others, requires strength and confidence first. In addition, she understood perspective-taking as a skill that goes beyond the social – and can help build resilience as a way of coping. Again, this approach appears less interested in skill teaching, and more geared towards repeated experience as a means for developing ways of being in relation to others.

7.4C Coping Skills

In the previous section on Behavioral Therapy and cognitive theoretical frameworks, I shared a quote from Beth in which she explained that “as directive as I get with skills” is promoting a universal understanding of how minds are “more similar than they are different”. As

a steadily non-directive therapist, Beth used comparable language to describe the directive style she assumed while discussing coping skills:

A great way to talk about talking back to yourself, talking back to yourself, being able to have that resilience to kind of experience thinking that makes you feel bad and then knowing what to do in order to kind of cope with it. That's I think about it as direct I get with skills is, you know, using the game that way to kind of integrate an actual behavior in that the character is experiencing... so this, you know, later on you get this thought and you don't know where it came from and it's really negative. And how does that affect you? Um, how do you respond when that happens? In character, of course, so it's also in that safe bubble of like we're not actually talking about you. We're not talking about yourself.

In this statement, Beth again echoed her focus on building resilience – discussed previously as a “perspective-taking skill” and here as a coping skill when the players encounter the Nothic – a monster, played by Beth, who feeds them negative cognitions about themselves to process and respond to. What is noteworthy in this discussion of coping skills is that Beth again emphasized the experiential aspect of skill development, explaining that their interaction with negative cognitions in the TRPG therapy will have later benefits when they encounter negative self-talk in real-life. She also explained the therapeutic mechanism of having this experience happen in the therapeutic setting and with an externalizing context of the game, describing the “safe bubble” of having this experience happen to one's character rather than “talking about yourself”. This statement also reflects the reoccurring pairing of a skill-based and behavioral approach, as she

explains that the directive towards a skill is a way of “integrating” a behavior that the player is experiencing within the safety of their character.

Throughout the interviews, Beth continued to emphasize resilience as a skill that she aims to build in her clients throughout therapy. In the following quote, she continued to emphasize that this is a skill that, in her perspective, is meant to be earned through experience rather than “forced” upon clients by the therapist:

The more messaging that kids can internalize around things like that, the more resilience you’re gonna build overtime. You know, like you can’t force it, but if you, you can kind of expose it, and keep it, keep it salient, and have it be a thing that they can experience. Right? I think that that’s like, yeah, I think that that’s an important resilience skill.

Beth also specified specific circumstances in which she hoped to encourage resilience as a coping strategy, such as navigating social interactions over Zoom and confronting conflict rather than being avoidant. Jared also mentioned that he would “teach” coping skills for Zoom interactions, and support clients in understanding how to manage their discomfort while on camera.

Beth also mentioned negative coping strategies, describing Player B, whose character would often drink heavily at taverns in the fantasy game world and would describe this habit as a coping mechanism for dealing with past trauma. Through conversations with the other group members and with the facilitating therapist, Beth explained that this character would have

explicit conversations with the group about using alcohol when he is “triggered” by bad memories. When I asked Beth about what the real-life implications of this were for the player – whether she felt this character’s alcoholism might be a projection from something he was witnessing in his real-life at home – she explained that, given her knowledge of the client, she sensed that he and the other kids were at a natural developmental point as pre-teens to be processing and making sense of alcohol and drug use in society and within their imminent social circles. When the character had to fight a battle hungover after a rest at a tavern the previous night, Beth linked the therapeutic moment back to the notion of consequences, yet another tie-in between skills-based therapy and more cognitive approaches.

7.4D Life Skills

One therapist, Mark, was explicit in that he felt the treatment was geared towards the development of skills, particularly social skills, as well as wanting players to learn “life skills” such as how to navigate difficult situations. However, the notion of “life skills” or “life lessons” had great variability among the TRPG therapists. An example of this was in an observation clip wherein Player R had been attacked by a Cloaker – a monster in the D&D game. While Player R is trapped, wrapped in the Cloaker, the four other players must deliberate on how to effectively rescue R and how to attack the Cloaker without hurting Player R. Mark described the life lesson he felt that the players were needing to take away from this therapeutic moment:

They were struggling with, well, I want to hurt the bad thing, but not my friend. Well, you might need to do both, because the bad thing’s going to hurt your friend. So, your

friend is going to get hurt. Life lesson is, try to make sure the bad thing doesn't hurt your friend too much. You know, to get, get rid of the bad thing.

In Mark's description, there is perhaps a more general "life lesson" about protecting one's friends to the best of one's ability. However, this therapeutic moment similarly was also described by the facilitating therapist, Beth, with a more experiential approach. Beth explained here that difficulty of navigating complex situations for people with "flexibility issues" or for people on the Spectrum:

Because it was like, they literally are like, exhausting every option to avoid hurting him. Even though he was going to get hurt if they didn't do anything. Right? So that was also then, you know, the tension push of like he's gonna get hurt regardless. So, there's maybe no good option here, which is I think a thing that like, for kids with like flexibility issues, right? Especially with like often with spectrums. Like, "If it's not the way I want it to be, then I can't do anything", or, "It's my way, it has to be this one way and if it's not that way" or in that, you know, script, then, "I can't really tolerate that." And so, really talking with kids just about like, "So, Plan A's not an option, the situation is definitely not ideal, right, but so what do you do with that? Where do you go with that to, to like, cause otherwise you're just stuck here, Right?" And so like, "How do you come up with the next best thing, when you can't get the best thing? Or the thing that you think is the best thing?"

Again, this difference among TRPG therapist reflects the primary tension Beth described in the previous section: the tension between a more experiential approach versus a directive approach to skills instruction. I will continue to discuss the Experiential approach in the next section, as it continued to be one of the most discussed among TRPG therapists.

7.5 Experiential Therapy Approach

Two of the TRPG therapists discussed the importance of player experience within therapeutic treatment. The more-CBT aligned therapists interviewed advocated for behavioral and skills treatment, whereas the facilitating therapist took on an explicitly non-CBT approach to treatment more focused on the experiential. However, the facilitating therapist had a strong basis for experiential-therapy in her approach to TRPG therapy. In her assertion that experience rather than skill instruction is at the basis of her approach, Beth repeatedly asserted that an experiential framework is the antithesis to a “lesson”. This was already previously discussed in the Skills-Based section, but will be expanded upon here.

Experiential approaches to psychotherapy derive from the lineage of the Gestalt school (Perls et al., 1951) as well as the humanistic framework of Carl Rogers (1957), borrowing from humanistic and phenomenological methods focused on increasing a patient’s awareness of his or her current feelings, perceptions, and physical state (Greenberg & Goldman, 1988). As will be discussed in the sections in which experiential focus was described by TRPG treatments in the following section, the proposed mechanism of psychological change is the patient’s awareness of and communication about his or her experience within the therapeutic setting. Louis described

using the Gestalt “empty chair” method by using the non-player character (NPCs) as a mediating technique.

Beth repeatedly contrasted her more experiential approach from a instruction or didactic style of therapy, explaining that instead modeling and the experience of the players was at the fore of the therapy. Here are two examples of her explaining the importance of experience:

Again, I don't teach. I don't wanna be like, this is how you do this. Like it's experiential. I'm modeling it, because it's real and because it's happening in between us, in our connection with each other. This kind of game is such a great opportunity to literally have them experience it...It's not a didactic lesson. It's just a thing that's happening and they can then be aware enough that it's happening and to see what and how it's affecting the character and then what the character is going to do about that.

Another TRPG therapist, Jared, also appeared to emphasize the notion of the therapeutic game as an “opportunity” for the experiential. However, aligned with his more CBT-oriented approach, Jared explained that the game provides opportunities without “real-world consequences” so that clients can feel the freedom to “explore possibilities”.

However, it appeared through further conversation that the attempt to dichotomize the experiential and the didactic is not so simple – and that perhaps there is some room for both approaches simultaneously. Beth appeared to synthesize these two dichotomies when she

explained that the experience of being with others in group allowed players to experience friendship in a profound way:

Nothing teaches like experience. Right? Like even you know even just the yeah that's the like the embodiment of it or just the discussion of it is more than just being like having a conversation about like so how do you make friends? What happens here?

In this statement she suggested that instead of teaching social skills or how to have friendships, the experience of being in relation with others will provide lasting experiential lesson for later on in the client lives. She continued to repeatedly discuss the benefits of relational experience, with a more directive and instruction-oriented stance, when she shared what she felt past clients took away from the therapy. She described to me a directive therapeutic activity in which she asked players to update their character sheets at the end of a past campaign:

In previous sessions, what I've done is if they actually learn lessons from these things, and if they get through the experience and they actually like, their character learns something, that solves, or gets them through that, or helps them cope with it, or helps them overcome it... I was actually writing kind of like statements on like index cards, and if they, when they overcame it, they would get a statement from me... and it's almost like updating their values, or their goals, you know the bonds, and the things about like, and that like acknowledge the growing in their character. They could actually like reference how they are using that statement, and that thing that they've learned about themselves in something that they're doing later on. Which I think they've all completely

forgotten about at this point, because I didn't, I don't think they got typed up exactly within the, in the mix of everything, but umm, you know, then they could get like say and advantage on a roll for something if they could say, oh well I learned that I am able to rely on, you know, to let other people help me and not try to do it all by myself, and then they did something collaboratively with umm, you know, they could reference it, or it's like in my new, my card and they could have a little reward for kind of using the things that their characters were growing.

In this instance, Beth utilized a more directive intervention style (the index cards) as well as referring to this experiential approach as a “lesson” – which directly conflicts with previous statements that contrast the experiential from the didactic. However the same emphasis was placed on the experience being produced in relation with others, such as learning to rely on others, – and with the notion that this experience will be a lesson referred back to later on. In this way the previous dichotomy between “experience” and “lesson” appears to dissolve into a compatible union: as Beth appeared to suggest, experience, rather than the therapist, is the teacher. In this example from Beth's TRPG treatment, the index cards are the critical mediating tool for player experience in that rather than having to choose between being in the interaction with other players or being pulled out of the interaction to process, the cards allow the players to stay in the gaming experience while also staying connected to their future and out-of-game selves.

The experiential approach described by the TRPG therapists had particular experiential aims: the therapists discussed encouraging the specific experiences of feelings such as fear or

discomfort, circumstances like threat or risk, and even the experience of death. Mark stressed the importance of allowing the players to experience failure during the therapeutic campaign, as well as have the opportunity to collaborate during stressful situations. Beth similarly echoed the experience of stressful situations, but focused more on the emotions that arise while the group faces a threat together. Beth explained that the experience of a threat was key to her facilitation of the TRPG therapy, in that threat “bring people together” in a shared and emotional way. An example of this was when Player R was stuck in the Cloaker, with the group having to figure out how to manage this threat. Beth explained that this threat management is unique to TRPG group treatment, and that it is hard to bring into an individualized therapeutic setting. When players experienced threat and anxiety, Beth encouraged them to talk about their feelings through the experience of their character: “[he] doesn’t have to be so stoic, he could also recognize that there was a pretty immense danger and might have a little bit of worry about that... and what is it like if [he] can start to talk about his feelings. It’s easier for [the character] than maybe the human behind him.” Discomfort, Beth explained, was also especially important for players on the Spectrum or with anxiety or control issues to experience within the therapy: “That space of like you know what guys, it is okay to do anything that feels uncomfortable sometimes. It is okay just because you know the sense of control helps but sometimes when you feel like you don't have control, there are things you can do to get through it and there's usually a reason why you do it.”

When the players would share that they were afraid or uncomfortable, Beth would normalize their experience as a natural product of being immersed in their character’s experience – as well as emphasize the externalizing component – that their character, and not themselves, were in danger. Beth explained that this marriage of both immersion and externalizing is a

critical part of the TRPG therapeutic experience: “it is the ability to experience both of that right it's it's that that's the power of play in general is that it can be I know that I am in the you know I am in charge of the rules of this and I am making the narrative and my character is not really in danger you know but I am also feeling and experiencing and I'm pulling in the threads because of things that I feel in my everyday life.” This occurred in one specific moment where a player asked, “Is there a spell to not be terrified?” – to which Beth responded with the reflection that the player’s character was terrified. Beth explained that this was a unique facet to therapeutic DMing, “I wouldn’t necessarily do that if I was just playing with like my friends or with my neighbor’s friends...Like I think there's another place that's also what she needs to get a little bit more immersed in the character and so it's both it's both. The capacity to externalize but it's also the opportunity to do a little bit more immersion and exploration of who I'm playing here. Which I think you know that's also important from a therapy perspective right?”

The discussion of how to manage threat and discomfort in a safe, therapeutic setting naturally at times landed in conversations about therapies, such as Exposure Therapy or Imaginal Exposure, that have a strong experiential component around confronting uncomfortable or threatening things. The notion of “exposure” was brought up by Beth as a gradual and safe experience within TRPG therapy, explaining that the more exposure to being in uncomfortable spaces in a low stakes situation, the more “learning” and “working through” the clients will have. In this way, her promotion of exposure to uncomfortable experiences was connected to coping skills such as self-regulation and organization. Beth also spoke about “modulating the exposure” to certain difficult topics, such as death. One player in the group, Player J, had an explicit referral from her individual therapist to speak about death and dying. Beth explained that this player had

a childhood history of major seizures, and that fear of dying often appeared to come up in individual therapy. In TRPG, the threat of character death is pervasive in each game with the level of combat and danger in the fantasy world. As a result, Beth explained, there are ample opportunities for players to grapple with character mortality in a “mechanistic” and “math-based way” without “danger or dysregulation potential”. An example from the observed therapy occurred when this player was seriously wounded in fantasy combat, and had to do a “death roll” – a rolling of the dice after which the rolled number would calculate whether the character would survive or not. When characters are in near-death situations, therapeutic DMs often have a stylistic choice as to how and if they will allow the characters to die. Beth explained in this situation that there were ways to bend the rules in order for the player to have a therapeutic experience of being unconscious and/or dead:

[If] she died I probably wouldn't have let her stay dead, right. Like it probably would have been like okay let's think creatively about some other way to kind of address this situation. And I think for that I think that's also modulating the exposure right, this is a thing that I knew is is it is a thing she's touched on with her therapist. And so it wouldn't necessarily know if that was I was very good not dead, you're unconscious, you're having like you know you can have whatever experience you want and I'm curious about that if there was something that could be interesting space of like what, you know, are you trying to get back in your body or you know but you know whether they take the bait or not. I don't want to do that again, is I think a great response.

In this therapeutic moment, with three separate death rolls, the character remained unconscious – during which time Beth asked the character was feeling and experiencing. Beth also continued to prepare Player J as the dice rolling would dictate how the events unfold:

I'm not wasn't you know not necessarily hand holding her through that quite as much. Um but you know conscious like as I was like prepping it you know like I you know kind of saying this is a thing that's happening. And I when you know like trying, I hate to do this but like there's a thing and here's how it goes and this is why he's doing this and this how the stories going... Space of like giving a little bit of fore warning for that to happen um and then also to see how she did. And she rolled with it for the most part.

As a result, Player J was able to role-play being “unconscious” as well as what the dying process might be like for the character. In this statement, Beth described the tension that she feels as the GM of the game, watching Player J roll the dice and having the dice dictate what is happening next: she says to Player J, “I hate to do this to you”. This discussion led Beth to share the complex therapeutic position of providing “exposure” and the experience of risk and threat to the client – which she referred to as being “a jerk”. She referred to an example from a past therapeutic campaign in which she utilized a player’s fear of needles within the TRPG story. In the campaign, the group ended up in a magical infirmary where the player had to undergo a blood test in order to assess combat damage – to which the player said to Beth, “I can’t do it! You’re a jerk for making me do this!” Beth encouraged the player to separate their own experience from the character’s experience:

Are you having a shot or is you know your character having the shot? And as your character, do you want your character to have a fear of needles or do you want them not? You get to choose here. Just because you have fear doesn't mean she does.... that kid knows the safety of like being able to say, "This sucks. I don't like this".... Yes she's at risk here...but it's not immediate, right? So there's this, you have a chance to like kind of stabilize and here's how that here's how the rules handle that.

The notion of therapist as “jerk” for providing the experience of risk and threat, also appeared aligned with a similar conversation from a more psychodynamic camp of the therapist as role-playing the “villain” or, in Beth’s case, the Nothic. Here Beth explained again that there is therapeutic value in role-playing the “jerk”, so that the client has the experience of discomfort and how to navigate that discomfort with tolerance or by saying, “This sucks!”.

However, despite the repeated notion of “exposure” as a component of this experiential therapy – there appeared from the interviews to be even more of an emphasis on experiential-fantasy rather than just experiential-exposure. To clarify this further, there is a strong emphasis on the experience within the fantasy world – such as the experience of a blood test in an imaginary infirmary – instead of a more traditional exposure therapy in which clients are asked to imagine the real-life phobia or threatening scenario (as in imaginal exposure therapy, i.e. imagining the blood test happening at the doctor’s office) or actually come up with strategies for gradual exposure towards the real life scenario (as in traditional exposure therapy, i.e. gradual steps towards a doctor’s appointment and blood test). As described in the quote on pg. 74, Beth explained that in her experiential approach, “imaginal experience” is intimately related to real

experience – giving the example of watching a combat scene in a movie and having a visceral, physical experience of heart racing. In the case of TRPG, Beth said that role-playing is not pretend, but instead “by role-playing, you are experiencing”.

When I asked Beth why an experiential-fantasy based therapy might be beneficial for Autistic clients, she again emphasized the importance of experiential therapies over a predominantly skill-based approach. However, the experiential emphasis she stressed was not just of experiencing fantasy itself – but even just the experience of talking about fantasy, would be therapeutic for this population. We discussed this within the example of “meta-gaming” – a gaming concept that describes when players appear to speak out of character about the game, the rules, or the mechanics. All of the TRPG therapists described that with meta-gaming, like with character death, there are a variety of therapeutic stylistic choices on how to manage when this occurs. For therapeutic gaming in particular, each expressed how meta-gaming could break the immersion of the players – which can be useful in some circumstances, such as when the player is overwhelmed by the fantasy play, or in many cases meta-gaming could be detrimental by taking the group out of game play. However, when discussing the importance of experiential-fantasy for an Autistic population in particular, Beth shared her DM choice to allow for moments of metagaming among Autistic clients. She explained that providing the players with the opportunity to discuss things they are interested in within the fantasy world, or outside of it, was immensely therapeutic – as opposed to therapies that avoid this experiential space for the sake of skills building:

I think when I let them run with their [fantasy-based] knowledge. You know, when you wanna lecture, when S is like, “Well Gore taught me all about Cloakers, and I didn’t think I’d ever need this information,” he’s making all of this excuse to be like, so here’s my knowledge because I read the monster manual. Because he knows that it’s not necessarily exactly what’s in the monster manual, but he still wants to use his information.

Here, and in the corresponding quotation on perseverative interests from pg. 75, Beth connected the experience of meta-gaming, such as Player S wanting to share his knowledge of Cloakers, to the Autistic quality of perseverative interests. She explained the therapeutic effect of encouraging discussion of these perseverative interests or meta-gaming in moments where the clients are excited, rather than re-directing or teaching social skills such as communication or listening. Again, here Beth discussed the tension between an experiential and a skill-based approach. In this way, not only was Beth reporting of the therapeutic use of an experiential framework for experiencing the fantasy itself – but also for the relational experience of discussing interests, which often have to do with fantasy-based topics (i.e. the D&D Monster Manual or Pokemon) or animals, and being accepted for these interests. Beth shared another example of encouraging discussion of interests within the therapy, with an example from a past client in an individual play therapy, non-TRPG modality. She shared the importance of talking about this child’s interests within therapy, utilizing mini figurines of animals as play objects, in the quotation of pg. 121 in which she describes providing a player with mini-figurines of animals to meet his interests in anteaters and cetaceans.

With this play therapy example of utilizing play objects, Beth contrasted two very different experiences: the experience of being in a therapeutic space where interests are welcomed and discussed versus the other areas in which a child on the Spectrum may be frustrated without the space to be themselves. This powerful example pairs on to the previous quotation in which Beth explained how children are encouraged in therapeutic spaces to be “better listeners” and “better communicators”, and engage in skills-based work, over the experiential and play-based approach of discussing what they care about. This example also will be expanded upon in the forthcoming section on Play Therapy, as many of the hallmarks of Beth’s experiential approach are intimately connected to a child-directed play therapy orientation. This can be seen in a final example of Beth’s discussion in the final interview after the last session, in which she explained to me that she prepares the overall narrative of the campaign and inserts opportunities for the players to have experiences, but ultimately operates with flexibility as to whether they take these opportunities up or not:

I'm not married to a worksheet or a script or like rehearsal. I'm wanting to throw out an option and give a given experience and see how it goes and if they go with it they go with it. And if they don't they don't right but so then so then there's content that they can engage with in the story and in that you know if they engage or how they engage is really up to them.

In this way, her approach offers the freedom to engage with the experiential therapeutic aspects offered as well as the agency to not engage. In much of this analysis, I have reported the ways in which Beth purposefully inserted experiential material relevant to the personal aspects of each

client -- such as phobias or fears. However, despite her intentional planning of the campaign narrative and the thoughtful insertion of these experiences, it is powerful to note Beth's clinical flexibility and the notion that the players will engage or not engage based upon their own preference and agency. This example highlights the marriage of experiential and narrative approaches in her TRPG therapy -- the cooperative use of storytelling with the insertion of experience that I will discuss further in this next section on Narrative Therapy.

7.6 Narrative Therapy

Utilizing the “narrative” as a treatment tool was discussed by all of the TRPG therapists, and identified as an key ingredient to both psychotherapy and gaming. The utility of the “narrative”, both the narrative of the game and a “narrative style” of psychotherapy, will be discussed at length throughout this section. In the interviews, the therapists spoke about using a “narrative style”, the clinical value of “collaborative storytelling”, and reflective questions that would scaffold the clients to story-tell. As is the case with so many parts of this thematic analysis of TRPG Interventions, there were so many areas of overlap with other theoretical frameworks (Experiential, Developmental, Cognitive, Play Therapy, Psychodynamic) as well as with the dialectics of therapeutic gaming and non-therapeutic gaming. Here I will discuss the complex and multiple ways in which the TRPG therapists described utilizing the “narrative” as a means for providing therapeutic experiences for the players.

Grounded in feminist, anthropological, and multicultural theories, a narrative approach to psychotherapy is founded in the notion that the stories we tell in the therapy space, such as

narrative theorist Mattingly's notion of an "illness narrative", are inherently influenced by social, cultural, and political context (White & Epston, 1990; Mattingly, 2000). In narrative approaches to treatment with children as well as adults, a collaboration occurs between therapist and patient in having "co-authorship" of an alternative narrative – in which the patient may view their narrative as separate from one's self through externalization – which was also mentioned as a clinical technique by TRPG therapists (Etchison & Kleist, 2000; Monk et al., 1997; White & Epston, 1990). This notion of "co-authorship" of the narrative was found throughout the TRPG therapists' clinical reasoning as not only a mechanism of change in the treatment, but of strong clinical value to both individual and group growth. There is also research that suggests the clinical utility of the "narrative" to the experience of therapeutic gaming, with literature corroborating TRPG therapist claims in this study that players must be engaged with the game in order for there to be narrative value and for that narrative to in turn be therapeutically effective (Chauvin et al., 2015).

Narrative has also played a large role in child psychotherapies, in which patients are encouraged to develop a story using narrative play techniques (Cattanach, 2006). As previously discussed in the literature review, role-playing game research on the role of narrative in child psychotherapies has credits narrative theorist Jerome Bruner's (1986) "distinctive narrative mode", or an increased engagement with narrative, as the cause for ToM improvement in players on the Autism Spectrum (Bormann & Greitemeyer, 2015; Mar et al., 2019; Kidd & Castano, 2013; Polkinghorne et al., 2021). There has also been extensive consideration of the use of narrative therapy techniques in making role-playing games effective (Enfield, 2007; Zayas & Lewis, 1986). Chauvin et al. (2015) argued that in order for TRPG players to experience a high

level of narrative value in the game, they must be engaged with the narrative throughout their interactions – a notion that TRPG therapists echoed in their sentiments shared in this following section. In this way, the narrative provides a sense of structure akin to the game’s rules, or mechanics, which narrative theorists have argued aligns well with the collaborative approaches of narrative therapy (White & Epston, 1990).

First and foremost, the “narrative” that the TRPG therapists repeatedly spoke of refers primarily to the game’s story – the story arc of the TRPG campaign that the therapist as the GM builds prior to the game. TRPG therapists approach the game’s story arc with different levels of preparation and varying degrees of adherence to the story or as Beth explains, “I’m not married to a worksheet or a script or like rehearsal. I’m wanting to throw out an option and give a given experience and see how it goes and if they go with it they go with it. And if they don’t they don’t right but so then so then there’s content that they can engage with in the story.” However, there was also some discussion of “narrative” as not only the story of the game but also the story of the characters (i.e. backstory), or even the internal “narratives” that the patients engage with – such as the “negative internal narratives” represented by the Nothic as discussed in the section on cognitive-behavioral approaches.

The therapists distinguished several different purposes of the narrative in TRPG therapy. The first purpose is that the narrative provides structure to the game, or as Jared explained to me: “The story gives enough guard rails to go down the steps with”. The second purpose of this narrative is to provide experiences for the client, as Jared continued to explain that the story allows for the narrative plot to guide the experiences the players have within the game, and that

this structure provides opportunities for experience “without real-world consequences”. These experiences that the narrative affords the players will constitute the bulk of the conversation about Narrative in this section, and it appears that the connection between a narrative and experiential approach – as described in the previous section – is very foundational to the TRPG modality.

The third purpose of the narrative is to build investment in the therapy and in the game. Mark explained that without investment in the narrative, TRPG does not work: “The methods not going to work. They have to have that buy in. So you need to have investment in the story, that investment in the game. Anything you can do as a DM to promote the story just helps the therapy along.” Louis agreed that investment, or in his words “engagement” in what he calls the “narrative journey” is the key ingredient to keeping the players engaged in the therapeutic treatment. Louis went so far as to explain that this purpose is the “whole idea behind any sort of RPG system – the narrative is what keeps us there. And if we can bring that narrative into a life, into a feeling of like I am invested in this narrative, then it changes the way we’re going to interact with other people.” How each TRPG therapist wielded the narrative as a therapeutic tool for investment and experience was quite different – and these differences are representative of variances in orientation that have been discussed previously in terms of more directive and non-directive approaches. I will discuss two of the ways in which TRPG therapists used narrative for therapeutic experiences: 1) using narrative to provide experiences that the therapist believes will be of direct benefit to the client and 2) using the narrative to scaffold the players as the independently and collaboratively build the narrative themselves.

“Force A Narrative” (Louis)

One way in which therapists utilized narrative is by building story arcs that would intentionally aim to benefit the therapeutic outcomes of the players as well as the group as a whole. Beth shared that she prepared and built the narrative of this campaign’s adventure with goals to promote collaboration and communication among players:

In terms of the DMing and the therapist-ing at the same time I would say, there’s the organicity... this kind of activity that you can then tune into and try to help through experience. And I would say from the story building part, I think there’s a little bit of like narrative stuff that I did put in this adventure... the broader focus of this arc, depending on how far they get into it, is really about the collaborating and the ability to be like, ‘We can’t just all do what we want to do. We are going to need to figure out and make a plan, and communicate to each other about that plan.

In addition to the building of overall story arcs that are aimed towards therapeutic gains, TRPG therapists can also improvise and build narrative over the course of the campaign as needed. Louis referred to this narrative approach as a way to “force a narrative” towards what “we”, the therapist, “think needs to happen”. An example from the therapy observations in which Louis saw a need to “force a narrative” was in conflict between the players in the second session, when Player S shocked and grasped Player J’s phantom steed and Player J angrily responded with a thunder clap spell that shocked the entire group. Louis and Beth, the facilitating therapist, had different narrative approaches in this particular example. Beth explained that she wanted to “let it

play out”, and have the conflict authentically ensue between the players and then return to the conflict in the next session through a dyadic role-play in which the conflict resolution could occur in character.

On the other hand, Louis proposed to “force the narrative” in this moment – which he explained as follows: “To force a narrative is to stop the adventure and force something else to happen,” and giving the example of a therapeutic group aimed at social skills, “If it’s a social skills group, we’re focusing on force a narrative of like, how do we direct the social atmosphere to solve this problem?” Louis explained that forcing the narrative was an opposing therapeutic move to Beth’s “play it out”: “If we can force a narrative that we think needs to happen, and see how it plays out, we don’t have to be like, ‘This is the only way I want it to play out.’ We can just force a certain conclusion to occur and see what happens”.

With the example of this therapeutic moment, Louis proposed stopping the game and forcing a narrative in which the thunderclap spell has an additional aspect to it – such as that the characters need to resolve the conflict and make-up in order to be healed as a group (“there’s only one way to heal it!”). In this way, Louis aimed to utilize the narrative as a directive intervention –as the therapist would plant a narrative in the game -- versus Beth, who utilized a more experiential narrative approach by building in the opportunity for a dyadic role play.

Louis also made an argument for the “force a narrative” approach when evaluating Beth’s narrative intervention of a dyadic role-play between Player S and Player J. Following the conflict at the end of the second session, Beth opened up the third session with a “long rest” opportunity in which the players can rest and heal from the combat, as well as engage in role-plays without

action. While Beth invited Player S and Player J to have a dyadic role-play, Louis advocated for a more directive approach via the use of an NPC, a Non-Player Character, played by the therapist:

You can build in the narrative and I would say if they're having a long rest in between stuff then never underestimate the opportunity for a campfire talk. Is for everyone's resting, you're coming off your long rest, you two, especially since they came in early, you two woke up early and the other two are sleeping and so you guys decided to have a conversation. That's a forced narrative that we've been talking about in a sense and then this can happen also with other NPCs and stuff like that. Like if they're in the cave, [the therapist] can be like, "And a small child goblin came out of nowhere and was like, 'Why are you guys why were you guys fighting earlier—yesterday? I'm still having—I'm still confused on this stuff.' And that campfire conversation can kind of have a really interesting aspect where the goblin can be anything. It can be a phantom. It can be a figment of their imagination. It can be something that one of them has physically summoned in a sense to bridge that gap um and that stuff. And if they don't really wanna talk about it, the NPC can do the talking for them.

In this example, Louis advocated that the therapist might force a narrative by assuming the role of an NPC, such as a goblin or phantom, who encourages the characters to resolve their conflict. In this way, Louis explained that the NPC and the therapist can "drive the narrative" so that the conflict management and therapeutic gains of the clients can occur. However, Louis also noted that the "force a narrative" approach, while having great benefits for the therapy and the

clients, can also have “disastrous consequences” – to which he mentions that he can see a lot of pros about sticking with a less-directive style.

Again, here the tension between more directive, skills-based approaches and less directive, experiential approaches appears as it did in the sections on other theoretical frameworks. Louis’s explanation of the choice point between the therapist stepping in with a more directive approach, such as “forcing a conversation” between two players or “forcing a narrative” for the game, or opting for a more non-directive approach to narrative, like he sees Beth doing with “letting it play out” implied that there are high stakes to the players engagement in the narrative and in the treatment overall, and that their engagement is in turn a huge driver of therapeutic value. The decision that keeps presenting itself throughout these chapters is whether engagement in the game will be benefited from therapist intervention that pauses the game for skills instruction or directing the narrative, or whether player engagement is better served by a non-directive approach in which the players “flow the narrative” and play out conflict. Ultimately, this choice point has to do – as Louis described – with the aims of the therapist and the therapeutic aims of the clinical moment. If conflict management and resolution is the primary therapeutic aim, the therapist must decide how to get players there – through directive intervention or through letting it play out.

Another example of this choice point occurred when Louis described using the gaming intervention of the NPC, the non-player character, to prompt conflict resolution while also utilizing an experiential approach – highlighting the semi-directive nature of the TRPG treatment and the integration of both non-directive and directive styles. Louis described the use of the NPC

as a way to “drive that narrative” and force the conflict resolution, whereas an NPC can also be used in a more experiential manner – as described in the previous section, from the Gestalt school in the sense of providing an “empty seat” exercise (Greenberg & Goldman, 1988). Also, while Louis explained that the “forced narrative” approach is a way of promoting “learning and understanding” as well as “where [patients] can probably, possibly improve moving forward”, Beth shared that her facilitation is much more geared towards the experiential in which she explains that she would like the players to have agency as to whether they take up the narrative or not. As a result, in Beth’s facilitation of the therapy, the players actually do not engage with the dyadic role-play opportunity – and appear to be uncomfortable with the narrative steered towards conflict resolution. Beth shared that she felt that the players found their own ways to resolve the conflict throughout the third session while in character, “And I thought the ways that [S and J] interacted actually throughout the session, both in character and not in character, I was like, ‘Oh, oh. That’s how they’re doing this actually.’ Like I think they did it without actually directly talking about it.” She pointed towards moments where Player S and Player J collaborated together, and one particular moment in the third session in which S playfully pulls Player J down with him on their delicate fall off of a staircase and onto a spectral pillow. This moment in the therapy, and Beth’s belief that the players will find their own ways to direct the narrative and engage therapeutically, is the second utilization of narrative: a player-driven narrative approach.

“Let us [the players] drive the narrative” (Louis)

A second way in which TRPG therapists described utilizing narrative as a therapeutic tool was as a means to scaffold the players so that they might collaboratively and independently build narrative themselves. Louis set up a comparison between the “force a narrative” approach and this second narrative approach, referencing the narrative approach of a DM with whom he plays recreationally with his own social group:

If you wanna see what we do as ‘narrative play’ ... and we go into some dark stuff... but you’ll see what we mean by when we force a narrative a different way... there’s an opportunity here and we wanna take that narratively driven thing, but you’re also gonna see [the DM] go in and tell us, “What happened here? Tell me with your own stuff. Tell me.’ That type of thing. And it allows us, let’s say if we’re gonna roll a natural twenty, he’s gonna let us drive the narrative.

Here Louis explained that the DM in his recreational group uses narrative in “a different way” by prompting the players with questions, eliciting their “own stuff” including “dark stuff”, and allowing the players to “drive the narrative” – or determine what happens next in the story arc. Louis explained that this is a different approach than “forcing a story on them”, sharing that in his therapeutic GM’ing – he will also ask questions that aim to elicit the storytelling of the players. Louis referred to this intervention as deriving from his developmental psychology orientation, citing Vygotsky as an influence for the developmental approach to scaffolding the narrative storytelling. This approach is clear in his response to a moment from the TRPG therapy, when in the first session the facilitating therapist introduces the newest player, a wizard named J, to the group by asking the other members, “How do you all know J?” The facilitating

therapist, Beth, explained that this more open-ended questioning did not exactly prompt immediate and imaginative answers and that she needed to support the players in coming up with answers for how the characters know one another. Louis shared Beth's perspective of the clinical moment, referring to this support of the players as a developmental, "Vygotsky style" of helping the players "bridge the narrative gap". Here he utilized a Vygotskian and developmental term of "bridge the gap" as the therapist filling in to help the client from one developmental step to the other by providing them with the bare minimum of support as a scaffold for eventual independence, in this case in a narrative way. He explained this further in the following quote, in which he also mentions why this sort of developmental approach to the narrative intervention works particularly well with Autistic clients:

So with kids on the Spectrum they always have difficulties with imagination and those types of things...instead of forcing a story on them, I would have build a narrative into it such as 'You guys are approached by this wizard who has some weird resemblance of someone you guys have met in the past. Do you guys remember anything? And kind of see what they do with that. And if someone's like, "Oh yeah we met this person in town" I'd be like, "Oh yeah? And what were you guys doing?" It helps them build the story themselves and it creates that Vygotsky style of "Let me help you with the bare minimum, enough to push you that way but I want you guys to focus on it" because when we tend to do it that way, we then see way more interaction, like "Yeah we met them at the tavern. They'd be like, "He bought me soup." And it's like cool, you know this soup this soup is really important and part of the storyline. This is where you guys bonded and that type of stuff. Now when you guys talked about this and this soup, do you remember

anything else about that about the first time you met this person? And then after they've built that storyline a little more, we can say, "Alright, we know where this person's from. You guys recognize them now... And so that would be a way to kind of help bring in that narrative style of being a little bit more um present in order to build the narrative but also to build the aspect of bringing the group cohesion together and helping them focus a little more on... on what they need to be able to manage that type of thing... That brings it just enough so that they create that narrative themselves and you're just barely guiding them.

As Louis explained, instead of forcing a narrative, in this second approach – the therapist utilizes questions ("You guys are approached by this wizard... Do you guys remember anything?") to scaffold the players.

Jared similarly discussed the intervention of asking questions to drive narrative, but referred to these questions as being either "descriptive" or "reflective" in nature. Descriptive questions, Jared said, were questions aimed at getting information from the clients such as, "What do you see in the cave?" whereas reflective questions like, "What is your character feeling?" would prompt the players to reflect as their characters. Jared explained that the therapist utilizes a "constant concert" of both descriptive and reflective questions and by doing so, "[the therapist is] getting information. You are getting therapeutic narrative. You are getting stuff to go on in the game. How much help the player needs determines whether you need reflective or descriptive." Again, a developmental perspective appeared useful here in assessing how much capacity the player had to independently build the narrative or if they needed support in the form of scaffolding. Mark and Jared also described the interventions such as providing the

players with pre-made “sentence connectors” or “conversation starters” as ways that the therapist scaffold players interactions with one another in the game.

Beth made a similar argument for scaffolding as an intervention for Autistic clients, in a similar sense to Louis’s argument that the players may need “scaffolding” to help with “difficulties with imagination”. However, Beth appeared to integrate a narrative approach with both a trauma-informed therapy as well as interpersonal neurobiology. She cited the work of interpersonal neurobiologist Dan Siegel, whose work on PTSD explains that trauma-informed therapy must assist clients with forming a “coherent narrative” of their trauma histories and general experience. Beth shared this perspective after watching a moment from the first session of the TRPG therapy in which she invites the players to introduce their characters, and a first, long pause occurs. Beth said to the players, “Don’t all go in at once!” and repeatedly prompted them to initiate conversation. In Beth’s perspective, she explained that she was modeling what it is like when a conversation falls flat, or “the connection drops”, as well as modeling the anxiety that one might feel during a conversation such as, “Am I alone here?”. She explained that she does not want to “teach” how to manage in this moment, but instead wanted to provide an experience and a modeling for the awkwardness and anxiety that can happen in a situation like this. She explained that this is an area where people, especially children on the Spectrum, can get “stuck” – much like in PTSD where there is a sense of being “stuck” in a traumatic narrative. She describes this “stuck-ness”:

Those interactions that they have with each other, the places where conversation falls flat, I want them to also be able to say, ‘I don’t know what to do.’ I think that’s another

piece of some of those quiet spaces of the places where I'm asking, and they don't say anything... there is a place too of this narrative. Well, not a narrative but a way to be able to say I, 'I don't actually know what we're supposed to do'. And, and how to do that and ways I've seen them do it in the past have been less, less prosocial, where the character just kind of starts [to say], 'I don't know what's going on, I don't know what's going on!' And, what do you need to do to know to figure out what's going on? Do you need to turn off YouTube? And do you need to ask somebody, "Hey, I'm not sure what you're trying to do here?" Do you need to talk to each other? Rather than, here's your popcorn with ideas and nobody actually listens to anybody else's. So those are other kind of the clinical places and things, that I'm trying to elicit and create experiences for, and also, I'm learning more about them as I get to know them of ways to kind of pull those in for them.

Here she explored the types of scaffolding that can occur, "the clinical spaces" in which she utilizes reflective questions to "pull" for and "elicit" interactional experiences. Beth explained that, by doing this scaffolding, there can be a creation of a "coherent narrative" of a given situation: a beginning, middle, and end that feels "coherent" and "a story about what's happening here with us" rather than the stuck-ness or anxiety. This is an especially poignant point, whether she was motioning towards this or not, in regards to Autism – where one theory of Autistic compartment is a "weak central coherence": Beth seemed to point to this as she explains that the Autistic players "don't always feel coherent". Next, she applied this interpersonal-neurobiology framework to the narrative story-telling aspect of TRPG therapy: she described how the collaborative story in TRPG therapy, along with the scaffolding and structure of rules, helps the clients to create a coherent narrative together.

I like lean into that, that interpersonal neurobiology piece the idea of a coherent narrative of about what's happening in an experience being so important, um, you know I think there is a place of like, we need to have , yeah, yeah, but I wanna have a story about what's happening here with us... I think it's probably more than just Dan Siegel, but Dan Siegel is like my doorway into that. Um, it's just that idea that the, if you have a story about your life that makes sense, you are gonna have a healthier integration of both of your difficult times of the challenges. You're gonna , you're gonna , you know that's, that's a trauma, trauma protective thing of if I can, if I can go through this experience with a beginning, middle and an end, it's not just this, this, this awful thing happens and I'm stuck here. And the story doesn't progress beyond it, um, you know, that theory, in that theory, the way that I've always heard it from him, is that that's where, that's where PTSD happens, where trauma gets stuck. Because I can't move through the story. Um, so his, his, the coherent narrative is that I have a I have a clear sense of a beginning, middle and end for my experiences. And then those experiences and those stories chain together into something. And so I try, I mean I think of you know, in thinking of these, these are kids who, you know, they don't always feel coherent, they don't always feel like they have a, a clear ability to, even in the game look at the story beginning, middle, end. What's the, like where do we start, where are we now, where do we wanna go, kind of space. And there you know, there again just comparing when I said earlier about I had tried this other game with them, and that for like my own needs but was probably not a good meet for their needs, is that they're not good at collaborating ,collaboratively creating a coherent narrative. For what they're doing they need scaffolding around

it. The rules I think of this game and the, the way is that the DM holds the story lets them be able to do that a little bit more.

However, Louis ultimately warned of a mistake that could be made by TRPG therapists in overly-scaffolding within a narrative approach. He seemed to explain that a major difference between a therapeutic and non-therapeutic DM is the way in which each could handle the “world-building” aspect of creating the story arc and game narrative. There was a moment in the final session of the TRPG Therapy in which the players were experiencing difficulty with coming up with a strategic plan: the group had to fight off several skeletal minotaurs and skeletons, while also trying to capture the healing crystal that they had searched for the entire adventure. Louis observed the group debating between fighting and strategizing, and explained that he always tries to have “two to three different options of handling a situation” that he can feed to the group to direct and support their decision-making, as well as give the “built-in” opportunity for the group to participate in narrative story-telling:

I always try to have two to three different options of handling a situation... And so that's a third way of handling this situation which is really unique um to be built in. And this is where that world-building that narrative story-telling is so important. When some GMs go into the concept of world-building every small detail out there and we would hands down tell you not to do that. Um and the reason is no matter what details you go through, you're never gonna hit them. Um and so it's like when you world-build, you world-build this room, there's something in the center that gives you a plus two to everything. Now you have these four skeletons and two minotaurs. That's the world-building you need to

do. Like you set the scene. Now you just flesh everything out a little bit based on what the group needs and how the group is reacting and I would give those three options in a different...a different sense to kind of be able to hone in on what options of the group you wanna go with.

Louis warned against DMs participating in so much “world-building” with “every small detail out there” that the players do not have an opportunity to do world-build themselves. Instead, Louis suggested the directive narrative intervention of providing a few different narrative options for the players to weigh and choose – almost like a “pick your own adventure”. In a similar vein to the developmental approach and the “bridging the narrative gap”, Louis explained that the DM must world-build enough so that the group can fill in the details. This sentiment was echoed by the other TRPG therapists, who all suggested that the narrative and story should be guided by the players themselves!

What Louis was suggesting is a scaffolding of independent narrative story-telling, which he explained is quite different from the more therapist-directed, “force a narrative” approach. He even referred to narrative structures, such as Shakespearean plays, to explain how the therapy works towards therapeutic “benefits” and motivates independent narrative capacity both in and out of game:

That’s where that driving force, that ability to feel powerful and to understand where we can get into the person’s psyche and guide the overall story arc into their benefits because, if you think about D&D, we do groups of somewhere between 3 to 6 and yes

you have an overall story arc. You have your beginning, middle, end story arc. Think of it as a kind of um Shakespearean play style three arcs. Um but in that overall story arc, you also have three to six individual arcs that you were trying to manage and those— managing those individual arcs can be difficult but also super, super interesting to see because you can weave them together in a way that they wouldn't have been able to do that or you can have them help weave it together which creates uh if we use a metaphorical um analogy symbolic idea, a net that is gonna catch them and be able to help them out in any sort of social engagement and social issue that arises in the game or outside of 'how can I like weave myself differently?' That critical thought is really what we're aiming for and to—the narrative itself is-is what we feel is the biggest um motivating mediator to do that.

Louis explained that the opportunity to narratively guide the game can empower each player, and allow them to feel agentic and powerful in the TRPG therapy. Here he also shared that the infusion of player goals and personal material into the game narrative, and the “weaving in” of these personal narratives with other player narratives and the overall story arc, provides an experience of “critical thought”. This critical thought, or rather the question of “How can I weave myself?” in social interactions, Louis suggested is motivated by the narrative style of the therapy. This leads to the third and final way in which the narrative approach functions in the TRPG therapy – from the therapist-directed “force a narrative”, to therapist scaffolding, to players' independent narrative storytelling.

“We allow the players to help guide the narrative” (Louis)

The final way in which TRPG therapists described the narrative approach to TRPG therapy was in the support of the players as their input fueled the narrative of the game. The client-driven narrative echoes other types of clinical traditions, such as child-directed play interventions and psychodynamic play therapy where the active imagination and play experience of the child guides the session. The assumption that whatever narrative material brought in by the players is valuable and meaningful was echoed here by TRPG therapists.

Louis described using player input to not only guide the narrative story arc but also build investment in the game. He named this intervention as the “imaginative breaking of the game” – as in the rules and mechanics of the TRPG would be suspended for the sake of client imagination and storytelling:

That’s part of our narrative, our imagination and what we call the imaginative breaking of the game. We don’t have to stay as heavy to the mechanics. We allow the players to help guide the narrative in a way that feels compelling but also gets them involved in that capacity... But that that’s where my mind goes to help bring it into a more therapeutic endeavor of like there’s an option to befriend, there’s an option to fight, there’s an option to help out as a party depending on what kind of needs to happen overall.

Here he explained that the move towards client guidance of narrative is a move towards a more “therapeutic endeavor” – suggesting that there is something clinically valuable to this narrative intervention. Beth similarly described the importance of allowing the players to guide the

narrative, but in a more collaborative sense amongst each other. In what she referred to as the “co-creation of narrative as experiential relationship building”, Beth referenced a past campaign in which two players collaborated on each other’s character backstories and repeatedly referenced these narratives in the game. Beth repeatedly remarked on the child-directed and independent nature of this narrative story-telling, saying “I had nothing to do with it” and “That feels so much more rich than anything I could have done”. She explained that this therapeutic experience was both experiential and relational, and that the co-creation of the narrative was built upon things the characters had experienced together. She related a therapeutic moment in the fourth session to this sentiment, in which the group makes jokes about eating the orcs they just killed – by eating them as “orc jerky”. Beth explained that the “jerky” was a reference – or a “callback” to a past campaign in which the group had done something similar with some fish they had found.

There were several examples of player-driven narratives from both the observed TRPG therapy and the interviews with TRPG therapists which display this narrative approach. One therapeutic moment in the fourth session was when the players were at the top of a long staircase going down into a dungeon. When the facilitating therapist described some “floating orbs of light” above the staircase, a patient player (“E”) remarked to the group that he believed these lights were “will of the wisps” – a bug-type monster in the D&D world. Beth explained later in the interview that while her initial narrative did not include will of the wisps, she made the decision to include E’s guess into the storyline and the group ends up battling with these creatures. When observing the clip of this moment, Louis applauded Beth’s inclusion of the player’s narrative and let the players “build their own narrative story”. Another example of this

narrative approach occurred when in the second session, the facilitating therapist also used Player E's idea in the story:

Then E says, "It's either a train station or a magical hospital." And I'm like, magic hospital is a great idea, yes that's what we're gonna call this [chuckles]. Like that was not necessarily how I conceptualized this tower and why people would come here, until he said that, right? So there's also this generativity that comes from letting them problem solve and letting them be right, ya know? Letting them figure it out and have that moment of "I'm right! It was it was it was a magic hospital!" Right, um that's important too.

Here Beth similarly echoed the notion that a child-directed narrative approach can empower the player: by utilizing their "generativity" and "letting them be right", there is an empowerment of the player's independent world-building capacity.

In conclusion, the narrative approach to TRPG therapy spanned different therapeutic styles – from more directive to less directive. This approach also appeared to intersect and merge with other clinical traditions. The narrative approach appeared integrated with an experiential approach in that the TRPG therapists spoke about using the narrative and the adventure story arc to set-up therapeutic experiences of the players. There was also much intersection with a developmental tradition, with the multiple citing of Vygotsky and the suggestion of therapist "scaffolding" for the players' more independent narrative capacity, which will be discussed in the next section. Additionally, the play therapy traditions of therapist-directed (directive) and child-directed or non-directive approaches was brought up and will be discussed in future analysis sections as well. Finally, cognitive and neurocognitive approaches also intersected with

the narrative approach – with the mention of interpersonal neurobiology’s concept of “coherent narrative” and the “negative internal narratives” apparent in cognitive frameworks.

7.7 Developmental Approach

As discussed in the previous section, there was surprisingly much overlap in the analysis between a developmental and a narrative approach. In the previous section on narrative approaches, I reported Louis’s perspective that TRPG therapy should help clients “bridge the narrative gap” – a borrowing of the Vygotskian terminology of “bridge the gap”. In this analysis, I will share how Louis described his primarily developmental, Vygotskian approach to TRPG therapy as well as how the other TRPG therapists utilized a developmental lens in order to track clients’ therapeutic progress and developmental stages.

Developmental therapy, or a developmental approaches to psychotherapy treatment, utilize developmental theory such as developmental stages of development to consider the specific developmental needs of the a patient (Ivey, 2006). Developmental approaches are often used with children, and developmental theory plays a large role in the theoretical frameworks that drive psychotherapy for Autism Spectrum and developmental disabilities. One of the primary developmental theorists who have contributed to developmental approach to psychotherapy, and was mentioned by Louis as a strong influence in his TRPG treatment, was the theoretical framework of Leo Vygotsky (1978). Vygotsky proposed that cognitive development is influenced by culture, language, and social interaction and that supporting a child’s development necessitates considering their zone of proximal development – or the range

of difficulty that child has with tasks and their level of need for scaffolding and assistance versus independent capacity (1978). Developmental approaches to psychotherapy have utilized the zone of proximal development as applied to the psychoanalytic therapeutic relationship (Wilson & Weinstein, 1996) as well as in understanding how to match therapist interventions with client development and potential (Leiman & Stiles, 2001).

Louis recalled the work of Vygotsky when explaining that his “Vygotsky style” of TRPG treatment is about supporting and scaffolding clients, and meeting them where they are at in terms of their capacity for problem solving and critical thinking. He described his interventions with players as “giving them just enough to get over the problem”, sharing that “when kids and adolescents hit a problem and they can’t do much um oh and they can’t figure out how to get there it’s our job as parents or facilitators to help bridge that gap just enough, not so that we’re solving the problem for them... but enough to get them there”. Louis also mentioned a tension he experiences as a therapist with a Vygotskian approach, in that there is some disagreement in the developmental tradition about whether to model for clients, or “show them how to do it”. He cited that using reflective questions could help scaffold players, giving them the support to think through multiple areas of a problem. He also mentioned that as a DM, he would at times use a gaming intervention such as slowing down the game-time to help the clients have more processing and thinking time:

I see it as a difficult scenario that it could have been Vygotsky in a different way of like, “Let’s go and talk about everything we know about this problem,”... the DM can kind of be like, “Time slows down, where one minute is equal to a tenth of a second... And kind

of help “Vygotsky”, or lead them down into that when they feel the problem overall is identified, solved and that type of stuff. And then like, “The mist clears; you guys are back in your bodies...”

The end goal of this developmental approach, Louis said, was to give the players just enough support “so that they can cognitively find the problem and solve the problem on their own”. Louis again referred to critical thinking with a developmental lens, explaining that by asking scaffolding questions such as “Why are you doing this?” the TRPG therapist is gauging the players’ capacity for this type of critical thinking – and can modulate this question to “What are you doing?” if he feels the players need additional scaffolding. These questions paired nicely onto the descriptive (“What are you doing?”) and reflective (“Why are you doing this?”) questions that Jared discussed in the section on narrative therapy:

Instead of saying like “Why are you doing this?” or “Why?” because the “why” tries to bring critical thought and if they can’t do it at that age, it just kills their um personal drive. Um so by saying “what” um “what is there meant—what is that” is a good thing.

This inclusion of a cognitive aspect to developmental capacity appeared to repeat amongst the other TRPG therapists. Beth pointed to moments of players’ “cognitive growth”, indicating that there were developmental milestones in critical thinking and understanding that she saw the players achieve. An example of this was how she observed the players deal with existential concepts of death and dying, in ways that she thought made sense for them “both mentally, and socially, and environmentally at this point”.

The notion of “progress”, or tracking the progress of players, also seemed to fit well into a developmental approach – in which there is a supposition that there are building blocks, and stages, of development. Therapists would track how the clients would emotionally respond to difficult situations, as well as their social skills, in order to determine if “progress” was being made in the treatment. Each of the therapists linked this “progress tracking” to a “client-centered” or “client-focused” approach to treatment. Therapists shared how they would directly ask the clients about their goals for therapy, what they would like to “work on” as well as issues that they “do not want to work on”. The therapists also appeared to evaluate the skills and level of development of the players before treatment, and tailor interventions to this stage. For example, Jared explained that he would differentiate between descriptive questions and reflective questions – much like Louis would – depending on the skills he sensed the client had developed at that point in time. Beth similarly discussed modifying her approach, specifically describing at one point she would switch to a more skills-based approach, based on the client’s needs:

It’s like that I mean again it’s child-directed, right? And in some ways it’s still holding onto that client-centered space of like if there’s if there’s a direction in that this is going and that’s ya know, and then it’s I think that one of that the skills come second. So I feel I’ve heard ya know and some of the other people who do this talk about like and it was really helpful framing for me too of like right, so if we’re if we keep coming up against this same kind of issue, right like and it [stutters] then I then I might have to teach a skill cause it maybe can’t be that we can organically solve this problem.

Beth linked this “client-centered space” to a child-directed approach, recalling the example of the “magic hospital” from earlier in the study. She explained that meeting the client where they are at developmentally in terms of skills in a “client-centered” manner, was similar to utilizing the player’s independently generated narrative material in a “child-directed” play therapy way. This analogy indicated that Beth was interested in meeting the client where they are at – whether developmentally (in terms of skill, age, capacity, etc.) or in terms of the material they are bringing into session (i.e. child-directed play therapy and narrative approaches).

A developmental lens to Autism treatment makes quite a lot of sense – given that Autism Spectrum Disorders are categorized as “developmental disabilities”. The TRPG therapist discussion of taking a developmental approach to “cognitive growth” and “treatment progress” may suggest that they are perhaps considering both “normative” and neurodivergent development. For example, considering what behavior or cognitive features are occurring as “developmentally appropriate” is quite complex when considering a population whose diagnostic criteria includes a supposition that their development is different from a normative track. Note the example of Louis above in which he re-calibrated from “Why?” to “What?” questions depending on what he observes as the developmental capacity and stage of the client. Additionally, the discussion of similarities between a “child-directed”, “child-centered”, and developmental approach to TRPG treatment may have significant implications for therapies with Autistic populations that celebrate neurodiversity and client agency. I will discuss further why I believe that this approach could be very impactful for an Autistic client-base.

7.8 Play Therapy

When beginning to research TRPG therapy, I had expected to hear about – and was correct in learning from interviews – the many different clinical modalities that TRPG therapists drew from. I had expected to hear about the influence of psychodynamic and behavioral traditions on TRPG as a form of Autism treatment, however I had not entirely predicted how the theoretical framework of play therapy might factor into this study for a number of reasons. First, I had rarely heard play therapy being discussed among TRPG therapists prior to beginning this study. I later realized in creating my literature review that this was quite surprising, given that this was a proposed form of treatment for child and adolescent populations – with whom play therapy is a popular therapeutic modality.

Second, it was interesting that play therapy became a central point of discussion and tension in the interviews with TRPG therapists in this study because of the TRPG therapy being used as a form of Autism treatment. While I was preparing my literature review prior to this study, it struck me that although I had not heard of TRPG therapy described as a group (rather than individual) form of play therapy – ultimately, TRPG therapy was a game-based and play-based modality! As the TRPG therapists would share with me in the interviews, so much of the play therapy tradition is present in this modality and so much of this treatment relied on the experience of play. I also realized that play therapy as a form of Autism treatment had a complex recent history in the psychological community. I considered how the psychodynamic origins of play therapy, specifically child-directed play therapy traditions, might have a complicated interaction with Autism treatment due to the shift away from psychodynamic therapy in the

1980s (Bromfield, 1989) and a rejection of the proposed psychogenic causes for Autism diagnosis. This appeared as a tension in the TRPG interviews, as I will discuss further in this section. I had also considered the way in which more prescriptive forms of treatment, such as behavioral therapies, had garnered a negative reputation with the Autism advocacy community for possibly promoting ableist behaviors instead of celebrating neurodivergence. However, I had not totally realized how behavioral therapies such as ABA had significant overlap with some contemporary “play”-oriented Autism treatment modalities, such as TEACCH.

As I will show in this section, some of the newer forms of play-based Autism treatment – like the child-directed approach to DIR Floortime – were discussed by the TRPG therapists as a major source of inspiration in their practice. Ultimately, I had not fully predicted how the original tensions in Autism treatment might also manifest in the play therapy tradition present in TRPG therapy and how the TRPG therapists might understand these tensions. Along with the other paradigm clashes I have discussed thus far – gaming vs. therapy, skills vs. experience, etc. – here I will also share the clash and coalescence of “directive” (i.e. therapist-directed) play therapy approaches and “non-directive” (i.e. child-directed) play therapy approaches present in TRPG therapy as a treatment for children and teens on the Autism Spectrum.

Where these tensions and emerging strands coalesce is in the question of what makes a therapy accessible for children? Is it the play-basis or the child-directedness, or is it some mashup of the two? These questions have been a long-time focus in the play and child therapy arenas, and these TRPG therapists grapple with similar questions in their debate about who directs the therapy and how the play functions in the TRPG treatment. For the purposes of this

section and later in the Discussion chapter, I will recollect their impressions of how TRPG treatment utilizes play and child-based approaches.

In this section, I will first share how each of the TRPG therapists described play therapy more generally as it pertained to TRPG treatment in their individual practice. I will then share some of the common tenants of play therapy that the TRPG therapists mentioned in this modality, such as the playing through of unconscious material and through uncomfortable situations, the importance of role play, and the consideration of play therapy “tools” (i.e. sandtray, puppets, figurines, RPG system). I will discuss some of the embedded sub-orientations and traditions within play therapy that the TRPG therapists discussed – such as Therapist-Directed and Child-Directed approaches, DIR Floortime, Child-Parent Therapy, as well as the influence of Humanistic and Psychodynamic (i.e. Psychoanalytic, Attachment Theory) theoretical frameworks on these distinct modalities. I will primarily focus on the major source of tension that occurred among the TRPG therapy interviews – the debate as to whether TRPG therapy, with D&D as the RPG system in particular, constituted more of a therapist-directed or child-directed approach. The answer to this question varied among the TRPG therapists based off of their clinical orientations as well as their style as a Dungeon Master. Yet, this tension was one of the most common elements among each of these interviews.

First, I want to share more generally how each TRPG therapist described “play therapy” as a theoretical framework when it was mentioned. The facilitating therapist, Beth, reported in the first interview that she primarily hails from the play therapy orientation in her facilitation of TRPG therapy – and that she utilizes a child-directed play therapy approach, which will be

discussed later on. In explaining the use of play therapy as a modality, she described her first clinical encounters with the theoretical framework of play therapy through the writing of Virginia Axline (1947) – a famous child-directed play therapist. Several of the core tenants she mentioned in her understanding of play therapy included providing a play outlet for real-world challenges, refraining from interpretation and naming what she sees instead, playing through discomfort and unconscious material, and role-play. Jared described play therapy models as being primarily oriented towards “letting the play happen”, and having a client-focused approach on meeting the children where they are at and not pushing them beyond discomfort. I will discuss a few of these core tenants here, and how they were described by the participants.

One of the ways in which the TRPG therapists described a “play therapy model” in the TRPG treatment was by specifically referencing the DIR Floortime approach and its influence more broadly on TRPG treatment . DIR Floortime is a developmental, non-directive play therapy designed specifically for young children on the Autism Spectrum. One therapist described this model and this approach as a “reflective style”, which the therapist explained as “letting the play happens”. An example of this description was when the interviewed therapist noted a clip from the treatment in which the therapist is engaging the players by allowing situations between them, even conflict, play out without much therapist mediation: “[The therapist] is meeting everyone where they’re at. She’s not taking them somewhere or forcing them to be somewhere. She is addressing [conflict] without addressing it, which I thought was awesome”.

The facilitating therapist acknowledged that what was referred to by the interviewed therapist as her “reflective style” was a core tenet of her play therapy approach. In response to

one player sinking down in her chair during a moment in the treatment, the TRPG therapist explained why she chose to narrate aloud the player's actions in character as "[J] is disappearing" and explained that this was a "play therapy" technique of acknowledging patient actions without, she emphasized, explicit interpretation of these actions:

I wanted to playfully acknowledge that I saw her taking the break and giving herself a little distance in a way that is okay, but also that we see it. Like I want you to know that we see you and I see you...In that same [way] that you would in play therapy, 'Oh that character is hiding under the bed...' you don't interpret necessarily but you name it and you see what you see. And when you see it and it's a think someone needs to have seen, you don't have to analyze it, you can just – if there's something there's value to it just being named and seen and recognize... Like if you're [rotating in your chair] that's cool, like I'm going to see it happening and if that's what you need to do it's okay. I'm not criticizing, it's done in a playful way.

The emphasis here is on non-interpretation as a play therapy technique, although non-interpretation of player embodied actions does not mean non-acknowledgement. The facilitating therapist emphasized both here and in other areas the importance of noticing player actions and gestures aloud. The therapist described how this play therapy intervention also attunes to the player's embodied gestures and physical role-play, not just for the benefit of the individual player but also for the group. The therapist explained that narrating the player's actions aloud also helps "translate" her actions for the other players so that they can also notice it. Helping players "be seen" or acknowledged was a repeated notion when the facilitating therapist

described her play therapy approach. She explained she knew “play therapy works” when she observed how the modality helped “children feel seen and experience whatever it is they’re experiencing with full acceptance”. The therapist expressed that she believed that this experience was critical for “healing and growth”. She gave the example of utilizing a toy or a book to validate a player’s anger and experience, narrating aloud “You look so angry” and allowing the patient to feel seen in their experience rather than run away.

Aligned with this non-interpretive approach, the facilitating therapist also described how she used this in other forms of play therapy. One of the core tenants of play therapy is the objects of the play – whether toys or games like TRPG. In TRPG treatment, the object of play is the TRPG game itself and the specific gaming system – in this case, Dungeons and Dragons. The TRPG therapist explained that with play is a clear modality for children, and describes building the therapeutic relationship in therapy through toys, drawing or “getting into the sandbox”. However, she explained that with adults – the primary modality is talk therapy, which can be challenging and even “awkward” for patients who struggle with knowing how to engage with others. For this reason, she explained that “the game” is the way to “bridge” these challenges, and provides the developmental shift from toys to talk therapy.

The facilitating therapist described utilizing her background as an “early childhood play therapist” and using small action figures and sandtrays in her play therapy approach in TRPG treatment. In her experiences with play objects, she would observe the players using the small figurines for comfort or soothing as well as fidgeting. However, she also explained how she understood the meaning of the play – she referred to “sand tray work”, a play therapy approach

with Jungian foundations, as being “founded on” that all symbols have meaning. She shared that with this in mind, she observes child play; “You don’t know what the symbol means to them and it doesn’t actually matter, right? Because they’re the one interacting with the symbol in the tray and that’s happening, that internal experience of what is powerful about it... it’s about being seen while they’re having that [experience] and being held while they have that experience but I don’t have to actually know exactly what all of this symbolism means for every single thing.”

The therapist gave an example of not-knowing about the symbolic meaning of play with a player who would pick up a small Buddha statue on the therapist’s table and play with it in the sand tray. When the player graduated from the therapy and had a final session with the therapist, the player brought all the other animal figurines in the room to say goodbye to the Buddha statue. The therapist explained that she had a “healthy hypothesis” that the Buddha was a symbol for the therapist herself, however she placed a therapeutic emphasis on the player having this experience – and being witnessed in this experience in the therapy – rather than on knowing the exact meaning of this play. The therapist employed this same sort of sensibility throughout the TRPG treatment, as she repeatedly refrained from interpreting the symbolism of the player’s actions and fantasy elements of the play.

Another way in which the TRPG treatment served as a sort of “bridge” or developmental stepping stone, pairing talk with a play approach, was described by the facilitating therapist. When describing her play therapy background and “child-directed” approach, she explained the tension between going to therapy as a child versus going as an adult and that the goals and outcomes were quite different in her perspective:

I think sometimes, we think about getting kids into therapy because they have to be...we gotta make sure that they're good adults and that they're ready to be, you know when they grow up they're healthy. And we want to prevent the worsening of symptoms. And I, and I think yes, yes...and also kids deserve to have happiness and pleasure and, and easiness in their childhood. And that's, you know, not every time an adult goes to therapy are they really working on long term goals. They're just working on like, 'I want to feel better right now, I want to feel good now' and I think kids deserve that too. And I think that's where the child-directed work really does create the experience of it.

Here she explained that what most clinicians refer to as “the presenting problem” – or the presenting reason for treatment - is quite different for adults and children entering the therapy space: adults are allowed to enter therapy just to “feel better” now, whereas for children the treatment is always in the service of preparing them to be better in the future. However, she said that a “child-directed” approach allows child patients to also have pleasure and ease, and feel better now – not just as a preparation for later on in life. She emphasized the importance of providing the experience through the play and enjoyment, rather than focus on skills, in actually achieving both outcomes – improvements both in present and future.

She even elaborated to explain, “You can't do good therapy with kids if you're constantly thinking about what ground I'm now that will benefit them ten years from now.” She explained that this approach more linked to a “public health approach” of treating symptoms early for the sole purpose of creating healthy adults later on. However, she explained that she drew from

Humanistic approaches in her child-directed play therapy to create the experience and the space for children to benefit in the now:

We give kids therapy because everybody deserves a space where they can just feel seen and heard and safe to talk about do to have their own experience because it makes their life less stressful right now right....And that taking that space to children deserve a good life while their children too, whether or not that means in 10 years they were going to have anxiety or they're going to have trouble with relationships because they're having this happen now.

She further warned that therapy that only explicit on treating “early symptoms”, the therapy no longer services the child patient in the present or the future: “If we get wrapped up in, ‘How do I order this sequence of behaviors so that this is better when he’s older, then we’re not responding to the child as who they are anymore. We’re trying to control who they potentially could be and all of the projections on that.” Here she directly contrasted a humanistic and child-directed approach, with behavioral and public-service health approaches.

She also provided one major example of skills that both child and adult therapy should address, and that often child therapy does not address: how to manage interpersonal conflict in a safe way (“we don’t teach kids how to fight and how to have conflict”). She mentioned that most of the time school-based therapy and child supports for conflict include separating children or making one apologize to the other for reconciliation – and that neither of these solutions truly teach how to manage negative feelings about others and make independent decisions for how to

act on these feelings appropriately. One example from the TRPG treatment was when the facilitating therapist noted towards the end of the campaign that the newest player, J, might not feel like she is a good fit in the group and had experienced interpersonal conflict with other players. Instead of wanting to force this fit, the facilitating therapist explained that she felt this was a crucial experience for Player J to have: “to be able to like live in the experience of ‘this just doesn’t feel right. I’m not sure I like these kids, I’m not sure how to hang out with them, and I don’t think it feels good to me. I don’t have to be in that situation. I think it’s a really important lesson.” The facilitating therapist emphasized that having the choice to make decisions about how to befriend or play with is inherently therapeutic – rather than the message that we have to play with everyone. She elaborated that she felt that not knowing how to handle conflict was something she saw many adults seeking therapy for later on in life – and that TRPG treatment was a safe environment for children to learn that skill.

Another key tenant of the play therapy approach that multiple TRPG therapists referenced in their interviews was the notion of “playing through discomfort”. There were a number of moments of conflict between the players throughout the treatment in which both the facilitating and interviewed therapists noted the importance of encouraging the players to “play” through it. Yet, even more of an emphasis was the encouragement for individual players to “play through” moments of their own individual discomfort. The facilitating therapist referred to this a “true-ism of play therapy in general”, and explained that she approaches treatment with players as “more fun means you’re more likely to get out of your comfort zone”. She also referred to this as a “foundation” of the play therapy approach, noting that she often sees that players will do things that are really uncomfortable when they are playing. One example of this was when she

commented on players growing more comfortable with “banter” while in character, which she explained was often very difficult for players especially when starting out as new to the game or new to a campaign. She explained that the more play time, the more comfortable players would get with bantering with each other – both in and out of game.

The facilitating therapist repeatedly referenced her play therapy background when describing how she approaches certain elements of being the Dungeon Master, especially when it came to her own role-play as an NPC (non-player character). For example, the facilitating therapist had to role-play as “the Nothic” – an NPC monster who is haunting the players during the campaign. She explained that even in non-TRPG play-based treatment, it is common for play therapists to role-play in a monster or antagonizing role for the purpose of eliciting a different response from patients. She described how this different role can help her to comment on aspects of what is going on in the treatment in a different way, as well as help players with developing flexibility in responding to the therapist differently:

I draw from my play therapy background. You [as the therapist] get to be a monster a lot of time in play therapy in general and knowing that’s okay, that you’re the monster and that’s what you need to be in that moment...I like the role play because I like that you can kind of not be the therapist and not the helper. It gives really great externalization options to commenting on things, this is not so much like social role-play... you can be blunt and you can be direct... you get to have that dual experience of like, they know me as somebody that is warm and is accepting and is going to laugh at their jokes and I think

they can hold that truth about somebody with that is also important for flexibility, right?

People can act in different ways and that's okay.

One of the largest tensions among the TRPG therapists when describing their utility of a play therapy approach was a matter of “directive” interventions. As was discussed in earlier sections on Experiential and Narrative traditions, the choice between directive and non-directive styles appeared as a major split between the TRPG therapists. As will be discussed in this section, this tension emerged in the use of several different language dichotomies: “guided” vs. “non-guided”, “intentional” style. “process” vs. “non-process”. Many of the interviewed therapists preferred a “directive” style as opposed to the what they saw as a more “non-process” and “non-directive” approach of the facilitating therapist. Some of these words appeared to be interchangeable with one another – such as referring to the facilitating therapist as “intentional” when she is guiding the players.

The TRPG therapists explained how and why they utilized play therapy approaches in their facilitation of treatment. One of the TRPG therapists described his own play therapy style as wanting to put the players in an uncomfortable position, and then will use a “reflective style” to encourage players to process moments of conflict. He explained that he felt that there were many traditional play therapists who were against a more “directive” and “intentional” style – but shared that in TRPG treatment he would often use more direction as a way to support players who might be resistant. A common deliberation among the TRPG therapists was whether to use a more directive or non-directive approach in moments of conflict between players – with some arguing that the players “play it out” without directive intervention from the therapist, and others

advocating for more guidance and processing led by the therapist. One TRPG therapist referred to the facilitating therapist's choice to not direct conflict resolution among the players as a function of her "predominantly play therapy model" and repeatedly used the words "hands-off" to describe her style.

One of the TRPG therapists advocated for a similar non-directive approach when describing his favorite technique of "just shutting up". The therapist explained that the best sessions he has run were the ones where he barely talked, and that the less he intervened – the more he saw players helping one another and building relationships and rapport. He especially commented on utilizing this technique even in moments where it might be awkward, for example – the first five minutes, or "Opening Space" of the therapy session.

"I do come to this with a very kind of child directed approach of like you're gonna, 'they're gonna go where they need to go' and I'm gonna, you know, it's my job to kind of hold the space and trust them." (Beth)

The facilitating therapist frequently referred to her approach as "child-directed", even when not specifically describing the play therapy. She constantly discussed the importance of the TRPG treatment as a "child-centered space", rather than therapist-directed. She repeatedly emphasized the importance of trusting the players, and expressed that a non-directive approach meant having "a certain amount of faith in the process" – referencing a Humanistic orientation in noting that the process would ultimately drive players to "self-actualization". She, and the other TRPG therapists, described taking cues from the players to increase their directedness of the game in

her own campaign building. For example, in one moment from the TRPG treatment a player decided that the building the therapist was describing the players in sounded like “a magic hospital”. Later while being interviewed on that moment, the facilitating therapist reported that she decided to make it a magic hospital in order to “make it child-directed” (as we heard earlier in the study). In response to this moment, the other TRPG therapists agreed with utilizing the player’s input to direct the game – with one therapist referring to this as “unconscious supervision” from the players. All of the TRPG therapists noted the way in which a child-centered approach like this one “empowers” TRPG players.

Finally, there were some nods to other forms of “child therapy” that were not explicitly just play-based that would best fit into this section’s discussion. The facilitating therapist repeatedly referred to her utility of “early childhood attachment language”, referencing her training at the Harvard Center for the Developing Child, when discussing the importance of players connecting with one another. She referred to these connections as “serves and returns” – using the language of the early attachment orientation and pairing it with the DIR Floortime approach to “circles of communication – explaining that player connection was the function of “Can they serve and return with each other?”.

Another area that the facilitating therapist drew from was Child-Parent Therapy, and utilized the term “ports of entry” from this orientation to describe a moment when parents and children can connect on something that happened in the therapy at a later point:

I feel like sometimes I don't have the full presence of mind to to kind of draw every thread in. Um but I also believe that you know the I think in child parent psychotherapy they use the term ports of entry. Right? There's always gonna be another port that you can get in. Um and so to come back to like, I didn't say it then but you can come back and say it later.

The facilitating therapist repeatedly reflected on “missed” opportunities in the therapy, referring to them as “ports”, while explaining her belief that there would also be the chance to return to emerging content at a later time in the therapy. However, borrowing this term from the child-parent psychotherapy and utilizing it in a TRPG context, illuminates the way in which TRPG therapists – while wearing multiple hats of therapist and Dungeon Master – are, like parents, having to juggle much in the therapy space. The other interviewed therapists commented on similar moments in the treatment, both reflecting on missed opportunities they witnessed between the facilitating therapists and players, as well as in their own practice. Two of the interviewed therapists emphasized the importance of having “individual check-ins” with players outside of the game, either privately or in individual therapy sessions, as a means of re-accessing that “port of entry”. Most spoke about building in time to reflect on a session after it had happened, and thinking about player-character growth as well as potentially building in “ports of entry” to the campaign arc.

Summary

This chapter reviewed the various theoretical traditions that TRPG therapists employ and borrow from in TRPG treatment. While each TRPG therapist described hailing from a specific theoretical orientation, each of the TRPG therapists recalled a variety of traditions in their own practice – lending to the overall sense that TRPG therapists are especially integrative of various traditions, and considerate of how these traditions may have historically been implicated in Autism studies. However, the main finding of this chapter was that the tension between “directive” and “non-directive” approaches emerged throughout the discussion of theoretical traditions. It could be found in the tension between “skills-based” (i.e. more directive) and “experiential” (i.e. non-directive) approaches – or in the choice point between “process” versus “non-process” interventions as will be discussed even further in the next chapter. These correlated tensions reflect the multiplicity of viewpoints inherent in each TRPG therapist’s approach to treatment, and the ways in which their clinical reasoning molds the theoretical tradition utilized to fit the specific needs of each Autistic player.

Chapter 8: TRPG Clinical Interventions

The previous chapter reviewed specific theoretical orientations that fueled TRPG therapist clinical intervention, while this chapter will discuss non-orientation aligned therapeutic techniques (i.e. Non-Interruption, Conflict Management) and logistics pertaining to the treatment frame (i.e. Referral, Consultation, etc.). Part of my hope is that this chapter on TRPG clinical interventions will be of special importance and utility to TRPG therapists more broadly in rendering an account of “best practices” for this treatment. This chapter contributes to a current gap in the role-playing game and therapeutic gaming literature in that there have not yet been any thorough accounts of the specific clinical interventions utilized in TRPG treatment. I am hoping that this aspect of my research will serve as a resource for future TRPG therapists.

In addition to specific theoretical orientations, the results of my analysis showed the use of particular therapeutic interventions, techniques, and frameworks for the therapy that were not specific to one orientation or clinical tradition. One way to think about the renderings of this section would be to think of the term “therapeutic frame”, a concept made famous by psychoanalyst Robert Langs (1976) and first applied by Marion Milner (1952) to express the settings and conditions of the therapy from the therapeutic relationship, to the context of the session and what happens within it. The notion of “setting the frame” is an important way of expressing how a therapist orients a patient to treatment, and to what Casement refers to as the “therapeutic environment” (2000), which includes both the structure of each session as well as the socialization process that occurs in orienting a patient to the unique types of interactions with the therapist and others that occur in the therapy space. For this reason, I would like to use the

same concept to organize how TRPG therapists set the therapeutic framework of treatment for their players and in describing how their techniques and interventions operate as part of the treatment frame. I will do this by discussing these interventions and techniques in a somewhat sequential manner, starting with the ways in which the therapists initiate and orient the players to the therapy and continuing on to how the therapists intervene during the therapy as well as track progress. The sub-sections of these results will be as followed:

8.1 Preparation

8.2 Opening Space

8.3 Circles of Communication

8.4 Managing Individual Players

8.5 Managing Group Dynamics

8.6 Process-Oriented Interventions (Individual and Group)

8.7 Tracking Progress

Part of my rationale in consolidating this section in this manner is that it allows for the logistical and organizational aspects of TRPG treatment to be highlighted, as well as spotlight specific orientations within that frame. I found from my interviews with TRPG therapists in this study that the therapeutic framework is something they felt deeply proud of: how they built characters with players, how they checked in with the players, how they navigated player interactions, how they mediated the tele-health platforms during COVID-19. These results show the innovative, creative, and thoughtful ways that TRPG therapists structure this modality for players.

8.1 Preparation

Coordinating and planning a TRPG treatment appears to have a great deal of moving parts: from preparing the players to discussing treatment with parents and outside providers, TRPG therapists described the numerous steps they took to set-up the treatment prior to the first session.

Several TRPG therapists referred to “Session Zero” as their first meeting with a player prior to the first session of the group treatment. They referred to Session Zero as a time to meet with the player, go over the rules of both the group and the gaming system, as well as build their character. Some described Session Zero as an individual session with a player, others mentioned that Session Zero could happen with the full group prior to playing.

Beth described her process for setting-up TRPG treatment as starting with a “parent intake” – speaking to the parent either in person or over the phone. She then conducts individual Session Zeros with individual players to build their characters with them. She described these two processes together as her “treatment planning” and explained that based off of these two meetings she will generate a “clinical sense” of the patient “based on how they create that character”. In developing this clinical sense of the player, she explained that she focuses on their personality as well as trying to “identify something that’s novel and that’s generated through them”. Ultimately, she describes wanting to find a theme for each player that has to do with something they deal with in their everyday life. This notion of a theme or issue that is self-

generated, or generated through the player's unique and individual presentation, was a highlight of her approach. For example, she described how one player would create dichotomous characters in each TRPG campaign – and that discussing this with the player had strong therapeutic outcomes: “This kid... every character... he would make character just for fun. And every single one is a dichotomy. It's like, two things that should not exist in one place. He and I had a lot of good therapeutic mileage on that theme.” Another example from her practice was when she worked with a player who had a needle phobia: the therapist was intentional about asking the player whether they wanted to include this fear of needles in their character's story or not.

Through this character building in Session Zero, Beth also described how she talked with the players about how she would utilize their themes in the therapeutic game. Both in Session Zero and throughout the gaming process, the therapist mentioned that she would “elicit content” from the players about themselves that she would then plant in the narrative for them to experience later. In Session Zero she would prepare the players for this eventual process, explaining to them that the other players would likely not know what content was true to the player's lives or to their characters:

And I do prep you know when they do make their characters we talk about like, so if we put stuff in here that is something that's about you or something that you know is hard for you like if I'm putting it in the story, no one else knows that that's for you right. So your stuff no one has to know that you know so and so is afraid of cats, so and so worries about getting sick, like but if those themes come into a story that you can deal with that

like and if you can we can talk about it you know. Like that's also like a thing so you know what is okay.

Beth also discussed receiving referrals for the group TRPG treatment from player's individual therapists. One example of this from the treatment was when a player's individual therapist referred the player due to questions of diagnostic clarification regarding Autism. The referral also included the player's medical history – such as a history of migraines and subsequent fear of death that was discussed in the individual treatment. The therapist described taking this referral into account when meeting with this player in Session Zero, as well as referred to these referral questions throughout the TRPG treatment. The therapist flagged moments where she noted that the player may be working on the referral question about fear of death in the group treatment and would use this to check-in with the player's individual therapist at a later time.

Louis explained that in his practice, Session Zeros are a time to discuss the topic of consent. He explained that consent, not just sexual consent but also how to ask for and gain consent from other players, is a significant topic in the gaming world right now. One example of this he gave in response to a clip from the treatment in which player S shocked and grasped player J's phantom steed without asking for permission. He suggested that a “consent conversation”, which is introduced to players in Session Zero, could have been a useful intervention in this moment during the therapy, and encouraging players to ask consent from one another for things like “Can I get your backpack? Can I put this spell on you? Can I do this type of thing?” He explained that he viewed this intervention as especially beneficial for players on the Spectrum, or any players who may have difficulty with discussing things like consent.

8.2 Opening Space

The first ten to fifteen minutes of each TRPG session came to be termed “The Opening Space” during this project, as it was something that all of the TRPG therapists discussed. The therapists explained that these initial moments of the session, whether spent with players filtering into the virtual space or in having casual conversation about the past week, were uniquely precious time and more clinically relevant than what immediately meets the observational eye. What at first looked like chit-chat later was described as valuable opportunities for connections to be made and relationships to be developed. Each therapist described a variety of techniques they used for making the most out of this Opening Space and identified the meanings they made of using this as an intentional intervention for players. Several TRPG therapists described using the Opening Space to check in with players about the previous week and ask about personal on-goings as well as make sure all players were in attendance. Beth emphasized the opening space as a time for “regular social interactions”, where players could just talk about things that they enjoy and even “do nothing” with one another.

During the opening space in the observed TRPG treatment, players would often bring in Memes and Youtube videos to share with one another, which Beth was both thrilled by and enthusiastically encouraged. She explained that making room in the treatment, both in person and over tele-health, for the inclusion of media and using technology in a sharing fashion helped to inspire conversation – rather than pose any sort of disruption. This, she said, helped to serve what she saw as the purpose of this opening space: an opportunity for players to build social skills and practice conversations about their interests. Jared shared that these initial check-ins

served an important function for the group, in that it created a platform for the players to establish their own group norms, set up their own structure for interactions, and learn to rely on each other. He explained that much of the goal of the group treatment of facilitating player interactions and engagement with one another throughout the session would start with the Opening Space. Several of the TRPG therapists explained that the utility of the Opening Space as a time for checking in with players about their week became even more of a necessity and a staple to the TRPG treatment after the transition to tele-health due to the pandemic. Each therapist noted that the time allotted for the Opening Space increased because of the pandemic, sometimes from an extra half hour to taking up the entire session in order to make room for the players to “just chat” about the new pressures of the shutdown.

The Opening Space was just one way in which the TRPG therapists described using interventions to scaffold interactions and support emerging conversation and connection among players – even if these interventions did not always lead to player success. Beth repeatedly emphasized the opening space as one of the many opportunities for players to try and oftentimes fail at initiating engagement with other players, and that this failure was also an essential form of social practice as well. For this reason, she identified that much of her job as the therapist – and much of her interventions – were tailored towards facilitating the conversation and engagement process. The therapists identified several specific interventions they used to facilitate this process. One scenario that occurred in this observed TRPG treatment was the introduction of a new player – both new to the group and new to role-playing games – to the treatment and to the other players. The therapists described group interventions to best facilitate this introduction and model for the other players how to welcome a newcomer.

8.3 Circles of Communication

TRPG therapists employed several ways to initiate TRPG treatment from intentional structuring of the first few minutes of every session to deliberate interventions designed to encourage interaction between players. In this section, I will discuss several techniques of how therapists built communication and collaboration of the players.

TRPG therapists drew from many different theoretical traditions when using these sorts of clinical interventions, from DIR Floortime to Early Childhood Attachment Theory. Some of the terminology used in this section to describe how TRPG therapists initiated and sustained contact between players is important to briefly review. This section is titled “Circles of Communication” because TRPG therapists referenced this term from the DIR Floortime theoretical framework for therapy with children on the Autism Spectrum. According to DIR literature that draws from developmental approaches to psychotherapy, a circle of communication is when the child either initiates or responds to an other’s (i.e. therapist, parent, peer) input – making it a closed circle of communication (Greenspan & Wieder, 1999). For children on the Spectrum, TRPG therapists and Autism psychotherapists argue, oftentimes circles of communication are left incomplete and the purpose of the psychotherapy is to support the formation of closed circles. Developmental and early attachment theorists, such as the Harvard Center on the Developing Child, supplements the terminology of the “closed circle” with their own terminology of “serve and return” in which the child experiences a reciprocity of communication from the adult (i.e. caregiver, parent, therapist) leading to a “volleying” (imagine

tennis!) of communication between them (Shonkoff, 2007). In this section, interventions described by TRPG therapists will utilize this notion of serve and return, like in tennis, when describing “passing the ball” of conversation between players as well as when players would initiate or sustain conversation by “carrying the ball” themselves.

Another set of directive interventions were in modeling and supporting conversations between players. Mark referred to “conversation connectors”, such as asking questions to the group to encourage elaboration of thinking. Several therapists discussed the use of “sentence starters” as a way of helping players initiate conversations or address conflict. Jared explained that the intervention of sentence starters provides the players were “something to build off of”, instead of having to “build the relationship fresh”. These interventions were explained as of a “play therapy style” and a way to intervene and support players who are often uncomfortable in conversation.

She described these sorts of interventions as a way of “passing the ball” of conversation between the players, and as a way of modeling for them how to carry on conversation. Beth explained that especially with the use of technology for tele-health , much of her work as facilitator was “holding” both the frame and the scaffolding of interactions, such that she felt she needed to intentionally prompt role-playing and provide a higher amount of scaffolding of player interaction. Both in-person and using tele-health, one of the main ways Beth described acting as a “bridge” for player interactions was in terms of supporting their emotional engagement with one another. She repeatedly spoke about encouraging players to practice with emotional attunement with one another by using explicit interventions to direct their attention to the

emotional experience of others. One example of this “bridging” occurred in the treatment when the characters were stuck on a staircase and deliberating as to whether they should jump off of it. In order to help one of the more headstrong players, Player E, understand that there were some in the party who were hesitant about this plan, Beth prompted Player E by stating out loud, “So you hear from the back of the line somebody is saying something about being nervous...” This intervention, she explained was a way to help Player E acknowledge the emotional temperature of the situation, as well as help the players coordinate with one another about their plan. She linked this intervention to an experiential lesson for Player E:

What does it mean to make space for someone to have a concern or make people feel differently about something than how you do it? He needed a stronger cue... a little bit of the carrying the ball metaphor. Like it was almost there but like I just think the social cue, I was trying to just kind of like bridge the interaction and that idea of like planning too – you guys, think before you act.

Beth elaborated that providing prompts for players to emotionally attune with one another not only provided social practice, but also served another purpose of helping the players be “put into a relationship with an emotion”.

Louis, with an approach rooted in the theoretical framework of Wilfred Bion, described the importance of using interventions that would “bridge” the gap between players and, in his words, “force communication” so that players could build up their own communication styles – a goal he perceived as primary to TRPG treatment. His techniques, which he described as

“Bionic”, were to provide direct questions to the players in order to encourage communication. Examples of this were asking players, “What are you noticing? Did you want to tell the group?”, “What do you tell your friend/teammate/party?”, “How do you guys respond to this?”. He explained that this technique “creates the conversation” and is inherently therapeutic as it supports the formation of group cohesion as well as encourages players to ask for help.

The TRPG therapists also noted when players were able to independently “carry the ball” of conversation between others, and when to not intervene. These “non-interventions”, or explicit decisions of the therapists to remain silent and not interrupt player interaction, were frequently discussed throughout the interviews. Mark referred to this type of intervention as “the power of the therapeutic shut-up” and “the non-interruptive strategy”. In particular, this therapist was highly observant of moments in the taped treatment when a non-interruptive strategy could have been more beneficial – noting times in which the facilitating therapist would ask two questions rapidly in a row or fill the conversation void. Louis also noted these moments in the therapy and offered the feedback that the players as a group should fill the conversation void rather than the therapist. These therapists explained that a non-interruptive strategy is critical when the goal of the group is social skills engagement, suggesting an “80/20 percent” break-up in conversation in which 80% of interactions should be player engagement and 20% should be the therapist engendering conversation. Jared explained that this ratio allowed players to “go at their own pace” in terms of engagement.

One specific aspect of treatment in which the “non-interruptive strategy” was offered as an intervention was in moments where the group had to deliberate, strategize, and plan together.

Jared referred to these moments in the treatment as “open strategy conversation”, and acknowledged when the facilitating therapist chose to allow the players to engage with each other independently rather than jump in with prompts:

I also like the way she just let them talk through their perceived failure...And it was very interesting how you know EB is not over there going, “Well, what else could you do? What other strategies to you have?” It’s literally like a, “Well, we all know what’s gonna happen like it’s there’s only way like this is gonna resolve itself.” But the way that she’s literally kind of like, “Yeah. Yeah. Pretend I’m not here guys”. Like just you know have your little board meeting... so their having this open strategy conversation and just letting that happen is just a great it’s a great set-up challenge to test how they’re gonna problem solve.

Other therapists also mentioned using silence as a technique not only for encouraging problem solving and collaboration, but also for helping players build trust and build rapport – which ultimately helps them build relationships. Mark said that the best TRPG sessions he facilitated were the ones where he did not speak at all, but also described the difficulty that therapists feel with wanting to fill the void when conversation drops among players. Beth also discussed the importance of providing a safe space in the therapy for “letting those moments happen” where players have to practice with “the death of conversation” – especially while using the tele-health platform where conversations might feel awkward. This allows players to learn from social situations that they encounter, rather than punishing them for approaching these situations “incorrectly” – which is an especially beneficial experience for people on the Autism Spectrum

who can sometimes struggle with “reciprocal relationships” (Pask, 2015). Thus creating a space for social mistakes to be made in a safe way, rather than corrected, is aligned with Beth’s approach. This practice, she explained, would build their capacity to independently grapple with initiating and continuing conversation – as opposed to receiving the scaffolding from the therapist.

There were several moments in the taped treatment where the therapist identified that this sort of non-intervention was of utmost importance. One scenario was in a seven-minute conversation among the players in which all participated in a discussion of whether or not they should take their magic items. The facilitating therapist explained that during this moment she was “just thinking about getting out of their way”. Another example was in her supporting one of the players with a speech disability, in which she described intentionally waiting in silence for over three minutes in order to encourage the player to get his full sentence out. She described this non-intervention as not only patiently creating space for the player’s speech formulation, but also a way to provide him with extra time to organize his thoughts and express them. After a few minutes of patiently non-intervening, the therapist then explained that she provided a “concrete, direct” intervention of asking him if he would like more time to pull his thoughts together – also encouraging him to even type out his thoughts on the keyboard instead of verbally expressing them. She explained that this intervention was meant to signal to the player that she wanted him to feel heard, as well as provide him with practice. A third example of non-intervention was when the facilitating therapist allowed a player to have a “soliloquy” while in character without intervening. She explained that by doing so, she hoped this would encourage the player to have practice with social awareness and encourage him to “read the room and read the situation” –

especially if he is to encounter blank stares as a response, she believed this would allow him to re-assess this behavior. Jared was especially supportive of this non-intervention, explaining that he admired that she did not “shut down” the player’s soliloquy which he felt contained a lot of this player’s knowledge of the game.

8.4 Managing Individual Players

There were a number of clinical interventions that TRPG therapists described using to manage the individual experiences of the players, while in the group treatment. Rather than describing interventions for managing group dynamics, which will be in the next section, these interventions piggybacked off of the Session Zero interventions described in the Preparation section above in which individual players would meet with the facilitating therapists to set goals and character build. With these preparatory interventions in mind, the interventions described in this section build off of these initial goals and detail how TRPG therapists attend to individual players during the duration of the treatment. These techniques included things like risk assessment, tracking player’s non-verbal gestures and communication, as well as validating and encouraging emotional expression.

One of the ways TRPG therapists assessed and intervened on individual player development was through tracking and reading their non-verbal gestures and emotional cues. Several therapists explained the importance of observing player embodiment and eye tracking as a way of taking the emotional temperature on players, and sensing whether they were overwhelmed, especially in the context of their role-playing. For example, Beth described

responding to a moment in the TRPG treatment in which she couldn't discern the newest player's feelings about a situation and whether she was overwhelmed, explaining that she could easily read the cues and note when players she knew better were irritable or whether they were roleplaying as irritable in the role of their characters. They explained that these interventions were especially helpful with the use of tele-health platform, and made more difficult whenever there were technology issues that led to players sometimes having to attend without use of their camera. Therapists also described watching player's faces and tracking their eye movement to assess their engagement in the therapeutic process. Beth noted by his appearance when one player appeared "ready" for a more explicit clinical intervention, "I think he knew, he was like, damn I'm gonna get therapy! I think looking at him and watching him, like I said yeah he was ready for something more intense too, I think [by] reading his cues."

Another brief example of TRPG therapists taking the pulse on individual players was in the example of utilizing an informal risk assessment procedure for suicidality. There was one moment in the observed TRPG treatment in which Player R's character repeatedly jokes in an Australian accent about his character committing suicide. With the mention of suicide in a session, I asked Beth in our following interview what she made of this and how TRPG therapy might include certain standardized clinical interventions such as risk assessment. In her clinical reasoning, Beth explained that she had made no observation of depressive symptoms for this player both in the rest of the game play as well as in his presenting problems for treatment – which led her to have to privately and simultaneously weigh both a clinical interpretation of this mentioning of suicide with a more symbolic, play-based interpretation. She explained that, in her approach, she would "mentally flag" this moment in her conceptualization of the player and

observe him more closely throughout the sessions yet she would not pause the game play for an individual check-in as of yet. Her answer seemed to highlight the importance of preserving the symbolic aspects of play – as she likened it to how play therapists might respond to the mention of death or the appearance of violence in the game play, with an open and unassuming attitude.

Some of the therapists explained that they used these cues as clinical indicators of player progress in the treatment. For example, Beth noted when the newest player was “role-playing with feeling” as a sign of her progress in the treatment. For the most seasoned player in the campaign, Beth described his therapeutic progress in treatment as marked by his change in posture and body language from when he first started. She especially noted that this change in the player’s embodiment led to him appearing more present and connected, as exemplified by his being more visible as well as using more physical humor in connecting with other players. Another unique clinical intervention around embodiment that Beth used was to provide players with physical cues that would prompt a feeling. For example, Beth noted that Player J looked nervous while the players were deliberating about their characters jumping from a staircase in the game. This led to an intervention in which Beth described how Player J’s character might be feeling in order to cue her that she was not in danger, without dismissing her feelings or explicitly counseling her:

Player J was scared as I was trying to give enough cues to Player J at that this was actually safe.... So what I was trying to do was kind of give the feedback of kind of like security... So like, “Yes you’re scared, but actually there are things happening in you that give you that feeling of...you feel like you can float. You feel like your buoyant,” It is

like trying to talk about the ways that we can tap into what our body knows... About what's safe and what's not—without explicitly looking at her going, “You're really not in danger here”... but I also wanted to give the cue of safety for them to either pick up or not.

These interventions not only allowed for the TRPG therapists to be more in touch with what the individual players might be feeling and experiencing both in character and out of it – they also helped to encourage the players to be more attuned with themselves. Therapists described providing emotional validation for players that allowed them to emotionally express what they were feeling, as well as explicitly prompting players to introspect.

The therapists also described interventions that provided individual spotlight for players, as well as individual praise and acknowledgement. Beth described a “conscious decision” in the third session to provide spotlight for Player R by having him be the player attacked by the Cloakers, and noted that this was a clinical intervention aimed to amplify this player's clinical goals. Another example from the treatment was when Beth deliberated on how to best encourage a shy player to speak up more in the sessions without making him uncomfortable. With similar attention to individual player's styles and needs, Jared noted ways in which he appreciated Beth's interventions that acknowledged and encouraged individual player's interests in a public way. He especially responded to this in one moment from the treatment in which one player proudly spoke about his character's building skills, and the therapist publicly acknowledged these skills – which he said helped the player self-praise and feel “allowed to stake their yum”.

Jared also used the intervention of public and private acknowledgement to praise player's development of skills or towards therapeutic goals.

8.5 Managing Group Dynamics

The TRPG therapists described a variety of clinical interventions they utilized to manage group dynamics, and more broadly address all of the players in the group. Some of these interventions helped to prompt the group to collaborate and have a collective experience, or sometimes they mentioned creative ways of using their role as therapist within the group dynamic. However, the TRPG therapists focused most heavily on one aspect of group interventions: managing interpersonal conflict among group members.

One group intervention discussed by TRPG therapists was utilizing their role as the therapist to stimulate and prompt the group dynamic. Beth referred to this as “being that other in the space” by providing self-disclosure to the players and modeling how to navigate awkward interactions. She alluded to this clinical intervention as being from a play therapy model, and explained one example of this intervention in the treatment when she acknowledged out loud that she was feeling awkward to the other players when no one responded to her saying, “Am I alone? Did everyone's mics cut out? What's happening?”. She explained that by acknowledging that she was feeling “a little anxious” because others weren't answering, she was modeling how this might have an impact on someone “not in a pathologized” way. Another way that TRPG therapists used their role as “other” for group intervention was in playing the role as “the jerk” as a way of promoting the players rallying together against a common enemy. This concept will be

discussed further in the gaming interventions section, as therapists literally role-played monsters, such as the Nothic, for similar means.

Jared repeatedly noted the use of group interventions in which the facilitating therapist would narrate the emotional context of a situation out loud in order to ensure all players were included and on the same page about what was going on. Meanwhile Mark often focused on using group interventions when the characters were in stressful situations in the game that would offer the players frequent opportunities to both collaborate and experience failure together.

The interpersonal conflict that occurred between Player S and Player J in the observed TRPG treatment sparked much discussion among the TRPG therapists about clinical interventions for managing conflict. To briefly review the event for this context: Player J conjured a “phantom steed” with a spell, which Player S – surprised by the sudden appearance of a magical horse – impulsively used a “shock and grasp” spell that attacked the horse. Taking this as an affront to her character, Player J then angrily cast a “thunderclap” spell that affected the health points of all of the players in the campaign. In response to the players’ surprise and the facilitating therapist’s interventions, many of the TRPG therapists reported that in their own facilitation of TRPG treatment they had a positive outlook on the inevitability of conflict between players. Mark emphasized that “conflict is not a bad thing, especially in a therapeutic sense” and described how he saw conflict as helping to inspire player growth as well as open up communication between players.

TRPG therapists highlighted the importance of acknowledging the conflict to the players when it occurs as a type of intervention. Jared appreciated the way in which he saw the facilitating therapist publicly identifying that the conflict between the players had occurred in a “non-judgmental fashion”, which he described as giving a description of the incident without putting the label of “fight” or “conflict” on it. He explained that refraining from labeling allowed the players to have their own experiences of what had happened:

One thing that I noticed specifically was her description of the incident. She specifically described it in a non-judgmental fashion. She didn't put a label on it at all. Like she didn't say 'so we want to talk about that conflict you guys had'. She didn't say 'we want to talk about that fight you had.' It was literally 'do we want to talk about that interaction' or there was some word that she used that was a non-committal term which is good because then as the facilitator she is not interpreting the event for them because that would have been leading the witness. You know, that would have obviously they would have taken a page from what she was doing.

Several of the TRPG therapists agreed that refraining from interpretation or placing a positive or negative valence on interactions between players was therapeutic. By contrast, Jared explained that the offering of “labels” as a group intervention could be useful when publicly tagging the nature of a relationship between two players. Beth provided an example of this type of “labeling” intervention in the treatment when she noted to the players that their characters were struggling due to lack of trust: “You can't falsely facilitate trust, right? This conflict is also a moment of that like, 'Yep you guys had trust with each other and that didn't work out so good, because you

didn't trust each other.' And that's a lesson too right? What do we need to do to really be connected and trust and get the benefits of working together." In reflecting that conflict was happening to the players, Beth discussed her clinical instincts to both validate player's defensiveness as well as provide the players with opportunities to "back out" of the conflict.

In deliberating about conflict management interventions, the TRPG therapists' responses echoed one of the larger emerging findings of this study – a tension between a directive versus a non-directive approach to treatment. When it came to conflict management, as opposed to other areas in the TRPG treatment, most of the TRPG therapists advocated a directive approach with clinical interventions designed to explicitly encourage players to address conflict. A number of interventions of this nature were described in the interviews as potential ways to respond to the conflict that happened between the players in the observed treatment.

Beth, the facilitating therapist, identified several directive interventions she utilized with the players in this treatment following the conflict between Player S and Player J. Following the conflict in the second sessions, she debated whether to send an email to all of the players as a way to prepare them for having conversations about the conflict in the next session. She explained that she usually does utilize an intervention like this, but in the case of conflict it may be helpful to "structure the play" in the next session so that it could be geared towards addressing it. However, Beth instead opted for a gaming intervention as she explained the following week that she choose to structure the play using dyadic role-playing and a "long rest" opportunity– two gaming interventions that will be discussed in the next section.

When discussing more directive ways to intervene and address conflict, Jared spoke about how to “confront” as a therapist in a way that is gentle. He explained that part of why he approached interventions this way was due to his prior work with victims of sexual abuse, and so much of the way he chose to confront conflict was with “learning the art of gentle confrontation”: “So I’ll go, ‘What do you mean by that? No, go ahead talk about that. It’s okay. Tell me more’”. Jared also appreciated the ways that the facilitating therapist provided players with the option to confront the conflict, but that she also did not immediately let players off the hook either. He repeatedly noted her “active” stance in acknowledging the consequences of the player conflict – for example, the facilitating therapist directly acknowledged that all of the player’s health points had suffered as a result of the “thundershock” spell from Player J as a response to player S. Many of the TRP therapists noted the importance of allowing for uncomfortable moments to happen while players confront conflict, as well as providing intentional “exit strategies” so that players could bow out from it if overwhelmed. Jared admired the way in which the facilitating therapist walked the line between a “hands-off” and a confrontation approach allowing discomfort to happen in the group dynamic – noting that the interactions between players were “chaotic” but that the therapist maintained a strong, firm presence (“insistent without being demanding”) in encouraging players to talk about what had happened. Several of the TRPG therapists spoke about different directive interventions to provide conflict mediation and resolution using this same strong, firm presence that would create a sense of safety and structure. Beth explained that “slight” mediation on the therapist’s part plays a large role in helping create the safety and support to mediate conflict.

There were also more “non-directive” interventions for conflict management discussed in the interviews. Jared repeatedly commented on the therapist’s “laissez faire” and “hands-off” way of managing the conflict, explaining that he felt this approach best fit the comfort levels of the players in the treatment. He also noted this in moments where players were deliberating or strategizing with one another, sometimes in a heated fashion, and that the therapist used an “open facilitation” approach of not privileging one player’s agenda over the other. Jared also commented that he appreciated that no player was forced to address or confront the conflict, and that the facilitating therapist “lets the awkward stay in the room” – allowing for player discomfort without pushing a resolution of it. Beth also acknowledged that this non-directive stance was an intentional part of her approach, as she explained that she constantly asked herself during facilitation “How do I let this play out?” – as in, thinking frequently about how to allow the players to play through conflict. She explained that she balanced this desire to “let it play out” with providing realistic consequences of conflict – such as, noting that the players, even if they hesitate or refrain from addressing conflict, will ultimately have to confront issues interpersonally with each other through play or in some other dynamic form.

Beth discussed her thought process for how and when to use directive versus non-directive clinical interventions, as well as when to consider alternative approaches. She spoke about knowing when to “pull back” on directive conflict management interventions, explaining that her goal with intervention in these moments is to provide the players first and foremost with an “autonomous” experience in the treatment. From this autonomous position, she felt that she could then prompt players by opening up conversation about what had happened between them. Similarly, when more directive interventions to address conflict failed in the treatment, Beth

attempted to use role-playing, specifically dyadic role-plays – a gaming intervention that will be discussed in the next section. She noted that the dyadic role-plays also did not bring about conflict mediation in the moment – and she recognized that she had to “give up on” the intervention because she did not want to force the players to resolve conflict. Ultimately, Beth noted that the players “found the balance” and indirectly resolved the conflict together sessions later – which she interpreted as being a direct result of not being forced to do so.

8.6 Process-Oriented Interventions

In clinical literature, “process” interventions are a specific designation for interventions that prompt patients to focus on their individual process in the session and in the treatment as a whole. A similar type of intervention and style is used in group therapy to encourage players to consider their experience in the group dynamic or in the group therapy; groups that operate in this fashion stylistically are often known as “process groups”. Process interventions can deepen a patient’s vulnerability and self-awareness, as well as enhance the patient’s relationship to both the therapist and the treatment as a whole. Process interventions may also be opportunities for checking in with the patient, sometimes known as “meta-process”, and asking how they are feeling about the treatment as well as ways it could be improved. TRPG therapists spoke about the ways in which they choose to include or intentionally exclude process-oriented techniques in the TRPG treatment, and what they understood these interventions do for their players.

While “checking-in” with players either individually or as a group does not necessarily indicate a sort of process intervention, doing so was a technique that all of the TRPG therapists

discussed using in treatment and often included some level of processing with players. Beth discussed checking-in outside of session with the newest player to see how she was acclimating to treatment as well as learning the rules of the game. She also described intentionally planning periodic check-ins with veteran players year to year, and would ask the players about their characters: “Anything you want to see [your character] do or like how do you want to see [your character] grow as you continue to play?” The outsider therapists, however, frequently spoke of their use of check-ins during the treatment, prompted by difficult moments in the therapy or as a way to process how the player was doing in their clinical goals. Mark explained different ways in which he would recall player’s individual goals and experiences from the beginning of treatment and explicitly check in with them on these things later on in treatment. He noticed moments in the observed treatment where he felt that players may have been introducing projected material from their own lives into their characters, and explained that he would want to follow-up with players after session to discuss it. Another clinical intervention he discussed using was “self-reflective questions” with players in individual check-ins, where he would explicitly ask the players how they feel they are doing in relation to their clinical goals:

We ask like, you know, ‘You’re here to talk about your impulse control issues for social skill development. How do you think that’s been going? Can you illustrate any examples of where you think you’ve grown with that? How has life outside of the game been going in those sorts of situations? How do you think gaming has helped with that?’ And then we also ask basically, ‘Is there anything else you want to work on?’... If somebody has an issue that they don’t want to work on, they don’t work on it.

Mark explained that this approach was “client-focused” in that it provided players with options as to what they would like to work on in treatment, and how they wanted to do so with the therapist. These “self-reflective questions” prompted players to think about themselves, as well as consider the treatment as a whole. Louis offered a similar type of process-oriented check-in with individual players, as he explained that in “one-on-one sessions” he would reflect on progress with players and ask, “You checked your behavior on this stuff now. That’s a really cool thing! What made you do that?” He emphasized that focusing on this one-to-one intervention was an aspect of the group treatment that felt separate from group interventions in his practice that focused on building cohesion.

Similarly, public individual check-ins were used by TRPG therapists to process how players were doing in stressful moments for their characters. This occurred in the observed TRPG treatment when the facilitating therapist, in front of the other players, checked-in with Player R as he was the only player who was in the grips of a Cloaker while the rest of the players deliberated on how to save him. Beth explained that this check-in served a larger function than just encouraging his individual processing and attunement, but that she was encouraging him to role-play how he was doing in order to build the other players’ investment in saving him. By contrast, Jared viewed this moment in the therapy and acknowledged the facilitating therapist’s intervention as a way of ensuring the player was doing okay – noting that he may not speak up if he was not.

Not only were individual check-ins a frequent intervention described by TRPG therapists, but they also noted the utility of group check-ins that promoted processing in a more public way.

Louis explained that group process interventions, such as asking “What are your characters feeling about this?”, affects group cohesion – and that refraining from processing could negatively impact players. Jared specifically noted the importance of these interventions to his own TRPG practice, and while watching the observed treatment he gave the feedback that he felt there were missed opportunities for the facilitating therapist to utilize group process interventions: “There were some pretty obvious lead check-ins towards that, [but] I didn’t hear a whole lot again during the entirety of everything. There wasn’t a whole lot of ‘How do you feel?’ questions, like there were not a bunch of intense check-ins”. Beth acknowledged this observation while reflecting on her own practice, repeatedly noting that she felt this was an area she needed to grow in within her own clinical practice:

When I watch it and review it, I’m like... oh there’s a place I could have just said like, “What’s happened?”... you know there are places I did like, “How are you feeling about the situation?” and like, “Let’s regroup and things like that...” And I think that one thing I need to do to get better too is do a little bit more check-ins, like it’s checking, making, just finding or getting more into a routine of doing a little bit more checking in with them. “How are we doing for real? How are we doing in the game?”

She explained that by adding this to her practice, as the other TRPG therapists emphasized, she believed that the group check-ins would increase a sense of safety and inclusion among players by providing them opportunities to give her feedback on the game.

However, despite acknowledging the utility of group process interventions, Beth overall explained that process interventions are not a major part of her practice or her therapeutic style for very explicit reasons. First, she explained that she felt that group process interventions – especially in eliciting player feedback about the game during the game – could risk breaking player immersion in the fantasy world and sacrifice their role-play. For this reason, she suggested utilizing these interventions in her future practice towards the end of each session. Yet, Beth’s approach proved to be even further divergent from the other interviewed TRPG therapists – who consistently emphasized process interventions and remarked on this as suggested feedback for the facilitating therapist while watching the tape. She explained that as a part of her own personal “stylistic choice”, she explicitly did not think of this TRPG treatment as a “process group”, in that she believes that a lot of the processing occurs implicitly and independently than it would in a group treatment with a process style that directly elicits this sort of experience. She elaborated on this point in stating that she sees this more subtle, implicit processing occurring especially when the players have a strong sense of cohesion in the group dynamic. Furthermore, she explained that in her perspective – more explicit check-ins might lead to a highlighting or over-emphasis on what could be construed as “problematic behaviors”, like in Mark’s example of checking-in about impulse control or Louis’s asking about specific behaviors. Instead, it appeared that in her form of check-ins, Beth opted for an approach that focused more on the character than the player, as in asking “How do you want [your character] to grow?”

Finally, Beth was the only TRPG therapists to explicitly mention the use of check-ins with players’ parents as an intervention. She described offering to meet with parents to “debrief” at the end of treatment, as well as have period check-ins between session with parents of new

players in order to field their concerns or questions. This intervention, she explained, helped her to gauge how the newest player was feeling about the therapy. She also mentioned that sometimes parents would email her with feedback and observations on the players.

8.7 Tracking Progress

In rounding up the clinical interventions, techniques, and therapeutic frameworks for TRPG treatment, one of the elements TRPG therapists considered in treatment was how to track the progress of players in the therapy. Just as they discussed setting goals in the initial stages of setting-up treatment (see previous Preparation section), TRPG therapists shared the ways in which they methodically tracked progress with clinical tools like session notes and binders for each player, as well as more abstract ways that the therapists would note progress for the players. For example, Mark described using session notes to reflect on the examples of progress for each player, as well as noting the group dynamics.

Beth also shared how she would note progress to players, as well as conduct conversations with players about continuing or graduating from the treatment. She provided an example of working with a player who had made progress with treatment and then later appeared disengaged. She explained that she wanted players to feel autonomous with initiating and continuing treatment, and would be intentional about noting if the player started to feel resistant about weekly attendance or appeared disengaged. She felt that it was necessary for treatment to be a choice, and that it was most therapeutic to listen to the player in order to preserve not only a sense of autonomy, but also allow the player to feel welcome to return at a later date. She also

mentioned one of the first members of the current group in the observed TRPG treatment who was “the first and only kid to graduate from group” after about a year of treatment. Beth explained that this player had made significant progress and had independently come to the realization that he did not “need therapy group anymore”.

Summary

This chapter reviewed the clinical interventions utilized by TRPG therapists that do not align to any specific theoretical tradition of psychotherapy, but instead lend to the overall “therapeutic frame” and structure of the treatment. The results in this chapter were presented thematically, but also reflect the narrative structure of the TRPG treatment as described by TRPG therapists from beginning of treatment to end. These clinical interventions described here lend to an overall sense of the “what” of TRPG treatment: what is happening in each session, and what the TRPG therapists are thinking behind each clinical intervention. These results also point to the ways in which TRPG therapy has some more traditional elements of a treatment – such as risk-assessment, individual check-ins for group members, and progress tracking. The results in this chapter also reveal the ways in which TRPG therapists might use conceptualization of a “presenting problem” for driving treatment goals or specific interventions within treatment.

Chapter 9: TRPG Gaming Interventions

Introduction

One of the main objectives of this study was to discern the different dialectics “at play” in therapeutic gaming. The term “therapeutic gaming” in and of itself reveals a marriage as well as a potential dichotomy between two of these dialectics, or approaches to TRPG treatment: there is the clinical aspect to TRPG as well as the gaming aspect. My hypothesis leading up to this study was that TRPG treatment would inherently include moments where therapists were drawing from these dichotomous backgrounds and finding creative ways to utilize both clinical and gaming interventions for their players’ benefits. The results of this study reveal that my hypothesis was correct in that TRPG therapists were often utilizing both clinical and gaming perspectives, sometimes alternating between the two and sometimes sacrificing one for the other. The TRPG therapists described many of the perspectives they drew upon in their clinical reasoning in treatment, including their own gaming experiences as players and DMs outside of the clinical space as well as within it. They also spoke at times about other gaming systems, or experiences with sci-fi or fantasy outside of gaming. Ultimately, each therapist had a way in which they described utilizing their gaming backgrounds and the mechanics (i.e. rules) of Dungeons and Dragons, and explained how these things were then implemented for means of therapeutic gaming. As many TRPG therapists and others in the gaming community have suggested, there are elements to TRPG games that inherently lend themselves well to a therapeutic experience, even outside of a therapeutic setting. In this chapter, I will share some of the gaming and DM techniques described by TRPG therapists as not necessarily specific to a therapeutic game

(despite being used by a therapeutic DM), but that have been found to have therapeutic benefits for players. I will also speak in this chapter about the ways in which TRPG and D&D mechanics were used with therapeutic intentions, as well as how these gaming interventions would at times create tension with the therapeutic space. This review of gaming interventions is by no means exhaustive, as there were countless gaming techniques observed and discussed in this game. However, the results I will review here came across as the most salient to the therapeutic nature of these interventions from the eyes of a researcher and clinician.

9.1 Game or Therapy?

“We don’t stretch the therapy to fit the game, we stretch the game to fit the therapy”

(Jared)

The tension TRPG therapists described emerged in moments where therapists had a choice whether to prioritize the game’s mechanics, rules, and story arc or the opportunity to provide a therapeutic experience. In therapeutic gaming, Jared explained from his perspective, the priority was always the therapeutic experience: “We don’t stretch the therapy to fit the game, we stretch the game to fit the therapy.” One example of this was when TRPG therapists described creating space and time in the game for the players to deliberate with one another and process, even in battle scenes where in a typical game this would not be the case. Beth, Jared, and Louis all described ways in which they would pause the game or create space in the opening minutes to allow players to meta-game, and talk with one another about what is happening – all in ways that would be unusual for a non-therapeutic game. Louis described a gaming

intervention paired with his Vygotskian background of scaffolding players processing by slowing down the time in the game:

It could have been Vygotsky in a different way of, let's go and talk about everything we know about this problem and think of it as kind of like her as the DM/GM can kind of be like, "Time slows down, where one minute is equal to a tenth of a second... And kind of help Vygotsky lead them down into that when they feel they [stutters] the problem overall identified, solved and that type of stuff the mist clears; you guys are back in your bodies.

Louis described interventions such as these as the "imaginative breaking of the game", and explained that interventions that help the players guide the narrative of the campaign and brings a "therapeutic endeavor" to the gaming. He further explained that in his approach, "we don't have to stay as heavy to the mechanics" and that "the whole idea behind therapeutic GM-ing" is that the therapist can at times break the rules in order to scaffold the players' experiences with problem-solving and relating to one another. Part of his inspiration for this approach, he explained, came from his own non-therapeutic gaming as a player where he has experienced a DM who will do things like skip turn order just to get players engaged. Furthermore, he explained that "breaking the rules" of the game can be enlightening for certain players as it helps them learn that sometimes "it's okay to break those rules in the social skills realm". Beth similarly privileged these moments of paused interaction as opportunities for the players to still engage in the game in alternative ways, such as using paused time to flesh out their character's backstories or even just to get to know one another better. Instead of completely taking them out

of the gaming space, Beth explained that these pauses actually encouraged players to be more immersed in co-creating this shared world.

9.2 Externalizing and Depersonalizing

The same tension arose between breaking and immersing when TRPG therapists described appealing to the players' characters through an intervention. Beth repeatedly described using "externalizing" and "depersonalizing" interventions, using the player's character to allow for interventions to work on two levels – the gaming level and the personal level. An example of "externalizing" was when Beth noted that one of her players appeared excessively worried that their character was going to die, to which Beth asked "Are you worried about this, or is your character worried about this?" She explained in the interview why this intervention would work on two levels, "And so if it's your character, let's talk about your character's fear of dying right now. What is happening for them? And just teaching the creation of space between the experience of anxiety and [how to] deal with anxiety". Beth further explained that utilizing a player's character in order to give the player feedback, ask about their feelings, or process an uncomfortable experience allows the player to "attribute[e] those uncomfortable experience to something that's not actually you, and gives you a better chance of learning about it and cultivating a curiosity about it." She likened this to a sort of "gradual exposure process", that encourages the player to talk about feelings or discomfort in a less threatening manner if it is through the guise of their character. Beth also discussed utilizing an externalizing technique to encourage the players to consider addressing the conflict: she explained to the players that, just like in a movie, if the characters had a fight – they would not just move on as if nothing

happened. She rationalized this intervention as provided a sense of safety for the players, by allowing them to externalize the conflict to the character-level.

9.3 Breaking Immersion

The notion of “breaking” or pausing the game play is important because it is one of the more fraught situations in a non-therapeutic gaming space. In non-therapeutic gaming, the decision to pause the game risks breaking player “immersion” in the gaming world, and that immersion is often noted in the literature as the key ingredient to some of the therapeutic benefits of the game as well as critical to player enjoyment and overall experience. Lankoski and Jarvela (2012) review the varying definitions of the term immersion in role-playing game studies, concluding that it is the “state where the fiction of the game takes over” the player’s experience such that the player “feels the same emotions as his or her character” as well as the situation in which a participant “assumes his or her character’s personality” (Castellani, 2009). Lankowski and Jarvela also distinguish between immersion and the concept of bleed in existing role-playing literature, such that “bleed” is the phenomena that describes when a character’s thoughts and feelings are swayed by the player’s own thoughts and feelings, as well as vice versa. Role-playing game theorists suggest that it is the “continuous” and “total” experiences of immersion and bleed, made possible through the “bracketing” of their lives and selves outside of the game, that is the proposed mechanism of action in what makes role-playing games fun and psychologically plausible (Fine, 2002). As the TRPG therapists in this study concurred, immersion and bleed are also vital ingredients to players engagement and investment in not only the game but the therapy as well.

Yet in the results of this study, it was fascinating to hear about some of the ways in which TRPG therapists narrated the therapeutic benefits of breaking with immersion and the world of the game. Another example of this came from Mark, who explained that sometimes when working with players who have difficulty differentiating between reality or fantasy – or perhaps were feeling overwhelmed by the fantasy space – he would encourage players to “roll a perception or deception check to break player immersion” and help remind players of the game’s structure and rules. In this way, TRPG therapists explained how the game’s rules were themselves of therapeutic benefit in providing immense structure and predictability for the therapy and experience.

9.4 Seeding the Bleed

Along with these techniques for “breaking immersion” there were numerous gaming techniques, devices, and interventions used by the TRPG therapists that appeared to do exactly the opposite – encourage immersion and engagement in the campaign and the game. Jared spoke about the importance of “seeding the bleed”, a gaming term which means that the DM should encourage the player to step inside the shoes of their fictional character and reality to the point where there is a sense of “spill-over” of the player into their character. Following the clip in which Player R was attacked by a Cloaker, Jared noted when Beth encouraged Player R to reflect publicly on his experience to the rest of the group as a way of “injecting more emotional context to the experience” so that the players could start to feel emotionally involved in the situation. He explained that “injecting” this emotional context was a way of seeding the bleed – and, he

elaborated, was a far more effective way of supporting the players than “proselytizing or preaching...she’s not having a twenty minute diatribe on the nature of coping skills”. In this way, he is directly contrasting a gaming intervention, seeding the bleed, with a clinical intervention, such as coping skills instruction.

9.5 Narrative

“The narrative is what keeps us there” (Louis)

Louis explained in his interview that he views the story arc, or narrative, of an RPG as the most essential gaming intervention for players. “The narrative is what keeps us there”, he said as he explained that the narrative – whether in TRPG or in video-gaming - is the way that players invested and engaged in the game and ultimately in the therapeutic treatment. In his approach, he described encouraging players to take part in guiding the narrative of the campaign, as well as the responsibility of the DM to “guide the overall story arc” towards the therapeutic benefits of the players. The end result, he explained, was that the player can feel “powerful” because the narrative feels tailored just towards their needs. Mark also tried to elicit player feedback so that he could tailor the game narrative towards them by using what he called “my dirty GM secret”. He described his technique of opening each session with asking players about what happened in the previous session, not only to re-engage them in the game but also to find out what was important to them so that he could continue to tailor the campaign story towards what was interesting for the players.

9.6 Encouraging Role-Play

One of the most key aspects of any TRPG is the role-playing, and the TRPG therapists explained how they encouraged and understood the therapeutic role of role-playing in the game. Each of the TRPG therapists spoke about the importance of encouraging character role-play for a number of different reasons: to encourage immersion and bleed, to elicit banter and relationship building among characters, to manage and resolve conflict, and to support players with emotional expression or “role-playing with feeling” as Beth said. Several gaming techniques were shared in interviews to actually elicit role-play between characters. One example from the observed treatment was the “Travel Montage”, which Beth used in the first session as a way to encourage individual players to share to the others about their character and role-play as their character. The intervention included each player taking turns, role-playing as their character, and sharing one anecdote from the long journey the group just had. The TRPG therapists all commented on the utility of this intervention as a way of spotlighting individual characters, encouraging players to share speaking time, and begin immersing themselves in the fantasy world in the first few minutes.

Similarly, there were gaming interventions discussed for eliciting role-playing among two or more players. Beth described the “long rest” technique, similar to Louis’s mentioned “campfire” technique, as providing the players with non-battle scenes and pauses on their journey in which the players could not only re-gain health points (according to the game’s mechanics) but also use as ample opportunity for role-playing with one another. Louis explained that this was a good way to inspire players to confront conflict as well as guide the “narrative” of

the campaign. Beth explained that with this group of players, spontaneous role-play was often difficult to independently initiate with one another – although she felt that the players were often better at role-playing in character while talking with her as the DM. In the observed treatment, Beth utilized a long rest technique to encourage “dyadic role-playing” in which she paired players together, especially two players in conflict, and allowed them to have a specific time to role-play with one another. While watching this moment in treatment, Jared commented on Beth’s DM-ing technique of putting the two in conflict together for a dyadic role-play, yet he also picked up on the fact that the players were not necessarily engaging each other well – as Beth also noted. For this reason, Jared recommended that in this moment Beth use a more directive conflict intervention outside of the mechanics of the game in order to “economize goals in the therapeutic RPG” and due to limited time. In this way, among the TRPG therapists there was a clear line of diverse clinical reasoning – of when to rely on a gaming technique versus when to potentially switch to a more directive clinical intervention: for the sake of timing and goals.

9.7 Non-Player Characters (NPCs)

Therapist role-play as “NPCS”, or non-player characters, was also a common gaming intervention discussed by TRPG therapists, and featured heavily in the observed TRPG treatment. The DM role-plays as an NPC for many reasons, as TRPG therapists in this study explained that they help to push along the campaign story, to role-play as “the monster”, as well as encourage interactions among players. In this treatment, Beth role-played as the monster “The Nothic” – a monster who mind-reads and extracts private information from player’s internal

minds and uses it to exploit them. In the game, Beth as the DM had each player roll a "deception check" in which each character had to share a secret about themselves –unknowing that Beth was the Nothic. Later on, Beth role-played the Nothic with a creepy, harrowing voice as she detailed characters' insecurities back to them, a technique which she described had therapeutic aims of encouraging players to talk back to negative thinking, and cultivate resiliency around self-doubt. Beth explained that role-playing as the "monster" is a hallmark of RPGs but also gives valuable therapeutic opportunities for players to engage in the therapy and with the therapist in a novel way. Louis agreed in that role-playing as an NPC can also help prompt player action, such as role-playing as an NPC that can help force conversations among players or even mediate conflict "through a third party".

9.8 Risk versus Reward

There was a final feature of the gaming interventions that I found quite surprising, despite it apparently being a core feature of the game: the role of risk and reward. In the final session of the treatment, I found myself amazed by the engagement and tenacity of the players in their final battle of the campaign: there was so much action going on, that I almost found it hard to follow along. I asked Beth about this later on, and I was dumbfounded when she explained the obvious answer that – as with any saga, say Star Wars – the final battle is what it all leads up to, and what all have been waiting for! Furthermore, she explained that in D&D in particular, battles against monsters play a specific role in the imaginative gaming as they provide a strong opportunity for the players to weigh the importance of risk versus reward in one final, major way. The theme of risk versus reward came up throughout the observed treatment, such as when the players had to

deliberate about a sign in a dungeon that told them that the characters had to leave their magic weapons behind in order to advance on their journey. In the third session, the players had to manage risk was when Player R was the only character attacked by a Cloaker, and the other characters had to save him without hurting him. And in the final session, the characters finally found the magic crystal that they had searched for all along, which while in its proximity gave them stat boosts: “All of the things you’ve never been good at, you’re good at!”. However, these stat boosts for the characters come at the price of danger with Beth role-playing as five different types of monsters who are attacking the characters and preventing them from obtaining the crystal. In this final encounter, Beth explained that the stat boosts were an intentional technique meant to prompt players to play outside of their comfort zones: for example, Player E who typically uses the “Eldridge Blast” spell could try dagger fighting with the increased boost to his abilities. Beth likened this intervention to encouraging the players to leave their magic items behind as a way of prompting them to weigh the risks of trying something new with the possible rewards it may bring to the character.

As I discussed in the sections on experiential therapy, Beth described the campaign’s theme of risk versus reward as having a clear alignment with clinical traditions of exposure therapy as they prompt the players to confront anxiety and risk in a safe manner as well as gradually have new experiences. However, Beth explained that the theme of risk versus reward is baked into any RPG even in non-therapeutic games, and that it appears to be a major contributor to player engagement and continuity with gaming. What I ascertained from this final session is that this theme is part of the key to what keeps players gaming, it’s the “hero’s journey” as Louis described – or the quest through dangerous terrain in search of reward (and actualization). Yet on

a more grounded level, when I thought about all of the players – especially the newest Player J – I realized that perhaps a critical part of role-playing and gaming is itself confronting risk, the risks of learning the rules of a new gaming system, or of role-playing a character and acting in front of others. There is a huge amount of stepping outside of one’s comfort zone that inherently exists when entering a role-play gaming space: there are social risks as well as personal risks of putting oneself out there, and contracting with others that you will all be entering and co-creating the same fantasy world. The rewards are like with any game – there is pleasure and camaraderie. However, there are rewards unique to role-play gaming such as feeling like an expert in your character and in your knowledge of the mechanics of the game, as well as the excitement of winning a battle against monsters. This larger theme of risk versus reward is not so much a gaming intervention per se but rather a function of gaming that can serve players on so many levels – and in therapeutic gaming, it has a unique capacity to catalyze personal growth.

Summary

This chapter reviews the gaming interventions used by TRPG therapists, and delineates these interventions as separate from the clinical interventions that are more akin to specific psychotherapeutic theoretical orientations and traditional therapy structure. The gaming interventions described in this chapter include elements of role-playing games that can be found both in non-therapeutic and therapeutic games, as TRPG therapists described ways in which certain aspects of the game are modified to support therapeutic goals. This chapter reviews not only specific interventions in therapeutic gaming, but also the way in which the core structure of therapeutic games (the narrative, risk vs. reward, characters) lends to a therapeutic experiences

for players. This chapter also synthesizes the TRPG therapist responses with existing role-playing literature on “immersion” and “bleed” to provide a compelling argument for how these concepts engage TRPG players in the therapeutic experience.

Chapter 10: Therapy Outcomes

Introduction

In this chapter, I will review the final aspect of clinical reasoning shared by TRPG therapists in their “chart talk”: the outcomes that they observed and/or aspired towards in their facilitation of TRPG treatment. The category of “Outcomes” was applied to statements made by TRPG therapists that described two things: a) the outcomes of the treatment either desired or noticed in each client’s growth and treatment progress (i.e. “Player S has grown in social skills over the past few weeks”) and b) more general treatment goals and outcomes they described in terms of TRPG as a modality in general (i.e. “I hope that all players feel a sense of belonging when in TRPG therapy”).

My rationale for designating “Outcomes” as a particular type of clinical reasoning was that each therapist discussed goals or aspirational hopes for treatment that they believed would be a good indication of what they are aiming for in their utilization of TRPG therapy. These described outcomes were measures of their orientation to interventions – both clinical and gaming – but also speak to what they believe are key levers in mechanisms of therapeutic change. For example, one participant mentioned that the goal of TRPG treatment was to create “group cohesion” as a means to then also develop an ability to differentiate between self and other, as well as stay immersed in the game. This outcome has clear alignment to his background in group therapy, and has clear implications for the types of intervention he would use in session to promote group and individual growth.

The outcomes the therapists describe have profound ramifications for their understanding of Autism Spectrum Conditions and how TRPG treatment works with this population. Each of these TRPG therapists hail from different settings and disciplines within the clinical field, which appeared to have profound impact on what they understood were the aims of their treatment. For example, the role of a social worker in a community mental health setting might seek different outcomes of treatment than a clinical psychologist in an outpatient private practice. I wanted to understand how TRPG treatment goals and projected outcomes might engender a celebration of neurodiversity, rather than aim towards neurotypical comportment and behavior. Ultimately, I was interested in comparing the participants' conceptualizations of Autism alongside perceived outcomes as a means to discern how their attitudes about Autism might be specific to this modality.

I organized this chapter by delineating five main “types” of outcomes discussed by TRPG therapists: relational , clinical/symptom improvement, identity and game. The primary outcomes discussed by TRPG therapists were a) relational outcomes, such as the treatment resulting in increased group cohesion or relatedness with others and b) the clinical improvement of symptoms.

10.1 Relational Outcomes

Mark, Louis, and Beth focused heavily on relational outcomes in their discussion of their aims for TRPG treatment. In the observed treatment, the facilitating therapist Beth appeared to

narrate session-specific relational outcomes that seemed to be designated at different points of the five-week treatment. For example, while the first session focused more on getting the players to talk to one another and build communication – later sessions aimed at more complex relational outcomes such as feeling a sense of belonging with one another and effectively navigating interpersonal conflict. These relational outcomes seemed to build upon one another, as if relying on the outcomes and progress from the last session – not only narratively in terms of story structure, but also in terms of how the players were growing both in their characters and with each other.

In the first session, the facilitating therapist Beth repeatedly emphasized the goal of engendering “meaningful conversation” and “meaningful interaction”: “Meaningful interaction... If nothing else happens, that is kind of my goal”. This was especially clear when in the first session, she intentionally refrained from interrupting a long discussion between two players about their character score sheets. What appeared to me, the observer, as a calculated and mathematical conversation between the two players was later clarified by Beth as “meaningful conversation... not nonsense”, and delightedly shared that they were independently conducting a conversation in which the players were helping each other prepare for the game. Meaningful interactions discussed in this session also included joking around (“healthy ribbing”), decision-making, and reviewing their experiences in past therapeutic games together (“they can kind of revel in their history together and reconnect to it”). The goal of setting up “meaningful interaction” was also supported by the outcomes of TRPG treatment proposed by Louis and Jared, who explained that these meaningful interactions would be the building blocks of other relational outcomes such as increased problem solving and group cohesion among players.

Although Jared did not focus on relational outcomes as much as clinical outcomes, when he did discuss relational objectives of the treatment, he seemed to draw upon group psychotherapy frameworks in discussing the group's autonomous establishment of group norms and a structure of interaction: "the group is automatically learning to rely on each other, they're setting up their own structure for interaction, they're kind of establishing their own group norms". This outcome especially struck me for its mention of "learning how to rely on each other" as a result of setting up these norms and structures of interaction. Additionally, the notion of setting up a "structure of interaction" recalled to me the goals of a non-directive therapeutic treatment as described by Bromfield (1989) in his play therapy work with children on the Autism Spectrum. Bromfield describes the play as being a way for the client to set up a "communication system" with the therapist, and that the goal is to find a comfortable mode of communication in which the Autistic client is de-sensitized to their anxieties about relating to others. TRPG players are not only setting up a communication system with the therapist but also are setting up ways of communicating with one another.

There appeared to be something particularly special about the development of group norms and communication systems in a TRPG setting – where, as Mark discussed, there is a collaborative building not only of norms and interaction, but also a collaborative building of a shared world. Jared seemed to focus on aspects of relationship building heavily, specifically the importance of creating an emotional connection to other players, "building" aspects of player relationship (rapport, trust, comfort) as well as character relationship (worlds), and then collaborating within that world. He especially noted moments where players were encouraging

and supporting one another, such as when the players cheered on Player J when she was frightened of the “Feather Fall” of jumping together off of the staircase in the game.

Jared also echoed Mark’s described goals of collaboration and communication, with specific attention to the management of group conflict. Jared described one goal for the clients as having the opportunity to discuss a moment of conflict with each other (“the elephant in the room”). He also identified this relational outcome in a moment from the observed treatment in which the players “went to each other’s defenses” as a way of protecting each other from a monster in the game.

“My overarching goal is to get these kids who don’t connect well with others and don’t have good ‘give and take’ necessarily to mutually enjoy something and enjoy it so much that they are able to work together to make it” (Beth)

Collaboration was also a primary goal in the observed TRPG treatment. In the final session of the observed treatment, with a very high stakes and high reward battle, Beth repeatedly emphasized the encouragement of strategy and planning between players: “that’s the goal is that they collaborate”. Yet this collaboration was also balanced with a desired outcome for the players to be flexible and creative with one another (“the value in the immediate satisfaction of being able to be creative with somebody else”), and ultimately to have fun. In the discussion of these outcomes, Beth appeared to be making a connection again between these elements of fun, collaboration, and creativity with the larger goal of finding value in friendships and connection both in the group and outside of group.

While all of the TRPG therapists discussed “collaboration” as a primary objective of treatment, Louis linked collaboration to the specific experience of problem-solving in TRPG therapy. Louis even identified interpersonal conflict as a type of “problem to be resolved” together through resolution. Louis argued that problem-solving amongst peers, rather than receiving the solution from the therapist, would allow for players to stay immersed in the game and the therapy as well as become more self-aware: “If we problem solve it that we figure out the solution ourselves it makes it much more likely to stay in our mind rather than if someone gives us a solution”. This statement has fascinating implications for how we might perceive of an individual player’s social skill development which is that the experience of group problem solving and collaboration might be more at the core of this development than skills teaching. Then, Louis elaborated on the outcome of group problem-solving to explain that doing so creates a sense of “group cohesion”:

Working as a team, figuring out the problem solving on their own, having that conversation around it, being able to do...like they were conversing. That’s group cohesion. They’re putting their heads together to figure out what is the best-case scenario um overall. And to be able to figure out, where do we have to go from here? So that group cohesion is them working together, focusing on what their needs are and how do we solve this problem that’s directly in front of us?

10.1A Group Cohesion

Louis also referred to “group cohesion” as what he sees as being the overall goal of the TRPG Modality: “Letting the group cohesion go is the whole point of us running these groups (298)”. Louis explained that a secondary outcome of group cohesion is the creation of a “subjective third”, explaining that he drew from Jungian and psychoanalytic theoretical frameworks in this way. Louis explained that the “subjective third” was the product of a relationship – the culture, the humor, and the shared history. Louis’s “subjective third” and Jared’s “structure of interaction” that is produced when in relation with another. This notion of “subjective third” is incredibly potent for TRPG therapy, where beyond producing inside jokes and ways of communicating, there is an even more concrete subjective third – which is the world of the game that is being built collaboratively. Louis continued to explain that a subjective third is created in TRPG therapy by “focusing in” and “allow[ing] our minds to mix and merge...[so] it becomes a thing to rely on”. This argument is also profound in its echoing of Jared’s statement on group norms and interactions being something the group can use to “rely on each other”.

Louis described narrative and developmental interventions for the outcome of group cohesion, such as using developmental scaffolding to help the players build the game’s narrative together which would thus stimulate group think and cohesion. Alternatively, Jared suggested more a more skills-based approach for prompting group cohesion. In his clinical reasoning, he explained pairing both a non-directive and a directive approach for encouraging “peer support learning” with players on the Spectrum by a) not interrupting peer interactions (“let them go”) and then b) providing positive reinforcement to acknowledge the collaboration between players. The outcome of this, he proposes, is “good social skill development”, “increased communication”, and the group “policing” one another by giving advice and being supportive to

one another – mirroring Louis’s suggestion that the group can then solve its own problems. Throughout his interview, Jared connected the notions of social skills development with group cohesion – such as the group creating their own norms and structure for interaction in the Opening Space, leading to the group coming to “rely on each other”. These perspectives of Jared and Louis reflect the way in which therapist interventions, both directive and non-directive, contribute to an autonomous nature of the players building group cohesion and group culture on their own – and how this in turn leads to social skill development. In this way, social skill development here is framed as something generated by the players – rather than as a method for teaching “neurotypical” ways of interacting. It also highlights the non-directive nature of “allowing” group cohesion to form by “letting it go” – and that this non-direction is what drives what Louis calls a “skilled development moment”.

Beth echoed Louis’s focus on problem solving and group cohesion in referring to a goal of the therapy as “experiential relationship-building”, which was creating opportunities for the players to work together through collaborative problem-solving, mutual support, and sharing with one another. In the rising action of the game’s story arc, and as the group had to make high-stakes decisions – such as leaving their magic items behind – Beth narrated seeing an increased experience of collaboration between group members in this second meeting. All of the TRPG therapists highlighted collaboration as a primary goal of treatment, and collaboration was discussed as a way of working together and helping one another with “pro-social behavior”.

Beth discussed seeing the players be more open with one another about their lives – the newest player to the group introduced her dog to the group members over the virtual platform –

which she interpreted as an outcome that came from being “invited in” to the group: “for her to bring that out and share it with people, to get really good feedback I think from it... here is a kid showing herself and being you know – this is her, you know, kind of responding to the invitation of being invited in”. Here the outcome connection was made between being invited in to the therapy group and to the game as a player, with the outcome of increased vulnerability and social interaction. Beth connected this experience to the larger therapeutic goals of each player: “This is their life. And the different things that they are spending their time with. And being able to share that part of themselves and also the places where those interests overlap... And I think that for them the just the experience of finding ways to do that with each other is also really important in terms of the things that they’re working on”.

“Parents will pop in with emails all the time giving feedback on what the kids are going home and talking about; and she said he told me this week that he, you know, he loves it and he really feels like the other kids in group have become some of his best friends. You know and its been like six months that they've been together and I just was like that's... I cried. This is why, this is why they need this.

This is why it's useful.” (Beth)

As described in the above quote, Beth also described the outcome of relationship-building and creating friendships – both in session and out of session. She illustrated in the interview how parents of children in the group had been pleasantly surprised that their children had found “best friends” in the group, stating “this is why they need this, this is why this is useful” and had even found relational successes outside of the group at school. The connection

between “meaningful interaction” and “friendship” felt profound to me as I realized that the scaffolding in the first session was a building block for friendships both inside of group and outside of group. The goal of supporting outside friendships continued to be prevalent throughout our interviews – as Beth described players creating friendships that were especially meaningful given their diagnosis:

And I was just kind of following up with dad, and they were down at the bottom of the stairwell outside my office just talking, like just beautiful, like beautiful, like casual, friendly...Like and you know and those moments of like when you have a kid who is on the spectrum who doesn't make friends easily, that was beautiful right? And it was just like that was, that was like a therapeutic outcome in and of itself of doing this kind of thing, I think.

“A moment of just like, ‘We know each other. I see you’...that feeling of like ‘we see you, like we see who you really are’ and yes, that’s the thing. I mean that is literally the thing, the box that says flaw, right? That’s the thing about yourself that gets in the way that gets you into trouble and we see it, and we’re gonna smile at it, and we know who you are.” (Beth)

At the halfway point in the therapeutic campaign Beth narrated observing even more intimate and complex relational outcomes in the third session. As the group continued to encounter difficult situations, both situationally with monsters and interpersonally with each other, the therapeutic outcomes discussed appeared to match the increasing intensity of the therapy. She highlighted the group’s ability to navigate conflict with one another through

disagreements about how to go about a problem, almost as an elaboration of the problem-solving outcomes in the previous session, as well as resolve a fight that happened between the players. Players continued to find ways to connect with one another, seemingly as a result of the conflicts, reassuring one another after a difficult decision had been made and supporting one another. Beth also identified several instances in which the players came to each other's aid, one of which was especially moving after a player had incorrectly calculated a decision: "and they just scooped him up ya know and there was no blaming and he just blamed himself but nobody else blamed him ya know. And they were like they were like we're gonna get you through this my friend." This support seemed to not only be situational, but Beth denoted a more personal nature to this sort of relationship building – a recognition of one another, both in character and out of character – "we see who you really are" in terms of where players might struggle. Echoing the group formation perspectives of Louis and Jared, Beth identified moments of more direct player-to-player connection, as well as a sedimentation of the group as a whole "it's their way of joining or acknowledging of this joined experience that they had".

"If you know how it feels then, you're going to find it outside in other places... get a felt sense of like this, because you are doing this group, you're gonna recognize it later when you're finding a good healthy relationship with someone else hopefully... the experience of one healthy attachment in a life, an early childhood event can make all the difference as to whether you end up sinking or swimming" (Beth)

The penultimate session of the observed treatment highlighted therapeutic outcomes having to do with the group achieving a sense of cohesion, and with the outcome of a shared

space where Beth observed “belonging”. As the quote above suggests, the outcome of experiencing and initiating healthy relationships – both inside and outside of group – continued through this session. In a progression from the first session in which the goal described was “meaningful interaction”, Beth noted observing “natural conversations” – a marker of independence and growth in relationship building throughout treatment. She tied this growth in communication to an overall sense of cohesion in the group “kids can get that cohesion, which you get from learning serves and returns”. A second part of this outcome, according to Beth, was a sense of a shared space – which she interpreted through identifying the many “callbacks”, or references to shared memories and experiences that had happened during the campaign:

They hit their stride in a way of that at that cohesive point... because there were so many callbacks... Here is our shared mythology, here is our shared, kind of content of language... it just kind of felt like a cultural gelling for them today this week... But it just shows how meaningful these kind of things are for them too, right? I think that’s also a thing of like, yeah, you have, all of these callbacks are pretty old, some of them... that’s become, that’s important, and it’s still in your head, and that’s cool.

As the group worked together to save one player in danger, Beth explained that the heightened risk of the situation led to not only cohesion on behalf of the rescuing players – but also promoted a sense of “belonging” for the player in trouble. Beth elaborated that by identifying the player in danger as worthy of being saved, the outcome was not just a comradery but also a very profound felt sense that the player was an integral part of the group. She then connected this outcome to a larger “overarching” theme in the campaign:

One of the things that I had tagged as kind of the bigger, overarching part was just, also just, promoting a sense of belonging and a sense of decreasing any sense of otherness, or outsidership, And I think of, you know, kind of based on kind of the referral questions, you know and the diagnosis and backgrounds for some of these kids, that is, that is a very common experience for them. Right? That look of like, “What’s wrong with you? What’s your problem? Umm, what’s your deal?” And just trying as much as possible to make the game and the, the group a space where they don’t have to have as much of that. Where there’s, where they can find a place where it’s like yeah, there’s this sense of belonging.

Here, a goal of reducing an experience of “outsidership” or “otherness”, as Beth explained that the players felt in their lives outside of the therapy, seemed to be at the core of the TRPG campaign. This example tied back to the described goal of healthy relationships within the campaign and with aspirations for outside of therapy as well, in providing the experience of belonging and relatedness.

In summary, there are unique outcomes perceived by TRPG therapists: the collaboration among group members is not only in service of relationship building, but also building a shared world with norms, structures of interaction, and cultural material that members can “rely on”. For clients on the Autism Spectrum, this has even more remarkable implications – the experience of group cohesion and problem-solving is quite a departure from experiences of social awkwardness, isolation, and lack of belonging. Instead of outcomes focused on “social skill development”, such as in popular Autism treatments, according to TRPG therapists this modality

is aimed towards a more complex form of social skill development that does not just take place intrapsychically (i.e. at the level of individual development as an internal process) but – as Louis explains – allows an interpersonal exchange and genuine building of relationships.

The TRPG therapists connected the experiential and fun aspects of the game to relational successes both inside and outside of group. Beyond mere “social skills” development as a desired treatment outcome, all TRPG therapists appeared to highlight experiences of relating to others in group as foundational to the experience of identifying and seeking out healthy, positive relationships. The special emphasis on the “value” of friendships is key here – not only as a means of encouraging relating to others, but also highlighting that social interaction and connection is valuable and meaningful in and of itself. This last point was made especially clear in a final anecdote that Beth shared about a player’s growth throughout treatment. While the player had previously been preoccupied with some of the more tangible, mechanical successes of the game, Beth described that by the end of the campaign – the player had come to understand that his relationships with other players was far more meaningful than his individual success, such as the items and objects he had acquired on the adventure: “You’ve learned that stuff is less important than people... and we have to respect each other”. Here the outcome is not just that relationships were built and made, but that the player came to recognize the intrinsic value in the collective – especially in respect to the inherent values of the game play, such as tangible wins or achievements in play. When considering this outcome in the context of an Autism population, there is a profound implication for how this therapy can support players on the Spectrum who may be perceived as (or may have a tendency to seem) preoccupied in fantasy or game-based worlds. Re-framing the game as not only a chance to make friends – both in group and outside of

it – but that a potential outcome is finding the value in making friends, seems to be a foundational step to a rich social life that is immeasurable to just a mere “social skill”.

10.2 Clinical and Symptom-Related Outcomes

The other main treatment outcome discussed by TRPG therapists pertained to specific changes observed in clinical symptoms or diagnostic compartment typically associated with psychotherapeutic outcomes and treatment terminology. I would like to be careful here as to consideration of these outcomes as neither “improvements” (as in “diagnostic improvement”) or “reductions” (“symptom reduction”), as this language might suggest and encourage ableist and neuro-typical interpretations aligned with a medical model definition of disability as something to be “cured”. Instead, I will stay faithful to the specific language used by each of the interviewed therapists – as their understanding of Outcomes in this regard will be critical for a discussion of how TRPG therapists view this modality as a treatment for Autistic clients.

I distinguish the outcomes in this section as separate from the Relational Outcomes discussed in the previous section for a few reasons. First, the outcomes discussed in this section are clinical in nature and are specific to individualized player outcomes – for example, describing the player as “much more attuned to the screen than he used to be” is an outcome of the treatment that is clinical in nature because it is having to do with attunement to the therapy and to others. Whereas, the Relational Outcomes were not specifically clinical and having to do with group cohesion, collaboration, and interaction. Second, these clinical outcomes are critical to the discussion of Autism Spectrum Conditions and diagnostic impressions of Autism that are

often having to do with how the Autistic individual relates to others and to his/her/their environment. The observed or desired outcomes within this category have major implications for how TRPG therapists understand Autism – as is discussed throughout this project in relation to Theory of Mind (ToM).

This section of the chapter is organized into several specific areas of clinical or symptom-related improvements identified as targeted outcomes by the TRPG therapists:

10.2A Self-Awareness and Insight

10.2B Emotional Expression and Regulation

10.2C Cognition

10.2D Embodiment

10.2E Therapeutic Experience

10.2F Interpersonal Interactions

10.2G Engagement

10.2H Communication Skills

10.2A Self-Awareness and Insight

Beth described an observed outcome of self-awareness and insight as a result of the TRPG therapy, with an expressed goal of the treatment being the “cultivation” of “curiosity in ourselves” and a “relationship to our own thinking”. She identified when players were exhibiting self-awareness in interpersonal situations: “There was this self-awareness piece, that he was like, ‘I can see that it is not working’ ... an awareness of both like what [the player] was doing and

like the impact it was having on others.” She also explained that she believed all of the players had the capacity for this self-awareness, specifically while in the context of TRPG therapy:

It’s cultivating that relationship to our own thinking too, and I think [there are] some kids who can’t...[but] they can do this. I’ve seen that, they can do this kind of thing with these characters better than they can when they talk about themselves as their human selves, as I call them.

The connection between self-awareness in character having direct outcomes for players was similar to the noted outcomes regarding insight. She described players newly narrating their internal thoughts (“but he never did before”) and beginning to provide a narrative about their character’s thoughts and feelings. She explained this as a clinical goal for at least one of the players: “That’s kind of my goal, personally with him, was there’s this like – I know you have a true self in there. I know you have thoughts and feelings about things, I know you’re a thinker, I can tell, and there’s something about it that you just won’t go that next step and say it. And so like, that is a thing where I see a growth in him...start to talk about his feelings”.

10.2B Emotional Expression and Regulation

As can be seen above, Beth appeared to naturally link outcomes related to insight and self-awareness to player outcomes in emotional expression and cognition. She explained her desired treatment outcome of emotional regulation, with the goal of supporting clients with modulating emotions as a means for better decision making, as well as tolerating discomfort.

When observing these outcomes in the players, rather than using the words of “increased” emotional expression, she used terms such as “richer emotional life”, “opening of emotional expression” or “broadening of emotional expression” to explain moments where clients were “vulnerable” and expressive in ways that were different than before or from their “everyday life”.

While Mark was far more focused on the Relational Outcomes of TRPG therapy than he was on the Clinical/Symptom related outcomes of the treatment, his discussion of clinical outcomes were heavily centered on the notion of diversifying a client’s impulse control and self-regulation (“act instead of react”). He repeatedly identified different moments in which he observed players recognizing potential negative consequences and changing their reactions and behaviors accordingly. Mark especially highlighted the assistance with this sort of processing from Beth or other players, as well as the importance of “verbalizing” this process.

10.2C Cognition

In addition to encouraging “cultivating a relationship to our own thinking” as a desired clinical outcome of treatment, Beth described how players responded particularly to negative cognition – self-deprecating thoughts and “messages that we get about ourselves about what we can and can’t do and whether what we do is good or bad”. This goal and outcome were a particular highlight in this therapeutic campaign, with the story arc revolving around the group’s encounter with the Nothic – a D&D monster who extract secrets and uses them to personally exploit and mentally attack the players within their own minds. Beth had each player interact

with the Nothic and observed how each responded to the negative messages the Nothic fed to them about themselves. She then noted how one player “talked back” to the monster, sharing that this was likely the first time the player had ever done that. She also highlighted the “different strategy” that one player took when responding to the Nothic. She explained feeling pleased that she did not see his usual arguing or negotiating with a negative presence, as Beth explained was the player’s tendency in his “real life”. Instead of being “on the defensive”, the player did not engage or fight with the monster and Beth proudly interpreted that he “walked away from something that was making [him] feel bad and wasn’t serving [him].”

Jared also stressed the outcome of increasing player cognitive or critical thinking capacity – such as the development of self-reflection (“a little bit more reflection”) and strategizing (“develop forethought... develop kind of like precognitive ability where you think through something beforehand”). Again, the framing of these outcomes as pertaining to difference rather than improvement felt clear in his encouragement that the players should “think in a way that [makes] them uncomfortable”, as an outcome that would denote growth and change in approach. Jared explicitly shared that one of his goals for players in TRPG therapy was that they are able to “think through situations” and to “encourage the process of analyzing”. Like Mark, he highlighted instances in which characters aptly identified consequences to their behaviors: “[Player J] was allowed her expression, and [Player S] was seeing a consequence, and the other players were also seeing ‘Whoa, so now what they’re doing affects me?’ It was beautiful.”

Like Jared, Louis similarly focused on aspects of critical thinking, strategic planning, and consequences when discussing the clinical outcomes he discerned of TRPG therapy. He

emphasized moments where the clients were either shown, or independently realized, a consequence to their behaviors “If they’re on the spectrum to be like, ‘Oh! My actions had a consequence and also I’m recognizing that’”. He also highlighted critical thinking about planning, going so far as to say “The critical thought is really what we’re aiming for”. Language of “improvement” was also used in this respect, as he explained that critical thinking and problem solving can help provide an “understanding of what’s happening, but also where they can probably and possibly improve going forward”.

10.2D Embodiment

Another clinical outcome that Beth discussed was the changes in embodiment observed in the players. She repeatedly used the word “different” to note changes in body language, movement, posture, and bodily awareness in space such as, “his posture and his body language is different than when we first started”. In a type of awareness similar to the outcome of self-awareness discussed previously, Beth explained how one of the players seemed to not only hold himself differently but also interact with the therapeutic space in a changed way:

He was in a dark room for like the first six [sessions], there was not enough light, we could barely see his face... and now all of a sudden he’s much more visible. He set up his space in a way that he is actually able to be seen in a different way.

Beth also noted other players for their different embodied interactions with the therapeutic space, and related this to an awareness not only of self but also an awareness of other:

I was actually like really proud of him too... Good job of checking in on where you are in space. You know, a kid with a diagnosis of Autism – what does it mean for him to actually ask, ‘Am I in the right... am I doing the right like, socially, am I here? Can you see me?’ You know, because that is, just the awareness of the other and the interaction, and the need to see each other in order to interact well...And so to see that he kind of held on to that from a previous session, and me catching him full screen and saying, ‘I can hear you so much better this is great’ and then for him to come in and do that, I was like... alright. Something things stuck here about like, how to stay connected in the game.

Beth seemed to link the clinical outcome of changes in embodiment to not only positive outcomes for game engagement, but also positive therapeutic outcomes as well as relational outcomes – the opportunity to be “seen” by others.

10.2E Therapeutic Experience

TRPG therapists described observed changes related specifically to the therapeutic experience. This category was perhaps the most difficult to parse out and discern, because it speaks to some of the “common factors” of psychotherapy outcomes and the products of a therapeutic experience that are somewhat intangible but very much felt and seen such as self-exploration, safe spaces, and comfort. With this there is also what Beth described as “experiential” outcomes, such as the experience of success, or the experience of “feeling good”.

There was also a discussion of some more concrete therapeutic experiences such as a player reducing their amount of individual therapy sessions as a result of the group TRPG therapy because he “didn’t feel like he needed it quite as much”. Yet it is important for the reader to keep in mind that this discussion of therapeutic outcomes is from the perspective of the facilitating therapist (Beth) based on her own observations and interactions with the players. While she shared things that players had said to her about their experience, this section does not aim to make any assertions about treatment efficacy or provide a first-hand account of what the players themselves found to be therapeutic. Instead, this is a snapshot of the therapeutic goals and perceived outcomes that this specific therapist has found in her own experiences of treating others.

Diverging from the outcomes discussed by the Outsider therapists, Louis was the only TRPG therapist to mention “healing” in his perceived outcomes of the modality. He specifically referred to the elements of therapy which he discussed as “Jungian” and “archetypal” in nature as particularly healing, especially as the players encountered and managed themselves while experiencing negative thoughts about themselves in the therapy: “Bringing an archetypal shadow into physical existence can be healing on a lot of different levels”.

“Kids will bring in their things and they’re much more comfortable dealing with their darker stuff” (Beth)

Beth echoed Louis’s sentiment that one desired outcome of TRPG treatment was patient ability to grappled with darker, or “shadow”, content from their personal lives within the therapy.

One desired therapeutic outcome that Beth shared as a goal and saw results within was the player's self-exploration: "I do have faith that when you do [TRPG therapy] for enough times over a certain amount of time, the stuff that they need to get out, either between each other or with me will come into it and they'll bring it and they'll show it to you and they'll work on it". She went further to share that this unconscious material is brought into treatment over time, and that she sees children becoming "much more comfortable with their darker stuff". In this way, she seems to be describing the mechanism of change in TRPG therapy as becoming more desensitized to the anxiety or discomfort brought up by confronting "darker" unconscious material – such as conflict with the therapist, with others, or even with themselves. The notion of projecting personal and "dark" material was echoed by Louis – who proclaimed that TRPG therapy allowed for a "healing" interaction with one's "Shadow" self, to borrow from Jungian psychology. One such example of this was a player who, typically extremely cautious in his everyday life, was exploring "risk-taking" and the consequences of impulsive behavior within the "safe" confines of his character and the therapeutic game.

A larger experiential goal that Beth discussed was her aim for the TRPG therapy to provide a safe space for the players to be seen and heard in the immediate moment. She emphasized the importance of "immediacy", in providing a space that allows for soothing and immediate relational response ("what he needs is you to respond to him right now. And that space of like 'right now' is really the thing that matters"). She drew comparisons in this goal between psychotherapy for child populations and adult populations, explaining that just as adults seek psychotherapy in order to experience immediate relief and positive feelings, child clients

deserve the same – an experience of “ease”, “feeling good”, and “success” in therapy and therapeutic gaming:

Kids deserve to have happiness and pleasure and, and easiness in their childhood and that's also, you know -- not every time an adult goes to therapy are they really working on long term goals. They're just working on like, 'I want to feel better right now, I want to feel good now because I don't.' And I think kids deserve that too, and I think that's where the child directed work really does create the experience of it that then they can find their places. You know because they can know how it feels to, to have that. I think that games do that too, that's like a whole other piece of like separate from even the content and like the stuff they're bringing, like just the experience of being together in the groups, just, found, it didn't, I didn't actually anticipate that when I was thinking about it.

Beth further highlighted that the therapeutic experience is separate from a “didactic lesson”, such as a skills-based therapy, explaining her belief that these positive and relational experiences would serve as more effective templates for seeking out similar experiences; “It’s really about the kids experiencing it. The experience of the success that will give them a sense of what’s gonna work and why it works”.

10.2F Interpersonal Interactions

There were several observed outcomes that Beth described aiming for and perceiving in the TRPG therapy regarding how players interacted with others. She acknowledged moments in

which players showed “increased flexibility” in their responses to challenging interpersonal conversations – especially highlighting times when there was an initiation of an interaction without any response and how this was tolerated well by players. Mark also highlighted the outcome of flexibility and openness in the hope that player’s build the capacity to respond to situations that do not go as planned.

Beth specifically noted moments where players were “pulling” for a response or reaction from others, but doing so in “socially appropriate ways” – which she explained as initiating interactions in a kind way, as well as conducting conversations using relevant information that others might be interested in. The inclusion of relevant, rather than irrelevant or hyper-personal, information was echoed by Jared – who repeatedly discussed this tendency within his clinical reasoning on ASD conceptualization. She also referred to a player’s goal for himself at the beginning of therapy to “think about others instead of himself”, and proudly observed this player achieving this goal.

10.2G Engagement

Engagement is a hallmark clinical outcome discussed in Autism treatment, and was echoed especially by Mark and Jared as a desired goal of TRPG therapy. Mark repeatedly pointed out instances of “more engagement”, and continuously referred to this as a goal not only in each session but overall in the modality. Jared focused heavily on the Clinical/Symptom outcomes of the modality, and appeared to speak more on the topic of “engagement” as a component to social skills (“social skills engagement”) and attention (“attentive eye contact”).

The notion of “engagement” appeared to have multiple meanings, not only in terms of engagement in the game – which is a specific tenant of gaming in which players must be engaged in the TRPG in order to be immersed in the shared fantasy. Engagement also may have been a sort of clinical reference to maintaining sustained attention, which is often a core tenant of Autism treatment.

In clinical terminology regarding Autism treatment, the notion of engagement is particular to the perceived attentional deficits in Autism Spectrum Conditions – with many therapies aiming to encourage or increase attention and engagement with others. In Beth’s responses, the term engagement was often utilized alongside the term “tracking” to express that the player was keeping up with the game, attending to others, and paying attention overall. However, it should also be noted here that engagement is a gaming term as well: engagement is a critical ingredient to the RPG experience of immersing oneself in the fantasy world and one’s character. I was careful within this discussion of outcomes among all the interviewed therapists to discern what sort of engagement was being discussed.

When the concept of “tracking” came up, Beth noted the many ways in which she encouraged and observed the players to “track” including paying attention to social cues, following along in a social conversation, and responding to other players. She spoke of having to “build” this tracking within the therapy, and witnessing the changes such as “improvement” and “growth” in the players’ tracking over time. It was especially fascinating to hear Beth acknowledge player tracking and engagement in cases and situations where it might not have seemed that this was happening: “Woah, again, he’s tracking it all! It’s all getting in there, as

much as it is hard to see that it is”. Beth’s careful attunement to perhaps neurodivergent attentional and engagement style here is key: it suggests that the player is in fact tracking in a way that is particular to him, and may seem different or hard to observe. This discussion may highlight a clinical outcome that is embracing of neurodivergent comportment, rather than encouraging of neurotypical displays of attention and engagement.

She also noted that players were “more attuned” to the therapy and the screen than they had been previously, and credited the use of D&D as a gaming system for this virtual engagement: “this engages them in a different way [from other gaming systems], they feel more confident, they know the rules”.

10.2H Communication Skills

“If I can just get you to communicate and attend and interact...” (Beth)

In this goal shared by Beth above, she is making specific differentiation between communication, attention or engagement, and socializing – which is the guidance for the distinguished areas of this section. She emphasized the importance of communication skills as a way of highlighting one aspect of her approach to treatment, which – as discussed in the Intervention section – pulls from the use of DIR Floortime, a non-directive form of play therapy designed for children on the Autism Spectrum. While discussing outcomes related to communication skills, Beth often cited DIR Floortime terminology of “circles of communication” – explaining that a desired goal and observed outcome in session was the

players developing the capacity to “close circles of communication”, or have effective initiation and response with one another. She was clear to differentiate the closed circles of communication between herself and the players, and those with each other – with the latter being the desired outcome. She highlighted the importance of these closed circles as a way for each of the players to “be seen” and receive “social feedback”. Beth also defined this outcome as a “skill” using one clinical example from the therapy:

They were both saying the same thing actually, but they were saying it differently, and it took them a little back and forth to kind of realize that...I think that's a really important skill people need, to realize when they're trying to communicate with somebody...you have differing ideas of what's happening and then to realize that, ‘No actually we're just talking about it differently,’ and to not do that in a defensive way or not get defensive when that's happening.

This sentiment highlights the skill-based outcome as not merely a relational outcome, but one in which the players are further developing and qualifying their defensive responses, and calibrating how to clearly communicate with one another through misunderstanding or confusion. Finally, Beth related the outcome of communication skills back to a desired relational outcome of outside relationships – as discussed in the previous section – explaining that she hoped that they could take these “leaps in communication” to their relationships with others.

Beth did utilize language such as “increased” when describing outcome goals of “increased emotional expression”, “increased expression overall”, and communication “a very

nice level of communication”. However, despite this language – there was also an underlying current of “difference” – as in encouraging the players to think and act in ways that were “different” from, rather than better or worse than, their usual ways. She framed what could be construed as an outcome in social skill development instead as lessons, such as “learn how process how people think about situations like that differently” or learning “the concept of maybe there’s things that you don’t talk about with other people, that you keep to yourself”. Louis also suggest an encouragement of difference rather than improvement – expressing that the aim in social interactions was to “build up” a “communication style”, as well as “change a little bit” the clients’ responses to difficult interpersonal situations.

10.2I Interdependence

Beth spoke on several accounts about the importance of developing an interdependent sensibility as an outcome for the players. She noted several times where she encouraged the players to “learn” how to take risks and rely on others – highlighting this as a type of experiential lesson. Beth also shared the response of one player, in which he expressed to her that he had learned this lesson within the TRPG therapy: “I learned that I am able to rely on [others], to let other people help me and not try to do it all by myself.” For another player in particular, the therapist explained that a part of their treatment goal was to feel secure in interdependence and that the player would not “get left hanging” by others as they had felt in other social experiences.

While many of the relational outcomes of TRPG therapy were discussed earlier in this chapter, I want to highlight the intrinsic, interpsychic nature of this outcome when discussed in a

clinical nature. Identifying the interpsychic building blocks of interdependent sensibilities and relational tendencies has profound implications for Autism psychotherapy. Rather than a teaching of “social skills”, often encouraging neurotypical rather than neurodivergent sociality, the notion of interdependence here is as an experience of what it is like to rely on others, and why this experience is therapeutic on an individual level as well as in a social capacity. This is not just about learning how to socialize or build relationships, but instead suggests a more foundational element to these experiences. This strikes me as a very meaningful outcome for individuals on Spectrum, whose experiences being in relationship and in reliance of others may be few and far between – as Beth suggests with the treatment goal for the player who often felt left behind in social exchanges. This relates back to the clinical outcome of therapeutic experience – that perhaps providing the experience of interdependence within the therapy provides a template for the interpsychic outcome of being able to rely on others.

10.3 Identity Outcomes

This category of outcomes discussed by TRPG therapists was having to do with the development of identity, self-hood, agency, and personality as an outcome of treatment. These outcomes are essential to the heart of this project in its pertaining to this study’s utilization of a critical disability methodology and the neurodiversity paradigm in outcomes that emphasize treatment that celebrates and encourages neurodivergent identities.

Mark focused the most on aspects of identity-building that he believed were desired goals and outcomes of the therapeutic treatment. He spoke about encouraging players to develop a

sense of “pride” and even “ability”, and discussed many therapeutic moments in which his aim was to foster moments of “spotlight” in which players could feel success and shine. He also repeatedly noted the desired goal that players develop the capacity to advocate for themselves – an outcome that feels especially poignant for disability-affirming psychotherapy with Autistic clients. Several times he repeated the very moving notion that he hoped to foster a sense of agency in his players, by giving them “a sense of ownership of the world” – meaning here both the fantasy world of the TRPG game, as well as the broader world in which they live.

Similar statements of empowerment and self-advocacy were echoed by the other interviewed therapists as desired outcomes. Jared said that he encouraged his players to “ask questions instead of being silent”, whereas Louis wanted his players to have “that ability to feel powerful”. Louis also explained that a major outcome of TRPG therapy, especially with the D&D system, is the recognition that all players and characters “can’t be good at everything”. He explained that this realization helped players to understand that identifying “how we are unique” is necessary both in game and in life. Again, this outcome struck me as particularly poignant for individuals with disabilities as a way to celebrate difference and divergence, and feel powerful and special in unique capabilities.

In regards to identity, Beth focused more on development of personality, humor, and creativity as well as the sense of confidence and accomplishment that comes as a result of these developments. Similar to the Clinical Outcome of therapeutic experience and self-exploration, Beth seemed to state related goal in a non-clinical context that the TRPG treatment is “about [players] learning about themselves in a way”. Within this goal, she acknowledged moments in

which players appeared to be grounded in their senses of self and proud of their identity. One example of this was her remarking that a player had a “swagger” to the way he played his character, that had not always been there. This “swagger”, she explained was like a sort of pride, explaining it as “Just that place of like ‘I am who I am.’” This observation stood out as powerful – an acknowledgement of identity and personality that is individual and “unique” – to borrow the word used by Jared.

Beth also highlighted the development of player’s humor as a key identity development that also led to the “social savvy growth arc” she observed in players who had developed a greater sense of humor as a result of the TRPG treatment. She explained that she felt this was a marker of growth because the players’ shared jokes there were “contextually appropriate” and “landed” with other players in a more meaningful way. This is a very potent observation, especially within the clinical understanding of Autistic sociality and comportment. Due to the proposed Theory of Mind deficit, many clinicians and researchers have come to understand Autistic sociality to be void of humor – as a result of difficulties with reading social cues and emotional reciprocity with others. This observation of humor as a significant social outcome and “growth” as a result of the TRPG therapy has profound implications for these supposed deficits.

Beth also appeared to link outcomes in which players received social responses to humor and creativity as building blocks to feelings of accomplishment and confidence. She noted when players even appeared more confident in their body language (“sits up taller”) as well as echoed the notion of “moments to shine” that was discussed by Mark. One moving example of this was when a player new to the game and therapy group played a significant role in defeating a

monster attacking the cohort. When the player says in the game that they feel “my life has meaning now”, Beth reflected to me that they understood this statement as a self-acknowledgement of accomplishment and pride both in character and out of character.

10.4 Gaming Outcomes

When designing this study, I expected that I might hear therapists utilize the competing paradigms of Gaming and Clinical approaches throughout their reasoning for decisions in the TRPG therapy. While these competing paradigms were certainly visible in the therapist discussion of Interventions, as seen in the previous chapter, this discussion of Outcomes also had a gaming component as well. In this section, I will share the desired outcomes and results that therapists perceived specifically in relation to how the players may have changed or grown in their gaming – such as their knowledge of and investment in the game, as well as their development in character.

The results of this study have shown that Clinical and Relational Outcomes were far more discussed by the interviewed TRPG therapists than the Gaming Outcomes – which is understandable given that this is a therapeutic RPG rather than a non-therapeutic RPG. Meaning, the therapists as DMs appeared to have more interest in cultivating and observing clinical and relational outcomes rather than improving how the game play of the patient players. However, as I will show in this section, there is definite importance to supporting players in their gaming growth even within a TRPG – as the therapist discussion reflects, for doing so has clear consequences for whether players will continue playing RPGs both in therapeutic and non-

therapeutic settings. In this way, there is a clear connection between Gaming Outcomes and the Relational Outcomes discussed earlier: the capacity to have friendships from the therapeutic group have lasting power outside of the group, as well as develop friendships in non-therapeutic gaming spaces is tied to how well players know the intricate mechanics and rules of D&D and their knowledge of their character.

One of the key desired outcomes discussed by Outsider therapists was the notion of engagement. In contrast to the use of engagement as described earlier in the section on interpsychic clinical outcomes, engagement here is used in the gaming terminology to define player “investment” in the game. Louis repeatedly stressed the importance of achieving player investment and engagement, remarking that this would ultimately lead to positive social interactions with others – again linking the relational outcomes: “[if] I am invested in this narrative, then it changes the way we’re going to interact with others.” He expressed that many of his interventions were conducted with the specific goal of “re-engaging” or “re-investing” players when he felt that this might be missing. Similarly, Mark connected investment both in the story and the game to the players’ “immersion” – meaning that if they are invested, then they will be able to become immersed in the fantasy play. Signs of player immersion and investment were reflected by the Outsider therapists as positive outcomes, such as the players having “little wins that are meaningful”, exploring decision-making in thoughtful and strategic ways according to the mechanics of the game, and having powerful character arcs during the campaign.

Beth focused the most on Game Outcomes as a desired result of the TRPG campaign. This focus especially centered on the development of the group’s newest player (both new to

group and new to D&D), as well as the continuing development of the seasoned players in the group with whom she had been already working for several campaigns. It appeared that Beth was tracking gaming outcomes closely as a sort of companion to clinical outcomes, especially in regard to player development of their character. She narrated this development as a sign of “treatment progress”: “A little more nuanced emotional understanding of their character. You know, that’s a pin that I’m putting in treatment progress basically for kids too, that’s kind of a little thing to keep my eye on overtime.” She continued on to explain that this “progress” manifests as a deep connection to the character, such that the player is attuned with the character’s thoughts and feelings. She acknowledged when a player appeared further immersed in his character than before (“I don’t think [he] stepped into this role as much as he has in this.”) and praised the “growth” in how another player would take steps to “actually get into and be the character”.

Intimately connected to an understanding of character, according to Beth, is the player’s ability to role-play. She frequently encouraged role-play between characters without therapist intervention, and often acknowledged player “growth” as a result of “emotive” role-playing and enthusiastic initiation of roleplay. Again, she made a direct connection between the role-play and the clinical outcomes in that “roleplaying with a feeling” contributes to greater experiential and therapeutic potential:

She’s role playing it with a feeling, you know, and that in some ways -- whether she knows that I’m doing this because it’s about her and about like her therapy -- I think

when it hits, and you are in a feeling, and it's experienced in that way...It's about as directive as I'll get with like this kind of stuff.

This outcome is key to the therapeutic work described by Beth in the Intervention section as well as the Clinical Outcomes discussed previously: the role-play “with a feeling” is perceived by the therapist as more experiential and therapeutic than if the role-play were without feeling – again, connecting back to the importance of a nuanced understanding of the character’s feelings and the immersion as critical factors to this experience. This appears to be a foundational reason for why Beth is so keen on the desired outcome of roleplaying amongst her players and their growth in this capacity throughout treatment.

Similar to role-play, Beth described a desired outcome of growth in *how* the players were playing the game. She seemed to highlight game play as a valuable way of learning about the players: “The things you can learn about a kid by asking them how they play their game is like incredible.” In a similar vein to the relational outcomes described previously, Beth noted moments where players took on helping roles as “support players”, supporting other players instead of being the “star” of the game. Beth also highlighted how increased knowledge of the game – such as becoming more familiar with their character spell sheet -- appeared to assist in building confidence for players:

[He] is getting it. He really has had that spell prepared since last week I think. But he has been growing in his knowledge too, of how the game works and what's helpful to know and how to be on top of that stuff. And also him organizing the character and organizing

the playstyle, I think is also showing here that he is building some confidence with the game too. And with that confidence has come some really good stuff.

For more seasoned players, Beth also connected knowledge of the game to creating a sense of pride and a meaningful departure from their everyday lives:

Kids take pride in their knowledge of the game...[there are] places where they can be experts and places where somebody who maybe in other situations in their life doesn't feel like they get to be an expert, get to be kind of a helper and have the knowledge.

She even noted that one player's growth in knowledge of the game over time, as well as his role-playing capacities, would likely make him a great Dungeon Master (DM) in the future. Beth explained that this outcome, of going from player to DM, is an occurrence she has seen in her therapeutic gaming groups – and has led to her including built-in DM-ing opportunities to therapeutic campaigns wherein players take turns leading the therapy group each week. This outcome has major implications for the player's future gaming and relational outcomes, as Outsider therapists also discussed the valuable potential in taking their gaming outside of therapy to social gaming groups at comic book stores and among friends. In this way, supporting the players in cultivating their gaming leadership qualities as DMs is like teaching a person to fish – giving them the tools to go forth and create other relational and possibly therapeutic outcomes for themselves long after the TRPG therapy is over.

Another gaming outcome Beth discussed was the co-creation of story and world building among players. This outcome is almost a marriage between the development of character and development of knowledge of the game, in which Beth observed the players excitedly connecting over their character's backstories and feeding the therapist's story arc together. Echoing the empowering outcomes described by Louis, Mark, and Jared, Beth explained that this outcome creates a sense of momentum and collaboration that is very empowering and reinforces a sense of agency over this game: "They get to kind of create truths about what these things are and those are also their decisions." Beth shared a moving example of this outcome in action during a past campaign in which the players built a long-lasting bond as a result of co-creating the narrative:

I think that whenever the kids start to co-create each other's backstories, I get really excited. Because it means they are connecting and it means they are trying to figure out how they relate to each other... and [Player B] actually knew more about [Player R's] backstory than he did... they started to build a bond... he started to feel trusting enough in the game... and like they actually connected and wrote stuff together too, like it was amazing... they've reconnected since and so it was just amazing. It was a year of this incredible co-creation of narrative where they just negotiated.

Summary

This chapter reviewed the varying goals of treatment described by TRPG therapists, and revealed some of the ways in which they identified these goals being met by players on the

Autism Spectrum in both the observed TRPG treatment and in their own practice. Most of the TRPG therapists focused on either relational or clinical outcomes of treatment, whereas gaming outcomes – such as how a player grew in their knowledge as a TRPG player or in their character development – were less often described. This reveals a particular focus on the way in which TRPG treatment specifically targets clinical aspects of Autism, as well as aims to promote relationality for TRPG players. Additionally, TRPG therapists emphasized the utility of this modality in boosting player self-esteem and sense of self as well as sense of belonging – and described the importance of these outcomes specifically for players on the Autism Spectrum.

Chapter 11: Discussion

Introduction

In this chapter, I will review the ultimate findings of this study which suggest that TRPG as a treatment modality integrates a variety of previously competing paradigms. My initial paragraphs will review the “paradigm clashes” historically present in Autism psychotherapy and in TRPG, including the tension between gaming and clinical paradigms, psychodynamic and behavioral theoretical traditions, and non-directive and directive approaches to treatment. The in-depth exploration of several TRPG therapists diverse backgrounds and approaches to clinical reasoning reveal that while therapists have historically prioritized one side of these paradigm clashes over the other, the multiplicity of viewpoints on display in this study actually lends itself to a generative tension between directive and non-directive elements. In other words, it was the fact that the TRPG therapists are gamers, as well as therapists, that they are able to interweave and intersect between the two so effectively – thus allowing an interweaving and intersecting amongst other paradigms as well. The multiplicity of approach allows for both directive and non-directive approaches to co-exist in ways that facilitate "fit" for spectrum youth who need both but have not traditionally gotten both in therapies that tend to foreground one or the other.

Ultimately, the results of this study reveal the “semi-directive” nature of TRPG treatment, first identified by Rosselet and Stauffer (2013). Whereas previous research described in my literature review defined therapy games as inherently directive due to their structure, goal-orientation, and the learning of skills through experiential learning (Flashman, 2015; Oren,

2008), previous research on RPGs in particular emphasized the ways in which the games could either be used directly in treatment as in game-play during groups sessions (Bersier, 2006; Enfield, 2007) or indirectly in treatment such as using content from games during sessions (Allison et al., 2006; Blackmon, 1994; Raghuraman, 2000). However, the results of this study are the first to expound on Rosselet and Stauffer's notion that this modality is "semi-directive" in its integration of directive and non-directive play therapy approaches – and elaborate on the significance of this finding in particular to the field of Autism psychotherapy. Whereas previous Autism psychotherapy consisted of the silo-ing of different theoretical traditions and the exclusion of non-directive approaches due to the conceptualization that Autistic symptomatology barred access to certain therapeutic styles, TRPG therapists embrace and integrate a wide variety of approaches in a client-centered and developmental way that meets the needs of Autistic patients. As will be discussed in the final sections of this chapter, this multiplicity of perspectives and the "semi-directive" nature of TRPG treatment ultimately provides a sense of "fit" for patients on the Autism Spectrum – utilizing the terminology of critical disability theorist Rosemarie Garland-Thomson to illustrate how this therapy "works" for patients on the Autism Spectrum.

The multi-vocal text of this study allowed me to garner not only a number of different TRPG therapists for interview, but also the use of a video-cue generated a variety of diverse perspectives from each TRPG therapist. The end result, this ethnographic dissertation, reveals the multiplicity inherent in these perspectives just like the *Preschool in Three Cultures* study it was modeled after. As Tedlock states, "ethnography can allow self and other to appear together with a single narrative that carries a multiplicity of dialoguing voices" (2000, p.471). It is this

multiplicity – the way in which each TRPG therapist is simultaneously embodying the role as clinician, Dungeon or Game Master, non-player character, and role-play gamer – that generated the richness of this study and allowed for the multi-dimensional, integrative, and cross-paradigm approaches that will be discussed in this chapter. This multiplicity appears correlated to the way in which TRPG therapists uniquely navigate and utilize a variety of seemingly dichotomized perspectives –therapeutic and gaming interventions, psychodynamic and behavioral therapy, non-directive and directive approaches – and in turn, lends to the multiplicity of perspectives about the Autism Spectrum. In the eyes of these TRPG therapists, the players too are straddling a number of different roles: as TRPG player, as TRPG patient, as their TRPG character, as Autistic. While other ethnographic and clinical anthropological projects have also proposed that this “multiplicity” lends greatly to our understanding of Autism Spectrum Disorder, this project highlights the ways in which this concept lends greatly to the work of therapists with Autistic patients (Barrett, 2017; McKearney & Zoanni, 2018). As is aligned with the spirit of this ethnography, an anthropological sensibility towards ontology of defining and understanding Autism allows for this “multiplicity” or what Holbraad et al. (2014) explain as “the multiplicity of forms of existence”. These varying role-plays of Autistic players refuse reduction, and thus the clinical reasoning of TRPG therapists provide profound, lived understanding of Autism Spectrum diagnosis and treatment and thus has a great deal to contribute to the emerging field of Autism psychotherapy.

11.1 Integrated Paradigms

The results of this dissertation reveal the clinical reasoning employed by TRPG therapists to describe the what, why, and how of their practice in TRPG treatment with players on the Autism Spectrum. In my “multi-vocal text”, the collected observations of treatment and interviews with four TRPG therapists elucidates the diverse range of backgrounds, clinical traditions, gaming experiences, and unique perspectives that coalesce to contribute to this treatment modality. Clinical anthropologist Cheryl Mattingly described the clinical language employed by occupational therapists when working with disabled patients as “chart talk” – the clinical language that clinicians utilize to justify interventions and treatment as tied closely to their understanding of diagnosis. Within this chart talk are a variety of different clinical reasoning processes, such as a client’s presenting problem, the clinician’s background and expertise, as well as the client’s experience in their larger world (Mattingly & Fleming, 1994; Schell & Cervero, 1993).

In my study, I listened to the “chart talk” of TRPG therapists and tried to discern what exactly their clinical reasoning included when making clinical decisions in this form of treatment. The reason for my question derived from my observation that TRPG treatment appeared to be an eclectic, and integrative therapeutic modality which inherently married two seemingly dichotomous fields: therapy and gaming. In my Introduction chapters of this study, I noted the ways in which a clinical ethnographic method like the one used in this study is effective at exposing what Kuhn (1970/2012) and Calabrese (2013) refer to as “paradigm clashes” and the competing frameworks of clinical thought and practice that can occur when studying a specific modality in its local implementation while using a broader clinical and medicalized perspective. I was preparing to wrestle with my own background as a clinician in the

field with observing one, five-session treatment of TRPG therapy. I wondered how therapists might grapple with opposing dialectics while facilitating therapeutic games, and how their previous experiences as clinicians, gamers, and Dungeon Masters might come into play. Ultimately the competing dialectics of gaming and therapy were not the only that emerged through my results – and what I will discuss in this chapter are the many diverse frameworks that “clashed” and merged in this form of treatment.

My results show that TRPG therapists named a wide range of influences, inspiration, and previous experience both from defined clinical traditions and experiences both inside and outside of therapy and gaming rooms. Utilizing my own clinical background as a psychologist, I analyzed the varying theoretical orientations that TRPG therapists named and drew from as well as the variety of clinical interventions employed to create a therapeutic frame for the treatment. My results indicated that, contrary to my initial hypothesis, the dichotomizing and integration of various theoretical traditions extended beyond the historic debate between psychodynamic and behavioral psychotherapy for Autism Spectrum. I also learned from the exciting ways that gaming provides opportunity for therapeutic experience, from specific Dungeon Master techniques to play strategies sourced from outside of the role-playing game sphere. These results comprised of the chapters on theoretical orientation, clinical interventions, and gaming interventions as one aspect of this clinical reasoning that TRPG therapists utilize to explain what they do in TRPG treatment on a moment-to-moment basis.

The second aspect of this study was to use this multi-vocal text to distill the clinical reasoning of TRPG therapists in their explanation of how therapeutic role-playing games

function as a treatment for players on the Autism Spectrum. From the perspective of an occupational therapist, Mattingly argued that clinical reasoning and how a clinician narrates and understands the lived experience of a person with a disability plays an intimate role in the way that a clinician devises and implements treatment. For this reason, I wanted to understand how the TRPG therapists understood Autism as a diagnosis and how they viewed the lived experience of the players in TRPG treatment. As my results show, the TRPG therapists describe their diverse conceptualizations of Autistic players: sometimes TRPG therapists utilized diagnostic criteria of Autistic symptomology when describing their players on the Spectrum (i.e., echolalia, Theory of Mind), while at other times they employed non-diagnostic and broader societal interpretations of Autism (i.e. rigidity) or referred to these conceptualizations as a type of “style”. At many times throughout this project, I leaned on my reflexivity as a clinical ethnographer to remember that the results of this study were the product of a specific definition of Autism from TRPG therapists. In the context of my participants, their conceptualization of Autism and its discussion in our interviews were a manifestation of their unique experiences with Autistic players in the context of therapeutic role-playing games. While their clinical reasoning around Autism certainly may have borrowed from other contexts, including their previous clinical experiences with patients on the Spectrum in other therapeutic settings, the beauty of a grounded ethnographic project such as this one was the ability to utilize the multi-vocal text that all interviews were directly applicable to an observable treatment – allowing all interviews to be grounded in this specific population and context of TRPG treatment. In defining and describing their conceptualization of Autism, my participants were referring to the specific manifestation and presentation of Autism borne through the context of the therapeutic gaming setting.

Critical disability theorist Rosemarie Garland-Thomson describes disability as a lived experience, meaning that it is a phenomenon borne out of dynamic interaction with one's environment. This definition in no way denies the internal aspects of disability or diagnosis, but rather posits that it is always in context and in relation to one's world. In this study, I integrate both a clinical ethnographic perspective and a critical disability methodology in assuming that the conceptualizations of Autism shared by TRPG therapists are representative of their distinct understanding of Autism borne out of specific culture of therapeutic gaming. They are describing their observations of Autistic behavior, personality, and symptom as a function of how they manifest in the gaming space. One powerful example of this from my results was the discussion of "Theory of Mind", a presumed deficit in Autistic individuals describing empathic difficulty with understanding others' mental states. In the context of the therapeutic game, TRPG therapists noted Theory of Mind as an "engagement" and "perspective" issue rather than a player's deficit in empathy. When analyzing the clinical reasoning of TRPG therapists on this matter, I noticed that interventions were more targeted towards engaging Autistic players in the game. This is just one example from the chart talk of how diagnostic conceptualization drives intervention. It is also just one profound anecdote that might indicate a hyper-specific and local understanding of Autism within the therapeutic gaming realm.

While my participants' contribution to this study perhaps showed a particular approach to Autism within the gaming context, there were also many areas in which their clinical reasoning adhered to more popular, clinical understandings of Autism. This was apparent in discussions on differential diagnosis, particularly pertaining to two of the players in the observed treatment who were not formally diagnosed with Autism but had been referred for testing and had rule-out

diagnoses of Autism from their respective mental health professionals. Overall, my results reveal a diverse range of perspectives regarding Autistic symptoms, challenges, and sociality and a highly specific way of conceptualizing TRPG as a treatment modality for players on the Spectrum that ultimately lends itself to a larger conversation in the emerging field of Autism psychotherapy in which integrated approaches provide access to treatment previously barred to Autistic patients.

The ways in which TRPG therapists explained the treatment “working” for players on the Spectrum was delineated in my analysis of how they described the potential outcomes of their interventions and treatment overall. The results of this analysis are to be found in the chapter Outcomes and describe the intentionality and objective embedded in their clinical reasoning. Their interviews showed that therapeutic gaming aspires towards encouraging player relationality, self-awareness, and identity building as well as aimed towards symptom improvement. This discussion revealed some of the larger goals of TRPG treatment as a modality for all players, but again – due to the hyper-specific nature of this study on Autism treatment – also says a great deal about what outcomes these therapists envision for their players on the Spectrum and how they understand the treatment operating as a support. Rosemarie Garland-Thomson posits that a disabled person experiences a sense of “fit” in their world when there is a harmonious, dynamic experience between one’s body and one’s environment. The term “harmonious” used by Rosemarie Garland-Thomson refers to a sense of mutual reciprocity and transaction between the disabled person and their environment, and many things can contribute to this experience of fit, including proper supports, accommodations, policies, and therapies. These supports do not eradicate or “cure” disability, but instead play a role in making

the lived experience of disability a more fluid one. In describing what they understood as the outcomes of TRPG treatment for players on the Spectrum, the TRPG therapists narrated how they saw TRPG therapy as supporting an experience of “fit”.

However, it is interesting to consider the various ways in the observed treatment in which TRPG therapists noted a specific “disharmony” for players: moments of interpersonal conflict, when the conversation “dropped” among players into awkward silence, or when players were uncomfortable or unsure in the gaming space. TRPG therapists described these moments of “disharmony” as opportunities for failure and growth perhaps unafforded to players in the real world, especially when neurotypical behavior is encouraged. By allowing for these experiences of “disharmony” in a safe, structured environment, TRPG therapists explained how the therapeutic game provided a sense of “fit” not by excluding moments of tension or conflict but – more aligned with Garland-Thomson’s definition of “harmonious”— permitting for these experiences to happen and for players to grow through and from them. As I will argue in the following sections, my results indicate that the semi-directive nature of the TRPG therapy leads to this sort of “harmonious” fit, even in situations of disharmony. One metaphor for this phenomenon can be found in parenting literature in which the interactions between caregivers and infants is compared to the musical concept of “counterpoint”: just as two melodies whose differences compliment each other over the course of a melody through tension and reconciliation, the alternating tension and reconciliation through the course of TRPG treatment leads to the growth and development of each individual player within a relational context (Rogoff et al., 1993; Bornstein, 2002; Custovero & Johnson-Green, 2008).

When synthesized together, the chapters on conceptualization, intervention, and outcome make up the different categories of chart talk that comprise a myriad of unique, diverse perspectives of the TRPG therapists on what, how, and why this treatment works for players on the Autism Spectrum. The emphasis throughout my findings is the concept of integration. However, it is more than just the marriage of seemingly opposing dialectics or the interweaving of multiple perspectives in the multi-vocal text that contributes to the significance of my results. Integration of psychotherapeutic perspectives is not novel to TRPG or Autism psychotherapy. However, it is the multiplicity of viewpoints inherent to the approach of TRPG therapists – the presence and utility of multiple perspectives at once – that creates a unique approach to Autism psychotherapy. It is not just that these perspectives and tensions co-exist, it is how they co-exist to contribute to the larger field of Autism psychotherapy.

11.2 TRPG as Autism Psychotherapy

In my literature review, and in my preparation for this study, I tracked the long history of psychotherapy approaches and treatments for Autism Spectrum Disorder in order to distinguish the unique and emerging position of the TRPG treatment modality for this population. My review revealed a transition from prior uses of psychodynamic therapies for Autism towards behavioral treatment. In this shift was a movement away from treatments that explored the emotions, thoughts, and identity of Autistic patients and geared more towards skills-based therapies targeting sociality and behavior. This change in therapeutic focus was accompanied by more highly structured therapies with target goals and data, as opposed to more fluid depth-oriented and insight-focused treatments.

Prior to this study, much of my own background as a training psychologist, Autism advocate, and prior Special Education teacher and case manager figured into how I observed the shift in what I saw was offered to Autistic patients as therapy. I wondered why my students on the Autism Spectrum were offered social skills groups and behavioral interventions in individual therapy as the sole option, whereas any person not on the Autism Spectrum was allowed access to a full range of psychotherapy orientations. My research on the history of Autism diagnosis and treatment elucidated my understanding of why psychodynamic therapies had historically lost favor in the Autism community and perhaps explained the barring of access to treatments that offered exploration of identity, emotion and thought for Autistic patients. In my work as a clinician with patients on the Autism Spectrum, I puzzled over the limited scope of therapeutic modalities in their addressing of the co-occurring anxiety and depression that often accompanies Autism Spectrum conditions and that behavioral and skills-based therapies alone could not necessarily account for this. However, part of my role as a clinical ethnographer in this study was to utilize my reflexivity in identifying some of my own blind-spots, preferences, and history on this matter. I believe that one of my blind-spots that emerged through the process of this research was only attending to what I saw as the main tension in the field of Autism psychotherapy as an ongoing battle between psychodynamic and behavioral camps. Through my research in this study and interviews with participants, I came to have a larger perspective of some of the broader tensions in Autism psychotherapy and how TRPG therapy figured into the scheme of things.

I listened to the ways in which my participants described their own frustrations with existing psychotherapy and treatment approaches for Autism that they saw in the field. One

therapist described her qualms with the “public health approach” to Autism psychotherapy with its main focus of symptom reduction. She decried the ways in which she saw children on the Spectrum be constantly “shut down” for aspects of their neurodiversity, such as their perseverative interests, both in therapeutic settings and in the therapeutic milieu of the school classroom. She also remarked on the ways in which children on the Spectrum are often forced to comply with societal expectations of sociality, including being forced towards conflict resolution with bullies and the notion that everyone should play with everyone. More broadly, she also noted the way in which psychotherapy for children as a whole was mostly geared towards future outcomes, such as solving problematic behaviors for the sake of later adulthood, rather than being focused on immediate relief, support, and exploration for the child in the present. These frustrations mirrored my own, but also transcended what I had labeled as the tension between psychodynamic and behavioral camps. Instead, these frustrations spoke more towards the larger movement of Autism treatment as a whole – the shift towards didactic skills teaching, the encouragement of neurotypicality, and the absence of a client-centered, whole-person approach to Autism.

As my results show, there were other reasons to dismantle my initial assumptions that the emergence of TRPG therapy in the long oeuvre of Autism psychotherapies might only implicate the psychodynamic versus behavioral battle. Each of the TRPG therapists described hailing from a particular therapeutic orientation: Mark identified as a CBT therapist, Louis as psychoanalytic (Jungian, Bionic, Freud), Beth as psychodynamic and from a play therapy approach, and Jared as CBT and Mindfulness-based. Yet, each also described using a variety of techniques, interventions, and theoretical frameworks borrowed from a myriad of traditions – as well as, of

course, utilizing gaming as an approach to treatment as well. What became ever more clear through my interviews with participants was the highly integrative nature of TRPG treatment, such that the modality does not comfortably sit in one distinct therapeutic camp.

Furthermore, my results suggest that in the perspectives of TRPG therapists – the TRPG treatment modality is a productive marriage of many different approaches to Autism psychotherapy in producing a highly structured treatment that incorporates skills-based didactics as well as opportunities for exploration and insight building. In my results, the therapists describe the high level of structure throughout therapeutic gaming. They described how the mechanics of the game, the rules, the narrative (or story arc), and the routines of the therapeutic frame provide a safe, reliable, and predictable container necessary for an Autism psychotherapy. Each of the therapists also referred to opportunities for skills-building, including didactic and explicit instruction of social skills, and interventions designed to increase executive functioning and problem-solving skills. The high level of structure and skills-focus of the TRPG treatment figured neatly into what I understood to be the more contemporary approaches to Autism psychotherapy, inherent in the shift towards behavioral treatment. Yet, my results also revealed that TRPG therapists saw treatment as highly explorative, process-oriented, and insight building. My participants described interventions tailored towards increasing player self-awareness and self-esteem, as well as supporting unconscious processes and interpersonal relatedness. In this way, I noted how their understanding of TRPG treatment borrowed and utilized aspects of earlier psychodynamic and insight-oriented approaches to Autism treatment. More and more, the TRPG therapists described an approach to TRPG treatment that appeared to merge past and contemporary Autism treatment approaches – and each likened this merger to the direction in the

field of Autism psychotherapy towards modalities like DIR Floortime (Greenspan & Wieder, 1999). I noticed the ways in which both TRPG treatment and the DIR approach utilized a play-oriented therapy with both structure and exploration. The tension between the psychodynamic and behavioral camps that I presumed to find in the multi-vocal text was less so apparent as compared to other emerging tensions.

The main tension I found in this study was the deliberation between using a directive versus a non-directive therapy. The other tensions I found was neatly embedded in this dilemma: the decision between a more skills-based approach (i.e., directive) and a more experiential (i.e. non-directive) approach, or a process-oriented approach (i.e. directive) versus a non-process oriented (i.e. non directive) approach. While these tensions have some connection to the prior dichotomous battle between psychodynamic and behavioral therapies, in the next section I will elucidate how these emerging tensions are representative of larger movement in the field of Autism psychotherapy and manifest in a unique way in the context of TRPG as a modality.

11.3 TRPG as Directive vs. Non-Directive Play Therapy

In this section I will unpack why this fascinating tension between directive and non-directive approaches exists, how this tension is ultimately borne out of competing dialectics in the play therapy tradition, and explore the relationship between these competing therapeutic dialectics in its use with patients on the Autism Spectrum. First, I will provide examples from the interviews that illustrate this emerging tension and next I will define the terms “directive and

“non-directive” from a larger clinical perspective and couch these terms within the various therapeutic traditions they belong to.

My results revealed a unique tension between a more directive approach to treatment and a “non-directive” approach. Throughout interviews, the TRPG therapists responded to clips from the observed treatment and offered their perspective on the interventions provided in respect to this tension. Jared repeatedly referred to the non-directive nature, and “hands-off” approach of the facilitating therapist, Beth. Beth described her approach as “child-directed” and explained her rationale for “letting things play out” rather than stepping in with explicit instruction of skills or directives for processing. Yet at other times, all of the therapists described a more directive approach to treatment such as “skill instruction”, or interventions to “force” conflict mediation or explicit guidance towards processing interpersonal or unconscious dynamics. While the therapists were sometimes at odds with one another about when to use a directive versus a non-directive approach to treatment, the results showed that all of the therapists appeared to be considering these tensions and found ways to integrate them into their treatment.

These observed tensions gesture towards one of the most fascinating, and unique aspects of TRPG treatment as a modality: the treatment is both inherently directive and non-directive, and – as my participants seemed to explain in their clinical reasoning – this integration is likely a key reason for why it “works”. As my participants explained, the TRPG treatment has a strong directive component: there is a therapist in the position of Dungeon Master who is in charge of structuring the narrative arc of the campaign, guiding the players, and enforcing the mechanics and rules of the gaming system. My participants described how the therapist plays an active role

in setting therapeutic goals with players during Session Zero, integrating these goals into the game by “weaving in” players’ unconscious content into the overall narrative, checking in with players both individually and within the group setting, and devising opportune therapeutic moments for players to interact with issues core to their clinical goals. The chapters on clinical and gaming interventions contain a thorough review of this intentional and explicit planning and intervention implementation that is very much indicative of a highly directive style.

Yet, despite this, an emerging tension throughout interviews was a focus on when therapists should and do consider using a non-directive approach: how to let interactions among players “play out”, allowing for group cohesion to form organically, and not interrupting player banter or role-play with one another. Mark spoke about the “power of the therapeutic shut-up” and that he feels the best therapeutic games are the ones in which the therapist does little to no speaking at all. When therapists considered the option of non-direction, there was a parallel dichotomy presented between experiential versus skill-based intervention. An example of this from the interviews was when both Jared and Beth noted a player’s distress within an interpersonal interaction and weighed the options of whether to seize an opportunity in the therapy to teach a coping skill, or to allow the experience of the player be a guide as to how to cope in the future. My chapter on theoretical orientation, specifically the sections on Experiential and Skills-based approaches, highlighted the way in which these tensions were repeatedly confronted by the TRPG therapists in their interviews. Whether debating between directive or non-directive or an experiential or skill-based approach, the distinct clinical reasoning of the TRPG therapists highlighted a core finding of this study which has origins in the play therapy tradition and broader implications for the field of Autism psychotherapy.

In one of the foundational studies on the use of therapeutic group role-playing games as a clinical intervention, Rosselet and Stauffer (2013) referred to the play therapy techniques in TRPG as “semi-directive”. Their study specifically examined the possible influence and utility of Adlerian play therapy techniques in the implementation of TRPG therapy with gifted adolescents. The researchers explained their use of Adlerian play therapy in TRPG because it has a “flexible” approach that “may incorporate varying levels of directivity progressively from non-directive to more directive” over the course of treatment (Kottman, 2011; Rosselet & Stauffer, 2013). Rosselet and Stauffer describe the ways in which they noted the divergent clinical reasoning, or “clinical judgement”, of TRPG counselors, as they took into account a “character’s intentions” or individual or group decisions in order to decide between a non-directive intervention, such as “carefully invite new dialogue” or a semi-directive one to “steer” the players or suggest that they experiment with their characters’ advantages or disadvantages. A similar scenario was debated by the facilitating therapist in the final session of the observed treatment, in which Beth debates how to use the game’s mechanics and her devised story line in order to explicitly encourage players to play out of their comfort zone by having increased stat points.

What the article by Rosselet and Stauffer, and much of the early literature on TRPG, do not acknowledge is the history of these terms “directive” and “semi-directive” and their possible implications in the play therapy approach as well as the field of Autism psychotherapy. The systemic literature review by Francis et al. (2022) on play-based interventions for children and adolescents on the Spectrum discussed at length the noteworthy history in this dichotomy

between “directive” and “non-directive” approaches both more generally and in its relation to Autism psychotherapy. As was discussed in my own literature review for this study, play therapy has a historical basis in the psychoanalytic tradition with the first documented case of play therapy being Freud’s Little Hans case study in 1909. Soon thereafter in 1929, psychoanalyst Melanie Klein applied psychoanalytic techniques to her work with young children. Anna Freud also utilized a psychoanalytic play therapy approach to helping children become more aware of unconscious material and thus reducing anxiety through play therapy (Waelder, 1933). Both Freud and Erikson emphasized the use of repetitive play to gain mastery over past trauma (Waelder, 1933). Then the emergence of therapy with play objects, such as the sandtray or “floor”-based games, emerged through psychoanalytic clinicians (Wells, 1912) and was taken up by Gestalt and Jungian psychotherapists. Gardner (1971) introduced the “mutual story telling” technique in which both the therapist and child co-create a story out of play – much like the co-creation of narrative in TRPG. The most prominent child psychotherapist, Donald Winnicott, considered play a central element to psychotherapy and mostly utilized a directive play therapy approach – choosing the form and object of play for clients, while also interpreting the play symbolically (Winnicott, 1988). However, Winnicott also approved of the non-directive approach of Virginia Axline – specifically her method’s refraining from interpretation. As the clinical field transitioned from the psychoanalytic schools of Europe to the humanistic tradition in the United States, Axline – a disciple of humanistic psychotherapist Carl Rogers – was the first to coin the term “play therapy” and lay foundations for what she referred to as “client-centered” play therapy.

In the foundational text on non-directive play therapy, Virginia Axline explains that a “non-directive” approach is one in which the therapist allows for the child to direct the play – leading to the parallel terminology of “child-directed”, “self-directive”, or “client-centered” play therapy. As opposed to a more directive tradition, also sometimes referred to as a “focused” approach, in which the play therapist designates and selects the objects of play as a means for accessing specific therapeutic goals (i.e. playing out maternal conflict through use of a baby doll), Axline explains that a “non-directive approach” allows the child to take the lead and necessitates a flexible and willing therapist who does not set parameters for the session or guide the child into a “pre-planned conversation”. Drawing from the humanistic tradition, Axline explains that the theoretical supposition behind a non-directive play therapy approach is that all children will inherently strive towards their potential and will inherently utilize the therapeutic space and play objects to, as Beth said, “go where they need to go” in the therapy. Axline also claimed that, in her perspective, all group therapy had an inherent “non-directive” component as the group dynamic would ultimately serve as a more primary leading force than a group therapist.

Beth, the facilitating therapist of the observed treatment, spoke at length about the influence of Axline and Rogers in her non-directive play therapy approach to TRPG treatment. In her interviews, she specifically highlighted the way that a non-directive approach aligns with and compliments the TRPG modality. In TRPG, she explained, there is an inherent “non-directive” nature in that the players role-play and act out scenarios, as well as the focus on fantasy. Beth also repeatedly explained that in her approach, she refrained from outwardly

interpreting play content – instead opting for role play to elicit what Axline calls “naturally interpretive material”.

However, my results from TRPG interviews revealed that there were a number of ways that the TRPG modality necessitates an approach that Axline would likely refer to as “directive”. While TRPG therapists described ways in which they tried to elicit players in “driving the narrative” of the game, or encouraged them to provide “unconscious supervision” to therapists as to how the story should progress – ultimately the child in TRPG is not exactly “the lead”: the therapist is the Dungeon Master. In the chapter on clinical and gaming interventions, the therapists described the extensive planning of each campaign, and each session within it – which conflicts with Axline’s “non-directive” approach without “pre-planned” activities by the therapist. They also described the immense utility of treatment goals for each player, and described the ways in which treatment goals functioned as they planned each session.

One of the major sources of the debate between a non-directive and directive approach occurred when the TRPG therapists debated as to whether to intervene on conflict among Player S and Player J. In their clinical reasoning, the therapists described the various reasons for and against staging a formal and directive intervention in which the therapist would encourage the players to confront the conflict between them in which the therapist would mediate. Gaming interventions such as staging a “campfire” or “long rest” were suggested as directive ways for the therapist to prompt player discussion of conflict, as well as clinical interventions such as checking in with the players outside of group or prompting process-oriented discussions. All of these interventions, in Axline’s definition, are of a more “directive” nature in that they initiate

and insert the therapist's agenda in the play. When delineating reasons not to utilize a directive approach, the TRPG therapists explained that for conflict resolution to be authentic and comfortable it perhaps had to be organically initiated and conducted by the players themselves. Additionally, multiple TRPG therapists described the specific difficulty of using a directive approach for conflict management with players on the Autism Spectrum. Despite multiple directive interventions aimed at encouraging the players to address conflict in the observed treatment, Beth ultimately opted for a "non-directive" approach when noting that directive interventions failed to elicit conflict resolution. In later sessions, she described ways in which she interpreted the conflict being "played out" organically among the players and resolved on their own terms in non-explicit language.

11.4 Directive and Non-Directive Therapy with Autistic Patients

"Research on using nondirective play therapy with children with Autism is almost non-existent"

(Josefi & Ryan, 2004)

As was discussed at length in my literature review, previous to this conducting this study I had believed that the foundations of play therapy in the psychoanalytic tradition were the only core issue in the field of Autism psychotherapy. In refusing the psychogenic explanation of Autism proposing core deficit, the Autism community had abruptly shifted away from psychoanalytic therapies towards behavioral therapies that did not insinuate parental blame – a shift that I had previously thought was the only core conflict at the heart of contemporary Autism

psychotherapy. However, these emerging themes from my results led me to further explore the legacy of non-directive and directive approaches with Autistic patients.

A paper by Josefi & Ryan in 2004 claimed that “research on using nondirective play therapy with children with Autism is almost non-existent”, citing only two previous papers (Kenny & Winick, 2000; Mitteldorf et al., 2001) as evidence to this supposition. Prior to 2000, there were few case studies on the use of play therapy both in individual and group settings with patients on the Autism Spectrum (Lowery, 1985; Lanyado, 1987; Wolfberg & Schuler, 1993; Bromfield, 1989). My own research confirmed these assertions, as I found that not only individual treatment but also group modalities recommended for Autistic patients often followed behavioral and CBT principles (Miller et al., 2014) and that “traditional” group therapy consisted of social skills groups (Habayeb et al., 2017) where there appeared to be a clear focus only on “evidence-based” social skill instruction with targeted goals. Josefi and Ryan suggest that behavioral treatments, rather than play therapy are most frequently cited in the existing literature, but mentioned that there was some very small and recent movement towards advocating for “child-centered play therapy as a viable treatment for children with Autism” and child-centered intervention that help children in building reciprocal relationships in naturalistic settings (Getz, 1996; Mitteldorf et al., 2001; Ray et al. 2012). Carrizales (2015) notes that few interventions exist in the CBT and behavioral approaches to address the “core relational deficit areas” of ASD (Greenspan & Wieder, 1991), whereas child-centered play therapy would directly target this by fostering safety, warmth, and self-regulation while in relationship (Badenoch & Bogdan, 2012; Ray et al., 2012).

However, researchers explained that the preference for directive therapies reasons went beyond the more traditional debate of psychoanalytic versus behavioral psychotherapies, and was more driven by conceptualization of Autistic patients as benefiting from increased structure in psychotherapy. Autism ethnographers have previously documented the ways in which highly structured environments and social interactions serve as a support for children on the Autism Spectrum in appropriate and culturally-aligned social interactions (Sirota, 2004; Sterponi & Shankey, 2004), as well as proactive engagement and collaboration in fictional narratives (Solomon, 2004; Ochs et al., 2004). Fein (2015) in her study on role-playing subcultures noted the existing literature that supported the need for external systems, both cultural and clinical, that provide organization and structure for Autistic individuals. Some of this prior research has already been mentioned, such as the conceptualization that Autistic individuals have weak executive function (Ozonoff et al., 1991) or bias towards local over global coherence (Happé & Frith, 2006), suggesting the need for external structure to support and mitigate Autistic interactions with others and with narratives. In her study, Fein shows how role-playing games offer support and structure for Autistic players by enabling successful interactions and fostering a sense of belonging and acceptance in gaming communities. She further explains that the structure of the gaming, the regular meetings, and the rules of engagement, provide a sense of safety and clarity for Autistic players. Her study serves as strong proof of the highly structured supports of TRPG treatment, which provide both structure and room for non-directed improvisation, as was also discussed by the TRPG therapists in this study.

However, the trend towards more structured forms of psychotherapy for patients on the Autism Spectrum had further implications regarding conceptualizations of Autistic patients and

their capacities towards play. The conceptualization of Autistic patients that led to a preference for directive play therapies was the assumption that Autistic patients were incapable of “spontaneous play”. Kenny and Winick (2000) noted the various reasons cited throughout existing literature for a reluctance against non-directive methods with Autistic patients, such as the supposition that Autistic children exhibit “repetitive and supposedly noncreative play” (Chiang & Carter, 2008; Kohls et al., 2012; Trevarthen & Delafield-Butt, 2013; Wulff, 1985), or that fantasy is “not applicable” to psychotherapy for Autism due to Autistic play being “frequently empty of excitement” and that narrative development “tends to be repetitive without psychic salience” (Shapiro, 2009). Previous theories also posited that Autistic children experience difficulty with pretend play that is symbolic and has non-literal communications (Harris & Leevers, 2000) In a survey of play therapists by Phillips and Landreth (1998) only twenty percent believed that play therapy could be utilized with children on the Spectrum – which researchers hypothesized accounted for the majority of play therapists who believed that “cognitive and play deficits” would inhibit the effectiveness of a play therapy approach. Ultimately, the previous literature suggests that the historic clinical reasoning in the field of Autism psychotherapy determined that perceived Autistic deficits inherently prohibited the effective use of non-directive play treatment.

The results of this study reveal that the clinical reasoning of TRPG therapists and their conceptualization of TRPG treatment for Autism tends to contradict these early claims about its inaccessibility for players on the Autism Spectrum. At no point did therapists refer to the “repetitive” behavior of players nor did they describe any barriers to players being able to access a sense of excitement or the fantasy content of the play. To the contrary, TRPG therapists spoke

about the importance of utilizing the treatment to elicit and encourage experiences of mutual joy, as well as incorporate players' suggestions that enriched the narrative story of the game. In this way the therapists viewed the treatment functioning as a scaffold for what earlier literature noted as Autistic deficits, yet without TRPG therapists acting from attitudes or clinical reasoning that suggested they viewed these deficits themselves. My results mirrored the findings of a recent study (2019) on Creative Group Therapy for children with Autism, in which Sharon Vaisvaser takes on Shapiro's 2009 claim that children with Autism struggle with play and her results indicate that children who initially did not play or talk experienced spontaneous exploration, co-creation of narrative stories, and mutual play as a result of her "non-directed dynamic approach" of the treatment. Vaisvaser explained that prior claims to poor spontaneity and lack of "self-induced exploration of social encounters" – contrary to prohibiting non-directive play as previously thought, actually point to the importance of "non-directed social environments" in which Autistic children feel safe and free to generate play and interaction organically.

Part of the issue with these earlier claims regarding Autistic deficit, and the way in which these claims effectively seemed to bar access for Autistic patients to any forms of non-directive play therapy, is that they fail to recognize the heterogeneity of the Autistic population. The dissolution of Asperger's as a diagnosis led to categorical definitions in the DSM-V of "Mild", "Moderate", and Severe" – terms which are controversial and often contested in the wider Autism community. It is possible that many of these earlier claims about Autistic patients being unable to benefit from non-directive play therapy refer specifically to patients on the Autism Spectrum who would likely qualify for DSM classification of "Severe" Autism that denotes a non-verbal quality, whereas the participants in the observed treatment were described as having

“high-functioning” Autism (or suspected of high-functioning Autism diagnosis), akin to the former DSM diagnosis of Asperger’s due to their language capacity. Yet in the context of this study and my use of critical disability methodology, it feels necessary to question these categorical distinctions of Autism both by clinicians and the DSM-V in considering how we might valorize neurotypicality by using terminology such as “high-functioning” or “severe” when referring to Autism diagnosis. “High-functioning” implies some degree of “fit” with neurotypical presentation and environment – the ability to “function well”, or more or less pass as neurotypical in public spaces perhaps due to an ability to utilize language in a normative way whereas a “severe” case would not. While this patient demographic in this study might explain why the interviewed TRPG therapists did not address non-directive play therapy as being inaccessible for some Autistic players, many TRPG therapists, including the well-known originator of therapeutic gaming Hawke Robinson, throughout the therapeutic gaming field have touted the use of TRPG as a treatment for players on all levels of the Autism Spectrum (Brown, 2022). Thus, it appears that TRPG treatment can make fantasy and play accessible for all and account for the heterogeneity in the Autism population – and what I will discuss in a later section is how and why this works as a function of the concept of “fit” by Rosemarie Garland-Thomson.

However, the recognition of heterogeneity in the Autistic population and the emphasis on the broad “Spectrum” inherent to this diagnosis has also played a strong role in the recently shifting landscape of Autism psychotherapy. A pivotal study by Mundy et al. (2007) claimed that current research in the field of Autism psychotherapy has not accounted for the heterogeneity in Autistic populations especially in regard to co-occurring anxiety and depression that often presents with patients on the Spectrum. Researchers explained that the failure to take into

account this frequent co-occurrence was a major pitfall of contemporary Autism psychotherapy. Furthermore, Mundy et al. claimed that the traditional format of group therapy for Autistic patients offered too structured and too linear an approach, and specifically named that CBT groups for anxiety with children on the Spectrum could lead to “negative self-evaluation” due to patients feeling evaluated as “less socially competent” (Bauminger et al., 2004; Capps et al., 1995). Instead, Mundy et al. proposed a strategy for matching intervention techniques to fit patient characteristics based off of the “factors that naturally vary among all children” as well as “non-syndrome specific factors”. These findings intimately align with the results of my own study, in which TRPG therapists discussed taking into account mood-related factors in their conceptualizations of Autistic players and paid close attention to the way in which anxiety in particular functions as a key feature of the lived experience of their players. As Jared pointed out in his differential diagnosis between anxiety and Autism: “I’m anxious not because of my Autism, [but] I’m socially anxious because of how other people might respond to my Autism”. He proposed that TRPG treatment accounted for this differential diagnosis and co-occurring experiences of anxiety and Autism by providing a narrative structure, clear mechanics, and social rules for a safe and predictable environment that reduces the anxiety for players on the Autism Spectrum. Ultimately, the proposed shift away from behavioral treatment that may induce a sense of neurodivergent stigma around social competence towards interventions tailored toward “non-syndrome specific factors” signifies a shifting attitude towards a child-centered approach in the field.

This movement towards client-centered approaches has been emphasized by Autism expert Dr. Laura Schreibman, who despite hailing from a traditional behavioral background has

pervasively acknowledged in recent years a shift away from “one size fits all” behavioral therapies towards a more individualized and integrated approach with less structure and an emphasis on intervention in a naturalistic setting – specifically naming the utility of play-based and child-centered approaches (Schreibman, 2012; Schreibman & Anderson, 2001; Ospina et al. 2008). TRPG researchers suggest that the development of social skills is often more successful for people on the Spectrum in a “natural social environment” –and thus the naturalistic game setting serves this function (Rust & Thanasiu, 2019). Like Mundy et al. propose, Shreibman et al. (2011) suggest considering factors like child personality, family background and the service setting when deliberating on the therapeutic approach with an Autistic patient and acknowledges the wide heterogeneity being recognized in the field. One example of this shift is the growing popularity and evidence basis for Greenspan’s “Floor Time Model” also referred to as DIR Floortime approach – which was frequently discussed by my participants in their interviews as an inspiration for their TRPG treatment. In his works, TRPG and DIRI Floortime therapist Mike Fields describes DIR as a non-directive and child-directed play therapy approach. Touted as an alternative to ABA, the Floortime model is a relationship-based approach which Fields explains as a perfect companion to TRPG for patients on the Spectrum. While modalities like the Early Start Denver Model have been growing an increasing evidence-basis, Fields claims in his works that they have a foundation based on DIR Floortime with an integration of a behavioral focus on teaching skills, attention, and language. Prior to this study, I was surprisingly unaware of the pervasive influence of DIR Floortime on TRPG treatment. As I had discussed in the sections on Play Therapy in Chapter 7, my reflexivity in this study was key to my observing possible blind-spots in my own research prior to this study – prioritizing the historical debate between psychodynamic and behavioral Autism treatments rather than identifying the specific legacy of

play therapy in the Autism community. Perhaps this development in my understanding only emerged through discussion about the tension between non-directive and directive play therapies in the interviews. However, the rise of child-led psychotherapies such as DIR Floortime and Son-Rise, appears to have played a major role in the simultaneous popularity of TRPG treatment as a non-directive option for Autism.

11.5 Integration of Non-Directive and Directive Autism Psychotherapy

“Nondirective and focused therapy are not mutually exclusive”

(Rasmussen & Cunningham, 1995)

In this contemporary movement towards more child-directed, individualized treatment for patients on the Spectrum is also, as Dr. Schreibman emphasized, a heavy focus on the integration of non-directive and directive approaches. In their study written in 2000, Kenny and Winnick describe utilizing a “non-directive play style” with directive interventions focused on personal hygiene and social skills for children on the Spectrum. The researchers explained that the child-centered components of their integrated model promoted a sense of acceptance for children on the Spectrum, and stated that play therapy is supportive for children with disabilities in that it allows them to “discover the physical and emotional strengths they have in relation to their deficits”. Conversely, the researchers noted that incorporating a directive approach allowed for the integration of social skills and the introduction of functional activities.

Utilizing Carmichael's (1993) theoretical framework, Kenny and Winick explained how the integration of directive and non-directive play therapy approaches were especially salient for children with disabilities in that they encourage the exploration of the "I am", the emotional development of the child, and the "I can" – the physical development of the child. Carmichael explained that "directive" interventions target the "I am" with activities selected by the therapist with specific therapeutic goals of increasing a patient's self-esteem and sense of self-efficacy, whereas the non-directive play interventions assume that the patient will "naturally seek" positive affirmations of their self-esteem and identity and explore their feelings if in a safe environment. This theoretical framework directly mirrors the foundational humanistic presuppositions found in Axline's initial literature on non-directive play therapy, as well as reflect alignment with my results and the clinical reasoning of the TRPG therapists in this study.

The interplay between and integration of non-directive and directive objectives in the TRPG modality have significant importance for players on the Spectrum. Participants in my study spoke about the importance of players on the Spectrum having autonomy and feeling "powerful" as a result of non-directive interventions that allowed players to organically contribute to the game narrative, independently process conflict with one another, and naturally stumble into therapeutic terrain that allowed them to explore their therapeutic goals. Alternatively, the participants in this study also noted the ways in which directive interventions in the TRPG modality were distinctly useful for supporting player experience of self-esteem. The primary example of this from the study was the gaming intervention of the Nothic, used in the observed treatment by Beth as a way for players to experience negative self-thoughts and practice positive self-talk. Beth also spoke about her "overarching goal" of promoting a sense of

belongingness and “decreasing any sense of otherness” – tagging this as especially essential for players on the Spectrum who have likely experienced social rejection and isolation in other settings. She described directive interventions that she explicitly embedded in the gaming space for players. I believe that this push towards integration is at the core of the tension that emerged among the TRPG therapists as they deliberated upon non-directive and directive interventions. While there was some discussion about the overall approach of each therapist’s style as belonging in one camp or the other, ultimately what my results conclude is that the therapists intentionally viewed and weighed the merits of each type of approach and that both were deeply embedded in TRPG therapy as a modality specifically for patients on the Autism Spectrum.

The voices of TRPG therapists in this study portray a clear, resounding answer for why they believe play therapy is a necessary treatment modality for players on the Autism Spectrum. As was discussed in the chapter on theoretical orientation, TRPG therapists explained that play helps patients get out of their comfort zone and engage better with the therapy space. By using play in the therapy through therapeutic gaming, they explained that players on the Spectrum have greater access and likelihood of exploring difficult topics and engaging in previously challenging experiences – such as socializing or conversating. TRPG therapists also explained that play allows for autonomy and freedom in the therapy space, especially with a non-directive approach, in that players can have the space and time to fantasize, discuss perseverative interests, and share their knowledge and interests through role-play, as well as pausing the game for meta-gaming and discussion of Youtube videos, world events, or cephalopods. Furthermore, the non-threatening, safe and autonomous nature of play and gaming spaces allowed players to have the

choice of how and when to process – or not process – difficult thoughts and feelings, either through talking or unconsciously playing through it.

In the ever-present tension between non-directive and directive interventions, TRPG therapists also elucidated why TRPG as a semi-directive approach is appropriate for players on the Spectrum. In describing her non-directive play therapy stance and its utility for players on the Spectrum, Beth explained that she wanted her approach to express to her players that “You are not a problem to be solved” – a message, she explains, often is diluted to children through directive approaches that focus heavily on correcting symptoms. The non-directive approach to TRPG, participants explained, provided players on the Spectrum with autonomy – with the safe environment and the freedom to naturally seek and explore aspects of their identity and relatedness – just as the Carmichael (1993) and Kenny & Winnick (2000) frameworks suggest. Yet TRPG therapists also explained the importance of integrating directive approaches for children on the Spectrum – of weaving in their presenting problem to the overall narrative, and devising opportunities for conflict resolution and experiences within the game wherein players can work on their therapeutic goals. TRPG therapists described the positive outcomes of the integration of non-directive and directive approaches for players on the Spectrum: the gentle and private ways in which players were able to work through and process therapeutic goals at their own pace and without an overtness of “hit you over the head that this is therapy”, as one participant stated. The TRPG therapists explained that this experience was a unique product of the semi-directive nature of this modality, and that it led to outcomes such as increased sense of belonging and self-advocacy, improved communication and relatedness, as well as higher self-esteem in players on the Spectrum.

Yet the results of my study render further meditations on the utility of TRPG as a treatment specifically for patient on the Autism Spectrum, and why it is exactly this tension and integration of non-directive and directive approaches that contributes to this conclusion. Part of the answer can be found in the contributions made by my participant Louis, who practices TRPG therapy with a developmental approach. Louis explained that there is something particularly fitting and, strangely, not so inherently obvious about utilizing a *developmental* framework when serving players with *developmental* disabilities. Citing the work of developmental theorist Vygotsky, Louis explained his interventions with terms like “scaffolding” and “bridging” as meeting his players where they were at developmentally and providing individualized interventions to help the players “bridge” to where they needed to go in the game. Louis explained this style as, “Let me help you with the bare minimum, enough to push you that way but I want you guys to focus on it.” Multiple TRPG therapists described similar interventions as gently “leading” the players towards collective aims like conflict resolution or problem-solving as well as encountering personal therapeutic goals. An emerging evidence-based modality in Autism psychotherapy, the Integrated Play Group Model, also utilizes a Vygostkian framework in which practitioners gently guide players on the Spectrum towards interactive play with one another with little therapist direction (Wolfberg & Schuler, 1993). This developmental approach of scaffolding brought to mind the image of a basketball game, with the therapist laying up the shot and the player dunking the ball in the basket – an integration of the directive and the non-directive, the instructional and the experiential. This use of a developmental approach, paired with Vygotsky’s theory of “zone of proximal development” also contributed to the notion of “guided participation” of Autism expert and clinical anthropologist Barbara Rogoff (2003).

Guided participation, or the notion that children use cultural tools with “skilled mentors” to shape their development, aligns with the merged directive and non-directive nature of scaffolding in TRPG therapy: there is therapist guidance within the clinical culture of the TRPG, paired with child-direction of the game. The reason why a developmental, scaffolding approach is important for patients on the Autism Spectrum is that it speaks to the very heart of disability issues by providing access.

In my literature review, I discuss the critical disability methodology utilized in this study and how this framework orients my position as a clinician in the field. An individualized, client-centered approach to play therapy takes into account the specific needs of each person as well as the “non-syndrome specific factors”. In carefully analyzing the clinical reasoning of the TRPG therapists in this study, what emerged was a consideration of how to integrate client-centered and scaffolding interventions to make therapeutic gaming and play accessible to players on the Spectrum – a feat that early literature thought impossible. This conclusion gets back to the core hypothesis of this study, which I will discuss at length in the next section: utilizing the lens of a critical disability methodology, these results corroborate the ways in which TRPG therapist facilitate a sense of “fit” for players on the Autism Spectrum.

11.6 Critical Disability Methodology and Autism Psychotherapy

In the introduction to this chapter, I reviewed my initial hypothesis driven by the critical disability framework of Rosemarie Garland-Thomson that TRPG therapy provided a sense of “fit” for players on the Autism Spectrum. In this section, I will discuss the varying evidence

suggestive of that claim from my results and how the integration of directive and non-directive approaches contributes to this conclusion. I will also discuss the broader implications this might have for future research and further understanding the direction of contemporary Autism psychotherapy.

My initial hypothesis for this study derived from anecdotal exchanges with TRPG therapists who claimed that “Autistic” qualities of their players differently emerged in the gaming space as opposed to the “real-world” outside of the game, noting that they were able to socialize, empathize, and cultivate self-awareness in ways that seemed foreign to Autism diagnosis. As I discuss at length in the earliest chapters of this dissertation, their claims also had significance to larger debates in the field of disability studies and spoke to the tension between traditional “deficit” models of disability in which treatment is meant to cure or fix, versus contemporary biopsychosocial understanding of disability as lived and in dynamic flux with one’s environment. These anecdotes from TRPG therapists did not necessarily claim that TRPG therapy had fixed or cured these perceived Autistic deficits, but rather that there was something special happening in the TRPG context and environment that lent itself to this observed phenomena of “disappearance”. The way in which TRPG therapists narrated this phenomena was the inspiration for this dissertation and a foundation for the interviews with my own participants. Yet, their perspectives drove home a larger question in the critical Autism and critical disability fields, which is – if disability is a function of a dynamic interaction with one’s environment, culture, societal systems, what then is the role of therapy? The neurodiversity paradigm of Autism has answered this question with the assertion that we must as a society and through our healing modalities celebrate individual difference, encourage – rather than modify – the large

Spectrum of neurodiverse presentation, and view Autism as more than diagnosis but also as personality, style, characteristic. The perspectives of my participants, shared at length in the chapter on Autism conceptualization, reflect the varied ways in which TRPG therapists view Autism with some continued reference to “deficit” or challenges, as well as their appreciation for style and character traits. Their perspectives also reflect the larger, growing literature of Autism experts who have also shifted their definitions of Autism to account for both individual and cultural definitions of Autism and towards acknowledgement of Autism as a style (Baron-Cohen, 2002; Costa & Grinker, 2018; Straus, 2011), “mode of engagement” (Fein, 2018), “essential element of personality” (Valtellina, 2018) as well as the understanding of Autism as a diagnosis that is culturally constituted (Brezis et al., 2016) in addition to being a phenomenological and lived experience (Donnellan et al., 2012; Mattingly, 2017). I believe that the literature reviewed earlier in this chapter (Schreibman, 2012; Francis et al., 2022) also acknowledges the shifting landscape towards the neurodiversity paradigm, in the emergence of psychotherapies that attend to heterogeneity, individual difference, and no “one size fits all” method.

In utilizing a critical disability methodology and the work of Rosemarie Garland-Thomson, I hypothesized that what these anecdotes from TRPG therapists might be pointing towards is an experience of “fit” – a phenomenon in which a person with a disability experiences a harmonious interaction in between self and world. It was this phenomena, I hypothesized, that led to this “disappearance” of ToM deficits much in the way that an elevator allows a person using a wheelchair to access the second floor of a building. Garland-Thomson’s theory is about so much more than just this notion of “access” which harkens to the “social model of disability” that proposes environmental and societal accommodations can provide access to those with

disabilities. Critical disability theorists explained that access alone is not the token of “fit” because it is a static outcome. Instead, “fit” is a dynamic, fluid, and embodied experience. Garland-Thomson does not indicate exactly how psychotherapies, or healing practices, might contribute to this experience. However, using my results from this study, I will argue that this theoretical framework is at play in producing the experience of therapeutic gaming observed by TRPG therapists. A limitation to this claim is that this study does not account for the lived experiences of players on the Spectrum in their own words – so there is no way of knowing, as a result of this study, whether they experience a sense of “fit”. Instead, by staying close to the examples of “fit” provided by my participants in their interviews, I aim to discern how the therapists themselves consider this modality as a therapeutic tool for creating “fit” for players on the Spectrum.

One example of the TRPG treatment providing a sense of “fit” for players on the Spectrum pertains to the Theory of Mind deficit. The initial anecdotal example provided in the Introduction to this dissertation was a TRPG explaining that “Theory of Mind” deficits “go out the window” in the context of TRPG treatment. In my results, I unpack the diverse ways in which TRPG therapists view “Theory of Mind” deficits – not as lack of empathy, but instead as a function of engagement and recognition of self and other. Their TRPG interventions, such as modeling awareness of other or encouraging player attunement with peers, highlight what they perceive of Theory of Mind deficit not as a function of an internal deficit – but rather they described it as an issue of knowledge or experience gap. TRPG therapists explained the way in which players on the Spectrum, due to previous isolation and social rejection, often are unpracticed with social reciprocity – or what Beth called the “serve and return” of conversation.

This lack of experience and practice, TRPG therapists explained, was the conceptualization driving TRPG interventions that provided players with directive interventions through scaffolding as well as experiential interventions aimed at “at-bat practice”. As Beth explained, if the players on the Spectrum could experience what it feels to “complete a circle of conversation” in the safety of the TRPG treatment – they would know how to do so with peers in the real world.

One of the ways Jared repeatedly discussed “Theory of Mind” deficits in relation to TRPG players was in noting moments where they may not abide by the rules of social etiquette – such as sharing the airwaves, or not having their character do a “one man show”. His interventions designed to support players in these moments are to scaffold their understanding of shared talking space. In the clinical literature on Theory of Mind, concepts such as relational frame theory, person perception, and attribution theory all contribute to what is perceived as an individual, and internal Autistic deficit. However, when piecing together these concepts in the scope of the TRPG therapists’ perspectives, it becomes clear that when players have been isolated or rejected socially – they lack the experience of interaction and engagement from the outside world that have taught the rules of socializing. Yet this interaction and engagement that is so key to the gaming experience is made safe and accessible for players on the Spectrum due to the high level of structure and predictability in the therapeutic gaming environment. In TRPG therapy, players on the Autism Spectrum are not merely learning the rules of social etiquette – they are learning the rules, mechanics, and etiquette of the gaming world. And this learning is not only didactic and skills-based as in some directive approaches to treatment, it is also experiential and child-directed. In this way, they are not learning a rigid system of rules for

interaction – nor are they being counseled towards only neurotypical interactions. As Louis referred to as the “imaginative breaking of the game”, TRPG players learn the rules – of social interaction and of the gaming space -- as well as how to break the rules for the sake of autonomy, creativity, and group cohesion.

An example of “fit” in regards to Theory of Mind occurred in the observed TRPG treatment. Beth noted the ways in which Player E historically had difficulty with the tele-health platform, and having self-awareness that his body and face were not always in the camera’s purview. This player often engaged in self-stimulation behavior and frequently fidgeted in contorting body shapes. The facilitating therapist explained her repeated directive intervention of reflecting out loud to the player that the group could not see him – explaining that this gentle reminder modeled what would occur in a social interaction if a peer were to give him the same feedback, rather than a didactic instruction of how to position the camera. Beth noted with excitement when in the third session, Player E independently asked the group members if they could see and hear him – which Beth explained was a sign of growth that with repeated experience, he had cultivated a sense of awareness of his embodiment in the therapeutic space and of others’ perceptions of him.

This study’s Chapter 6 on Autism conceptualization was chock full of examples in which TRPG therapists identified ways that the gaming interventions and game space debunked the notion of ToM deficits as pervasive and core to ASD. Beth repeatedly noted ways in which players on the Spectrum through the game play were able to access aspects of emotional expression and self-awareness that the clinical community often narrates as inaccessible to

people on the Spectrum due to ToM deficits. One example from the results was in Chapter 6.1C in which Beth noted that one player on the Spectrum was able to talk about anger and frustration as a result of sensorimotor interventions in the TRPG that encouraged him to notice his bodily experiences of emotions (“This kid is [on the] Spectrum, right? But now he is talking about anger and frustration!”). Another example Beth shared with the same sense of wonder and enthusiasm was from the same chapter (6.2) in which she noted a player’s newfound awareness of other, a skill she saw garnered through the treatment, to check-in with other players about whether they could see him on the tele-health platform (“[For] a kid with Autism, what does it mean for him to actually ask, ‘Am I in the right? Am I doing the right thing like socially? Can you see me?...because that is the awareness of the other, and the interaction and the need to see each other in order to interact well”). She also observed the way in which the gaming interventions allowed for players to be more attuned to the thoughts of their character, which in turn led to more attunement with themselves and others. Beth also spoke about the ways that the TRPG treatment interventions allowed players to speak about their perseverative interests (6.5), helped players to understand sarcasm for the first time (6.1B) through practicing conversations, and met their sensorimotor needs through play objects so that they could stay immersed in the game space without distractions (6.1E).

The facilitating therapist explained that her overarching goal for the TRPG treatment was to have each player experience a sense of “belonging” – another experience of “fit”. Many of the TRPG therapists pointed to the therapeutic game’s way of producing a sense of “group cohesion”, which in turn leads to a sense of fit in that the players learn to rely on each other, develop group culture and norms, in ways that are potentially novel for most of them in their

previous social interactions. Whereas in other clinical settings, “social skill development” would be the learning of neurotypical ways of interaction – Jared noted that social skill development in TRPG treatment occurred experientially, through the culture and experience of the game. Beth also pointed to the experiential aspects of the treatment in producing this same phenomenon through the gaming experience of collaboratively facing the threats and dangers of monsters and combat in the game has a way of bringing about group cohesion. All of the TRPG therapists, especially Louis, pointed to the primary goal of group cohesion in TRPG treatment and Beth explained that this was especially healing for players on the Spectrum who had likely experienced social rejection and a sense of “outsiderness” in the past. Beth spoke about the way in which she designed a gaming intervention so that Player R would be the only player to be attacked by a Cloaker in order to prompt the players to work together and collaborate in order to save him. She explained her excitement when the players deliberately worked together to weigh the risks involved with saving Player R, and used a directive intervention of asking Player R how he was feeling in front of the rest of the group in order to prompt his role-playing. Again, the facilitating therapist was impressed by the way Player R got into the mindset of how his character might be feeling and articulated this to the group. Here, the players not only accessed an experience of “belonging” and group cohesion – but also exemplified empathic recognition and emotional reciprocity, which Beth noted might classically be considered out of reach for Autistic players due to Theory of Mind deficits.

As Beth explained, players on the Spectrum can sometimes experience greater ease with empathic recognition and articulation of feelings in the context of the game. She conceptualized this as being a function of role-playing, and having the safety and structure of a character: “They

can sometimes do this better with their characters than in real life”. One of the key aspects of TRPG treatment that facilitates this experience of “fit” is the use interventions that allow for players to “externalize” and “depersonalize” – for example, it is more accessible to answer how one’s character might be feeling, than identifying how the player or a peer is feeling. As Tabin (2005) proposed, the characters in TRPG serve as a “transitional object” between a player and the “space of the game”, which in turn helps the player to “establish a sense of self-representation and control” within a given scenario. Vaisvaser (2019) also noted in her study on creative group therapy the way in which a “transitional object”, a theory of child psychotherapy D.W. Winnicott (1971), helps to provide a “projective distance” for children on the Autism Spectrum that is necessary for the feelings of safety in social interactions. In this way, the player’s character in the TRPG treatment – as well as the interventions used by TRPG therapists to utilize this character and the role-play – are a vital part of what makes social interactions for players on the Autism Spectrum safe and accessible. And in turn, outcomes such as those observed in the taped TRPG treatment can occur in which players on the Spectrum can demonstrate empathy, emotion recognition, and engagement with self and other.

The area in which the debate between non-directive and directive approaches became most apparent was in moments where TRPG therapists noted that players were not engaged with either the game or the therapy. Some of these moments were narrated by therapists as issues with engagement pertaining to attention or focus, with some therapists referring to interventions that are specifically designed towards players with ADHD or issues with concentration. At other times, therapists noted players non-engaging with peers in interpersonal interactions or in confronting conflict – which many of the therapists noted as potentially a knowledge gap, as in

the players perhaps did not know how to comfortably engage. In response to these varying reasons for non-engagement, TRPG therapists debated more directive interventions – such as the instruction of social skills, or directly addressing the player’s character (“So, what does Player S think about this?”) – versus non-directive interventions that gently acknowledged the player’s non-engagement without offering a modification.

Two examples that portray the varying degrees of non-engagement from the TRPG therapy were as follows. The first scenario is when the facilitating therapist noted that she was unsure initially if player R was paying attention because he had not spoken in a while, positing that perhaps he was looking at something else on his computer screen like a Youtube video. In her clinical reasoning, Beth chose to privately note what she was observing with Player R but wait to directly intervene. While watching Player R in the multivocal text, Jared had noted that Player R also appeared “checked out” and had suggested using a directive intervention, such as appealing to him directly to role-play. However, later in treatment Beth noted that Player R was “tracking” more, had stronger levels of eye contact, and was verbally responding to things happening in the game. Beth appeared to explain that part of how she understood this change was through the gaming intervention she devised of having Player R’s character be put in danger with the Cloakers – leading Player R to experience a sense of belonging and camaraderie as the fellow players tried to save him. In this way, the narrative and the gaming interventions were the intervention for non-engagement appearing to be caused by distractions – which was aligned with Louis’s perspective that the narrative of the game is a key engagement and investment tool. Player R’s change in the sessions exemplifies one experience of “fit” as the therapist utilized the

semi-directive nature therapeutic game, and the way in which it invites players, to organically accommodate his non-engagement without pathologizing his distraction.

Another example of “fit” with non-engagement was in regards to players not engaging with the conflict resolution process, which occurred in the observed treatment in the conflict between Player S and Player J. Many of the TRPG therapists noted that for many players, and in particular for players on the Spectrum, confronting and resolving interpersonal conflict could be extremely uncomfortable due to not having prior experience with doing so. For this reason, many of the TRPG therapists debated how to scaffold and support player experiences with conflict resolution during the therapeutic game. Louis described using gaming interventions, such as the “campfire” or the use of the therapist as an NPC, so that players could re-engage with the narrative and that this would “force” them to confront conflict in a safe way. One particular vignette of “non-engagement” from the clinical tape was in the session immediately following the conflict between the players, in which Beth directly invited the players to discuss the conflict from the previous session and Player J visibly slumped down in her swivel chair and turned the chair around so that her back was to the screen. Beth indicated in her conceptualization of this moment that this was Player J’s non-verbal way of communicating feeling overwhelmed or overstimulated by the prospect of discussing “hard and scary feelings”. For this reason, Beth explained that she chose to acknowledge Player J’s action by narrating her actions to the rest of the group, but specifically using her character’s name: “J has disappeared!”.

This gaming intervention, Beth had explained earlier, was the TRPG technique of the “murky mirror model” – observing a player’s non-verbal gestures or actions and narrating them

as their character's actions as a way of encouraging immersion. Again, this is a way in which TRPG therapists intentionally use the transitional object of the TRPG character to help players access a sense of self-awareness about their feelings and embodiment with safety. Ultimately, Beth explained that narrating the player's non-engagement lets the player know that the therapist sees and cares about her, and acknowledges that she might be feeling overwhelmed without forcing her to work through and confront interpersonal conflict. This example was one of many instances in which Beth reasoned her preference for not spotlighting "problematic behaviors", such as non-engagement, and instead wanted players to access the overarching theme of feeling "seen" and a sense of belonging. Later in the game, Beth also reasoned that Player J independently engaged in conflict resolution through "playing it out" with Player S – via role-play and gaming.

These examples of TRPG conceptualizations and interventions for non-engagement as a manifestation of "fit" for Autistic players illustrate Alvarez's (1992, 2012) concept of "vitalizing" interactions with Autistic patients. Alvarez describes the process in therapy with Autistic patients of the therapist actively reaching out to contact and "reclaim" a patient who is previously viewed as "inaccessible", leading the patient to re-engage in the world of emotions and relationships. Vaisvaser (2019), in her study on creative group therapy, also utilizes Alvarez's concept of vitalizing interaction to describe the way in which therapists attune with the non-verbal and verbal signaling of non-engagement by patients on the Spectrum and first allow them to withdraw before this process of re-claiming the patient into connectedness. The allowance of the withdrawal is on display in Beth's interventions with Player R and Player J, with her acknowledgement that this withdrawal may feel necessary due to the threatening and

unfamiliar nature of social engagement. The semi-directive nature of the TRPG, the gaming interventions and directive interventions described here, also exemplify the approach of the TRPG therapists as they reach out to contact the Autistic players and “reclaim” them into the world of the TRPG. Both the allowance for withdrawal and reclamation interventions signal one way in which TRPG therapists create “fit” for Autistic players: non-engagement is allowable, and re-engagement is possible and even self-generated through the safety of their characters and the semi-directive aspects of therapeutic gaming.

Another way TRPG therapists appeared to narrate the experience of “fit” through the semi-directive nature of the therapy was in the formation of group ritual, culture, and joy. Vaisvaser (2019) noted in her study that the forming of group rituals in therapy with Autistic patients led to experiences of “mutual joy” and joint action – a concept of engagement and dyadic collaboration found in Autism literature. The TRPG therapists also described the importance of rituals in the TRPG therapy, particularly in their discussion of the “Opening Space” found in the results chapter on intervention. This Opening Space, the first ten to fifteen minutes of the game, was an explicit gaming intervention common to therapeutic gaming in which there is no game or role-play, just a flexible time period where players enter the treatment space and have the opportunity to discuss aspects of their life outside of treatment. In the observed treatment, the Opening Space was a time when players would share Youtube videos and memes, as well as discuss television shows or movies. The TRPG therapists even explained that during the pandemic, in the switch over to tele-health, there were some games in which rituals like the Opening Space would take over the entirety of the game. Beth described how during the pandemic, the same campaign of players in the observed treatment spent many

sessions without any combat or journeying in the narrative – instead, opting instead to have their characters cook and eat a meal together. In the observed treatment, she noted the return of this same ritual when the players successfully defeated the Cloakers in battle and had decided to have a bonfire in which they roasted and ate the Cloakers together. Beth explained the profound significance of moments like these in the game, where the players independently create a ritual and their own “culture” with a “shared history”. The TRPG therapists explained that these moments of mutual joy, ritual, and community are extremely important for players on the Spectrum in experiencing a sense of group cohesion and a sense of belonging. Accessing joy in the therapy space, the TRPG therapists explained, was not only essential for de-stigmatizing therapy for players on the Spectrum during adolescents or as adults. Beth also suggested that joy and a sense of relief in the therapy space, “feeling good now”, was just as crucial for players on the Spectrum as it was for anyone in therapy.

Another aspect of the semi-directive nature of TRPG treatment that seemingly contributes to a sense of “fit” is the way in which TRPG therapists would pause the game for meta-gaming or the sharing of perseverative interests. As Jared said, “We stretch the game to fit the therapy” – meaning, that TRPG therapists would describe their decisions to pause or stop the game for the purpose of a therapeutic moment. Therapists described this as a unique aspect of the therapeutic gaming: for example meta-gaming, or talking about the game out of character, would often be discouraged in non-therapeutic gaming settings for the sake of not breaking immersion. However, in therapeutic gaming, TRPG therapists described the therapeutic utility of meta-gaming for players on the Spectrum whom they see as deriving a sense of pride and competency from sharing their knowledge about the game. This “stretching” of the game for Autistic players

is more than just an accommodation, it is a unique recognition of the way that the therapeutic game can, again, contribute to Autistic players feeling seen, acknowledged, and a sense of belonging. It is quite remarkable that the concept of “fit” can also be observed in Jared’s statement: in most clinical settings and talk therapy treatments, the experience of Autistic patients is often one of feeling “stretched” and pushed to meet the demands of the talk therapy modality. This includes the experience of feeling pushed towards neurotypical styles of communication, as well as being in a type of social exchange that many on the Autism Spectrum can find uncomfortable. In the case of TRPG therapy, TRPG therapists are stretching the game to fit the therapy and the patient – in and of itself, the modality is inherently modifiable and stretchable to provide a sense of fit for players on the Spectrum.

Similarly, TRPG therapists described the profound effects of allowing players to contribute or guide the game’s narrative. Beth described a moment in which Player E identified a setting in the game as “a magic hospital”, which Beth immediately took up and added to the game’s narrative. Mark detailed his “dirty GM secret” of asking the players about the previous week’s session in order to discern feedback on what players wanted more or less of in the game’s story. Louis identified this process of discretely eliciting and utilizing player’s feedback in the game as a form of “unconscious supervision”, that made players feel “powerful” and autonomous in the gaming space in their ability to co-create the game’s world and help drive the story’s narrative. For players on the Autism Spectrum, this effect was uniquely supportive the TRPG therapists said, in that it helped players feel a sense of autonomy and control in a world that often feels overwhelming and overstimulating. In this way, these interventions that employ both directive and non-directive elements, contribute to the players experience of “fit” in that

there is a seamless, dynamic relationship between self and world in which the players have a sense of control.

11.7 Cultural Understanding of Autism through Therapeutic Gaming

My method of clinical ethnography and its heritage in cultural psychiatry and clinical anthropology might provide additional rationale for the integration of directive and non-directive approaches with players on the Autism Spectrum. In my Introductory chapters, I cite the work of clinical ethnographer Joseph Calabrese (2013) as an inspiration for this study in its usage of the concept “therapeutic emplotment”. With its applications to both the field of clinical anthropology by Good (2012) and disability studies through Mattingly & Fleming(1994), therapeutic emplotment is defined by Calabrese as “interpretive activity or social application of a preformed cultural narrative placing events into a meaningful story or otherwise supporting health”. As was described earlier in the discussion section, primary to Mattingly’s concept of “chart talk” is that clinical reasoning of clinicians working with disabilities inherently has a narrative element wherein the explanation and experience of a patient’s disability are described as a “story of illness”. Calabrese describes Mattingly’s model of therapeutic emplotment as a “co-constructed improved narrative” between patient and clinician – much akin to the “co-created narrative” of the TRPG described by participants in my study. Calabrese emphasizes the importance of ritual and symbolism in the therapy, as well as a therapist’s non-directive approach in eliciting patient narratives of illness and working collaboratively to “fashion a therapeutic story” in which the patient can have a cohesive experience of self and symptom.

In Calabrese's work, he describes the therapeutic employment of a patient's narrative in the healing process of a peyote ceremony in which participants encounter elements of this co-constructed narrative throughout the symbolism and ritual of the peyote experience. In TRPG treatment, the therapists described weaving the player's presenting problems into a larger narrative of their character's backstory and into the co-created narrative of the game's journey. An example of this therapeutic story was described by Beth of Player J, when in Session Zero while devising Player J's character she explained that she wanted to "play a character who had been crippled for life and compensated for their disability by using magic". The TRPG therapist explained that for a child suspected of an Autism diagnosis, devising and role-playing a character with a disability was an important experiential and phenomenological therapeutic experiment that allowed the player to make sense and meaning of her own lived experience. This was one of many examples of how the theoretical frameworks around illness narratives in Mattingly and Calabrese came to life through the scope of disability and Autism in this present study.

Ultimately, Calabrese argues, therapeutic employment happens on a cultural level when patients are immersed in a "symbol -laden communal ritual" that contributes to their overall healing narrative. That this process happens on the cultural level of healing points to the heart of this clinical ethnography – and the way in which the culture of the therapeutic gaming space, and the culture of RPGs, contributes to therapeutic change and growth. The TRPG therapists explained the ways in which both the narrative of the game, as well as the rituals the players create in the gaming space, contribute to a sense of the players creating their own type of "culture" amongst each other. The method of clinical ethnography used in this study highlighted

the unique culture of the TRPG clinical space as well as the culture co-created by players on the Spectrum.

Calabrese's work provides a profound template through which to view the narrative therapeutic elements of TRPG therapy, and the ways in which "therapeutic emplotment", as Mattingly argues, has distinct utility with disabled patients that frame the way in which this work benefits Autistic players in TRPG treatment. Why this work is particularly essential for marginalized populations Calabrese argues, is that diagnosis and healing modalities are shaped by the cultures in which they are formed. The fields of cultural psychiatry and medical anthropology encourage us to consider the ways in which we understand diagnosis and therapy as being informed by hyper-local, hyper-specific meaning making. In this study, my results reveal the very specific conceptualization of Autism diagnosis by a very specific community of therapists. Their conceptualizations and interventions, their clinical reasoning, and how they narrate this modality as a therapeutic tool, are all driven by the hyper-local context of TRPG. The results of this study contribute to the larger Autism field in denoting one particular way of viewing and understanding Autism diagnosis and treatment, and might contribute to emerging understandings of how diagnosis and treatment are deeply embedded in a cultural context.

11.8 Implications for Future Research

The results of this study reveal a number of implications for future research on Autism psychotherapies and for the future of therapeutic gaming with Autistic players. My results show an integration of previously competing clinical traditions, behavioral and psychodynamic, non-

directive and directive approaches, and in this way build a compelling evidence base for the integration in future Autism psychotherapy research and clinical practice. As was discussed at length in this chapter, the field of Autism psychotherapy is continuing to move towards more individualistic therapies in naturalistic settings, with less structure and more child-directed intervention. The naturalistic setting of gaming and the semi-directive nature of TRPG described by participants in this study provide strong evidence that there is strong forward momentum for TRPG as a modality for Autistic patients. As was discussed in Chapter 2 on methodology, this study utilized a video-cued method in order to observe a natural setting of TRPG treatment and thus the results of this study corroborate the importance of a “naturalistic” setting of treatment in a gaming space – or in this case, a virtual gaming space.

The results of this study also indicate a unique focus on the use of developmental scaffolding interventions as well as a relational focus on providing the experience of group cohesion and communication for players on the Spectrum. The chapter on Outcomes reviews the many relational outcomes sought by TRPG therapists for their Autistic players, such as prompting a sense of group cohesion and connectedness with others. The relational outcomes discussed in Chapter 10 have profound implications for Autism psychotherapy in that it suggests that TRPG therapists view players on the Spectrum as not only capable of cultivating connection and relationality with others evidenced by the group cohesion and circles of communication in the game, but also that the appearance of previously perceived Autistic deficits, such as lack of empathy or emotional reciprocity, seems to shift through and in connection with other players while role-playing in the therapeutic game. This finding relates back to the Introduction of this study in which Autism diagnostic criteria was reviewed as well as the question of how a

relational and intersubjective understanding of Autism correlates nicely with the phenomenon of symptoms emerging through and within relation to other. Paired with the literature on relational approaches with Autism Spectrum Disorders reviewed in the literature review of this study, these results suggest that TRPG researchers view treatment as providing access for a greater relational experience for players on the Spectrum and indicate their belief that this is a possibility for players on the Spectrum despite “Theory of Mind deficits” that suggest otherwise.

As a play-based approach used with patients at all ages, not just children, TRPG also offers a unique opportunity for players on the Spectrum beyond infancy and childhood. This expands on the evidence-base of DIR Floortime for young players on the Spectrum, and also contributes to another emerging area in the Autism field of “play-based” therapies. “Play-based” interventions do not necessarily utilize the “programmatically” structure of a specific game or play object, and instead utilize a strength-based and developmental focus to incorporate aspects of play throughout individual and group psychotherapy using both non-directive and directive approaches as well as varying types of play (Francis et al., 2022; Gallo-Lopez & Rubin, 2012; Gibson et al., 2021; Grant, 2016). While my study focused specifically on the programmatic use of Dungeons and Dragons and role-playing games, my results show the many ways that TRPG therapists incorporated aspects of play from other sources such as sandtray, action figurines, the video game *Zelda*, and dominoes. TRPG therapists also repeatedly emphasized the importance of play, both in therapeutic games and non-therapeutic games, as a key factor for helping players tolerate discomfort and uncertainty, or as Winnicott (1971) said “Tolerance for uncertainty is vital for the development of play” – and how this was especially important for players on the Autism Spectrum. These aspects of play that are non-specific to role-playing games illustrated

the way in which the more general spirit of play permeates TRPG treatment, or as Winnicott said, “Playing is itself a therapy”. For this reason, I propose the significance of “play-based” or “play-inspired” therapies for patients on the Autism Spectrum and implore future research to discern the way in which play in many forms can figure into both individual and group treatment.

One of the thrilling aspects of being a clinical ethnographer is the opportunity for my clinical research to directly influence and impact my clinical practice. In using clinical ethnography as my method for this study, I not only had the chance to draw from my own perspective as a clinician with patients on the Autism Spectrum, but I also had the distinct opportunity of utilizing this research in my own clinical work. As was discussed in the early chapters of this dissertation, I utilized my reflexivity as a clinical ethnographer and clinician during this project. While working on this dissertation I was also completing the required doctoral internship training at a hospital site in which I worked with Autistic patients both in outpatient and inpatient settings. Though I am not trained as a TRPG therapist, I was able to utilize a “play-inspired” and “play-based” approach with my patients on the Spectrum while not using any specific therapeutic gaming. I drew from the wisdom of my participants and the results of this study while working with an adolescent Autistic patient whom I will call “RJ”. Like many Autistic patients before finding TRPG therapy, RJ had previously experienced little success with traditional outpatient talk therapy and he had entered treatment with me with a skeptical attitude. Though I did not utilize a specific game, in our virtual thirty minute sessions I invited RJ to engage in treatment with me by discussing his favorite toys and games – leading him to explore and process significant aspects of his developmental trajectory, namely his current

developmental dilemma between childhood and adulthood. I had the voices of the TRPG therapists in my mind as I encouraged RJ to speak to me about his feelings through Youtube videos, act out a family dynamic using action figures, or process his ambivalence about growing up by sharing memories of his childhood toys. Play, in various forms, was our primary method of connection and engagement and I saw RJ gradually grow in his relationships with family and friends outside of treatment. By the end of our work together, RJ reported feeling more comfort with expressing his feelings and his mother shared feeling “blown away” by newly noticing RJ’s empathy and relatedness at home. This clinical example served as a sort of case study in utilizing the “play-based” approach I observed in the TRPG treatment, without the TRPG itself, and I believe that this is fertile ground for future research and exploration of this sort of approach with patients on the Autism Spectrum. I have included this clinical example from my own practice in order to highlight the ways in which the results of this study are applicable even outside of game-specific settings.

The way in which this study utilizes critical disability methodology and Rosemarie Garland-Thomson’s theory of “fit” in order to describe therapeutic interventions that work for patients with disabilities may also have fruitful implications for future research. In this study, I utilized this theory to conceptualize Autism as a “lived” phenomenon and psychotherapy as a dynamic, rather than corrective, experience. There are many uses for this theoretical framework in the ever-growing field of Autism psychotherapy studies and the ways in which Autism researchers are continuing to understand Autism. As described in my literature review, disability and the issues of patients with disabilities is still not a primary focus in psychology training programs and there is still much work to be done in the field for having trained clinicians operate

outside of the medical or deficit model of disability. My study is but one of many possible examples of marrying a critical disability methodology with psychotherapy research.

While the field of role-playing game studies is continuing to grow, this study was the first of its kind to observe TRPG treatment and interview TRPG therapists using clinical tape. There is still much work to be done on TRPG treatment as a whole, and more work should be done to contribute to its growing evidence basis for the general population. This was also the first study to specifically focus on TRPG treatment as a psychotherapy modality for patients on the Autism Spectrum, and the field would benefit from further research that analyzes the utility of this treatment with Autistic players. One consideration in this present study is that it analyzes Autistic experience from the perspectives of therapists, but it does not address the experience of the Autistic players themselves. In utilizing a critical disability methodology and approach, I want to note the importance of research that attends to the lived experience and voices of people with disabilities in their own words. While this study focused on clinician perspectives as a means of learning how the clinical community might better understand Autism Spectrum diagnoses and treatment, it is extremely necessary for future research to attend to player perspectives as well.

This study also has implications for the use of tele-health platforms for TRPG and Autism treatment. Due to the COVID-19 pandemic, this project had to shift and accommodate for the switch from in-person therapeutic gaming to the use of video therapy. While some of the participants in this study had already been utilizing tele-health platforms for TRPG in order to make treatment more accessible to patients, some of the TRPG therapists were having to adjust

to recent modifications to the gaming and therapy experience for players. This shift also had implications for working with Autistic populations, as was discussed in the conceptualization chapter of this study, in that there was some perception that attention and interpersonal difficulties associated with Autism might be amplified in the tele-health space. This study reveals the necessary ways that TRPG therapists adjusted and accommodated this treatment in general, but especially for patients on the Spectrum, and indicates fruitful ground for future research on tele-health for therapeutic gaming and for this population in particular. Additionally, my participants spoke about their enthusiasm for the tele-health platform and the pandemic-related easing of legality regarding out-of-state clinical practice as a means of providing TRPG access to players across the country. This provision, they explained, was significant in that players who do not live on either coast often do not have as many opportunities for accessing therapeutic gaming and that tele-health provided players with disabilities both the physical access to the game space as well as the privilege of choosing their provider.

Additionally, my results have implications for the ways in which TRPG therapists and non-therapeutic Dungeon Masters might facilitate and modify the game for players on the Autism Spectrum. There is already some indication that the gaming field is further taking into account neurodivergence, as well as other identity factors like race and gender, and coming up with ways to modify the game (Polkinghorne et al., 2021).

11.9 Limitations

There are number of limitations to this current study that are important to name in my concluding remarks. First, as a clinical ethnography, this study has in-depth focus on only one five session treatment and the perspectives of only four TRPG therapists. While this sort of hyper-specific and hyperlocalized focus is a bedrock of the clinical ethnographic method, I recognize that the results of this study might have been different with different therapists or with different players.

Additionally, one unplanned aspect of this project was the switch to tele-health and the COVID-19 pandemic. This study was initially designed as an observation of in-person therapeutic gaming, and my method had to abruptly shift to accommodate the tele-health space and use of technology. While my participants repeatedly maintained that the overall structure and experience of the therapeutic gaming was comparable to the in-person experience of the therapy, there was some acknowledgement of what aspects of the treatment might be lost in the shift to tele-health. Some of these lost experiences according to TRPG therapists were increased opportunities for connection among players and more in-person experiences with communication, which TRPG therapists noted were particularly essential for players on the Spectrum. However, the TRPG therapists also spoke about what was gained by the switch to tele-health – more accessibility for players, opportunities for therapists to observe players in an even more naturalistic environment of their home spaces, and the easy addition of digital media like Youtube videos or memes in session. There were aspects of the tele-health platform that therapists argued made the therapeutic experience even richer. However, the tele-health nature of this study means that there is still room for future research that observes in-person TRPG with players on the Spectrum and how this might render different results.

Another limitation of this current study was that I as the researcher was operating from a clinical and academic background and perspective. While I had conducted prior research regarding role-playing games and observed hours of gaming prior to this study, I have no personal experience with Dungeons and Dragons or role-playing games outside of this research. For this reason, I was explicit that my perspective in this study had a much heavier clinical lens when conducting interviews with therapists about the competing dialectics of gaming and clinical interventions. There was probably much more to explore in my data set from the gaming perspective, and as a gamer I may have observed or picked up on different themes in the data. Additionally, another researcher may have focused more heavily on the “gaming” conceptualizations of players, such as their expertise level or prior gaming experience. A researcher with gaming experience also might have had more background with which to interpret the TRPG therapists’ “gaming” interventions and may have focused differently on these interventions in interviews. These limitations point to the possibility of future research on TRPG conducted by researchers with gaming backgrounds and expertise.

As a qualitative study, this current project has no claims as to the efficacy of TRPG as a modality in general or in specific use with the Autism population. This study presents the perspectives of TRPG therapists in what they believe is efficacious about this modality with this population, yet further research would be indicated for a quantitative approach with a pre/post-test model. However, this limitation accounts for a specific historical tradition of “evidence-based research” for clinical practice as only originating from quantitative methods. I believe that the present study accounts for an emerging shift in the field of Autism psychotherapy research,

away from limiting notions of “evidence-based research” towards what Autism researcher Dr. Laura Schreibman called “practice-based evidence” (Schreibman et al., 2011). This study on TRPG treatment, especially in the era of virtual and tele-health psychotherapy, has a “practice-based” focus by attending to the experiences of therapists and privileging clinical expertise and practice in the Autism psychotherapy movement.

Finally, one limitation of this study was that the observed treatment comprised of a heterogeneous patient group with not all patients having an official Autism diagnosis. Three of the five players had formal Autism diagnoses, and two had suspected Autism diagnoses pending evaluation. This diagnostic make-up led to discussion among TRPG therapists about differential diagnosis that revealed clinical understandings of Autism symptomatology and assessment. However, this limitation could point to the utility of future research in which TRPG is utilized as a modality with only patients with confirmed Autism diagnoses. Another limitation in terms of demographic was that the group of players observed was quite small and thus there was less heterogeneity in terms of race, gender, ethnicity and socioeconomic status. A small population in a study does not allow for much variability in the data and thus it will be important for future research to be conducted with a wider range of participants.

Closing Remarks

As I reflect back on the process of planning, proposing, and executing this ethnographic study – I think of the multiplicity of viewpoints I have come to cultivate along the way, as is also representative of the multiplicity revealed by this ethnographic project. As clinician, student,

researcher, Autism advocate, and former Special Education teacher, I have “role-played” as many characters and this, like my participants, has generated a rich and complex understanding of Autism diagnosis and treatment. It is this multiplicity that garners the richness, and reminds me of the dangers of reductive perspectives of Autism and the siloed theoretical camps of clinicians. There is no one-size-fits-all approach to psychotherapy or to Autism, and this study exemplifies the way in which not only integration of approaches but also inter-disciplinary and cross-paradigmatic role-playing can help us as psychotherapists understand the lived, cultural, and dynamic experiences of patients on the Autism Spectrum.

I have had the humbling experience as a training clinician to observe and interview other clinicians in their therapeutic practice – an experience for which I will be eternally grateful and by which my own clinical practice will forever be improved. While setting out to observe therapy sessions is no easy feat for a training researcher, the many years of energy and labor on this project point to the importance of studying and learning from other clinicians. The multi-vocal text and this ethnography show the critical need for clinicians to watch, observe, and reflect on one another’s practice, just as the TRPG therapists in this study did. Integration of theoretical traditions and psychotherapy approaches alone is not what keeps the wheel of our field turning. Our definitions of Autism, disability, and what is “therapeutic” will expand through exchange and by a growing chorus of voices – a multi-vocal, multiplicity.

Appendix A: Semi-Structured Video-Cued Interview Guide

The purpose of this interview is to explore your facilitation of tabletop role play game therapy. I would like you to talk about how you make decisions as a therapist and game master, and what sorts of reasoning you use to describe your approach and how you make decisions in the moment in TRPG therapy.

Introductory Questions (consistent for all participants):

1. What is your experience/background as a game master?
2. What is your background as a gamer?
3. How would you describe your approach or techniques as being a game master?
4. What is your background/training as a therapist?
5. How would you describe your orientation, approach or techniques as a therapist?

Video-Cued Interview:

We are now going to watch the video recording of your TRPG therapy session.

I will be asking you questions about what is happening in the video, and recording you on audio-tape. During the video, you are welcome to jump in at any point and/or pause the video to describe your thought process during the therapy – including moments of tension or conflict, as well as moments where perhaps you did not know what to do. I ask that any time either of us speaks, we will first describe what just happened as to give context.

1. Describe what happened at this moment.
2. What makes this moment stand out to you?
3. What are you thinking about here?
4. What decisions did you make?
5. How did you make this decision?
6. What were you drawing on for making this decision?

At the end of each clip that the therapist selected or paused, I will ask:

1. Why did you select this clip to watch?
2. Why is this moment significant?

At the end of the video, I will ask:

1. In thinking about the moments we stopped and talked about today, when or how did you feel like you were thinking as a clinician?
2. When or how did you feel like you were thinking as a Game Master (GM)?

Appendix B: Semi-Structured Video-Cued Interview Guide

The purpose of this interview is to explore the use of tabletop role play game therapy. I would like you to talk about how you make decisions as a therapist and game master, and what sorts of reasoning you use to describe your approach in TRPG therapy.

Introductory Questions (consistent for all participants):

1. What is your experience/background as a game master?
2. What is your background as a gamer?
3. How would you describe your approach or techniques as being a game master?
4. What is your background/training as a therapist?
5. How would you describe your orientation, approach or techniques as a therapist?

Video-Cued Interview:

We are now going to watch a video recording of a TRPG therapy session. As you watch the video, I would like you to think about what is happening in the TRPG therapy session, and what you might do if you were conducting the therapy session.

During the video, you are welcome to jump in at any point and/or pause the video to describe your thought process during the therapy – including moments of tension or conflict, as well as moments where you are not sure what is happening. I ask that any time either of us speaks, we will first describe what just happened as to give context. At the end, I will ask you some questions.

1. What do you think about how therapist conducted the TRPG therapy session?
2. What interventions, techniques, approaches did you recognize?

At the end of each clip that the therapist paused, I will ask:

1. Why did you select this clip to watch?
2. Why is this moment significant?

At the end of the video, I will ask:

1. In thinking about the moments we stopped and talked about today, when or how did you feel like you were thinking as a clinician?
2. When or how did you feel like you were thinking as a Game Master (GM)?

Appendix C: CHILD'S AGREEMENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: TABLETOP ROLE-PLAYING GAMES AS AUTISM PSYCHOTHERAPY: A
VIDEO-CUED MULTIVOCAL CLINICAL ETHNOGRAPHY

WHO IS DOING THE STUDY?

Principal Investigator

Adina Rubin-Budick, M.A.

Clinical Psychology, PhD Student

Duquesne University

Research Associate:

Advisor:

Elizabeth Fein, Ph.D.

Associate Professor

Duquesne University

Preliminary note: Dr. _____, who is the therapist conducting the therapy session, will facilitate the assenting process with the participants.

WHAT IS A STUDY?

Given the age of the participants (10-15 years old) and their varying levels of education and cognitive styles, it is not assumed that they will be able to read, and so the following will be read to the child participants:

Research studies help us learn new things. We can test new ideas and ways of doing things. First, we ask a question. Then we try to find the answer. Myself and my friend, Ms. Adina will be doing a study right here in our D&D group! Before I tell you about it though, I want you to know that you can ask us any questions that you want to, whenever you want, and if you don't feel like joining in, tell us and it is okay.

WHY IS THIS STUDY BEING DONE?

There are kids all over the country, just like you, who also play in D&D groups with adults like Dr. _____. Ms. Adina wants to learn what Dr. _____ does in the D&D group with you all, so that she can learn how to make a group like this of her own – as well as teach other people how to do it too! You won't see Ms. Adina, but she will be video-taping our D&D groups and will be watching what Dr. _____ does when she is with you.

WHAT DO YOU HAVE TO DO?

You don't have to do anything outside of the usual D&D play we usually do. Just play like you always do! You might see a video camera or a microphone near Dr. _____, so that Ms. Adina can see and hear what is going on. Just be careful when you are walking around the room so that we can keep this equipment and you safe!

HOW LONG WILL YOU BE IN THE STUDY?

Ms. Adina will be videotaping all of our D&D sessions this summer, so this will last for all six of our meetings. When we return in the Fall, the study will be over.

IS THIS STUDY HARMFUL? HOW IS IT HELPFUL?

Being a part of this study will help us to learn about the fun you all have in this group, and how Dr. _____ makes this all happen. It will also help Dr. _____ learn so that she can make your groups even better in the future! It might even help kids in other D&D groups in other states too!

If you feel uncomfortable with anything, please let us know and we will stop and do whatever we can to make you feel better.

WILL YOU GET PAID TO DO THIS STUDY?

N/A

This is a developmentally inappropriate question to address with this age group.

ARE OTHER PEOPLE GOING TO KNOW WHAT YOU DID OR SAID?

Dr. _____ and Ms. Adina will know what you did or said in the D&D group. We will keep what you tell us private. There will be two other therapists who will also watch video of the D&D group, but they will not know your names and will not be focusing on you in the video – they will be focusing on Dr. _____. They will be learning from the video about how Dr. _____ led the D&D group

Ms. Adina might also write this in a big paper someday, but she will use a pretend name for you like Sally or Bobby, etc.

[Please see parent consent for other confidential information that is not age-appropriate to share with these participants]

CAN YOU QUIT IF YOU WANT?

You are always allowed to say no if you don't want to play D&D and be videotaped! Just let Dr. _____ know.

CAN YOU HEAR ABOUT WHAT HAPPENED?

When we are all done with the study, Dr. _____ can tell you about what she learned!

OK, WOULD YOU LIKE TO DO IT?

Dr. _____ will receive verbal assent from each child to participate in this study.

Did the child verbally assent: ____ yes ____ no

Did the child withdraw before the study was complete: ____ yes ____ no

Date:

Parent/Legal Guardian's Signature Date

Researcher's Signature Date

Appendix D: PARENTAL PERMISSION FORM

TITLE:

TABLETOP ROLE-PLAYING GAMES AS AUTISM PSYCHOTHERAPY: A VIDEO-CUED
MULTIVOCAL CLINICAL ETHNOGRAPHY

WHO IS DOING THE RESEARCH?

Principal Investigator

Adina Rubin-Budick, M.A.

Clinical Psychology, PhD Student

Duquesne University

Research Associate:

Advisor:

Elizabeth Fein, Ph.D.

Associate Professor

Duquesne University

SOURCE OF SUPPORT:

This study is being performed as partial fulfillment of the requirements for the doctoral degree in
Clinical Psychology at Duquesne University.

WHY IS THIS RESEARCH STUDY BEING DONE?

Your child is being asked to participate in a research project that involves video-taping of the D&D group therapy led by Dr. _____. The focus of the research will not be on your child, or any other children in the group, but rather on Dr. _____ as she designs and implements the therapeutic treatment. This research study is being done in order to understand how therapists, like Dr. _____, think about Table-top Roleplaying Game (TRPG) treatment – like the one your child is in – as a psychotherapeutic treatment. Video observation of the therapy and subsequent interviews with Dr. _____ will be about her clinical approach, expertise, and decision-making while she facilitates group therapy. These videos and interviews will be shown to two other therapists, who are under the oath of HIPAA confidentiality. Your child's name will not be disclosed at any time, and will be removed from audio.

In order for your child to participate in this study, your child must:

- 1) Assent to participate in the six sessions of TRPG therapy this summer with Dr. _____
- 2) Assent to be videotaped during the therapy sessions

WHAT WILL MY CHILD BE ASKED TO DO?

The things your child will be asked to do in this study include:

- 1) If you consent to have your child participate in the study, Dr. _____ will discuss the study with your child and the other participants in a developmentally-appropriate way.

2) Dr. _____ will videotape all six therapy sessions and conduct D&D group therapy.

These are the only requests that will be made of you and your child.

WHAT ARE THE RISKS AND BENEFITS OF THIS STUDY?

Participating in this project poses no psychological, emotional or physical risk to your child.

Your child's participation in this project may lend further support to already-existing programs, as well as provide them with therapeutic programming over the summer months.

WILL MY CHILD BE PAID FOR TAKING PART IN THIS RESEARCH STUDY?

There will be no compensation for child's participation in this study.

CONFIDENTIALITY:

Your child's participation in this study and any personal information that you or your child provides will be kept confidential at all times and to every extent possible.

Your child's appearance in the video will be the only identifiable information shown to other therapists, who operate under HIPAA confidentiality agreements. Your child's name and any other identifiable information will be removed from all audio and video. For the duration of the study, any and all electronic information gathered will be stored on a secure, encrypted drive.

All written and electronic forms will be kept secure. Written notes will be kept in a secure file. No identity will be made in data analysis. Any materials with personal identifying information will be maintained for three years after the completion of the research and then destroyed.

RIGHT TO WITHDRAW:

You are under no obligation to give permission for your child to participate in this study, and you may withdraw your permission within 7 days by notifying a member of the research team. Please note that once your child has assented and participated in the study, the information provided cannot be withdrawn as it will be de-identified shortly after collection.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me and my child. I also understand that my child's participation is voluntary and that I am free to withdraw my permission for my child at any time, for any reason.

On these terms, I agree that I am willing to allow my child to participate in this research project. I understand that should I have any further questions about my child's participation in this study, I may contact Adina Rubin-Budick at rubinbudicka@duq.edu or Dr. _____. Should I have questions regarding protection of human subject issues, I may contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.1886.

Parent / Legal Guardian's Signature Date

Researcher's Signature Date

Appendix E: Coding Schema

My coding will specifically identify different elements of the therapists' clinical reasoning:

A. Case Conceptualization:

- a. I will code for diagnostic language, as well as beliefs and attitudes about Autism Spectrum conditions as the therapists discuss ways in which they conceptualized client symptoms and needs.
- b. The aim is to understand how the therapist would understand the client's experience of "misfit", and what factors contribute to their lived experience and diagnostic structure.
- c. This coding will use yellow highlighting. I will also use **bold font** within this coding category to specifically note beliefs or attitudes about Autism symptomatology.

B. Interventions:

- a. I will code for the different techniques and approaches the therapists use as they discuss the ways that treatment, including specific interventions, were conducted in the video.
- b. I will specifically identify in my coding the varying psychotherapeutic traditions and modalities (ex: exposure therapy, psychoanalysis) that therapists' mention, as well as the different types of gamer or Game Master actions that the therapists use.

- c. The aim is to understand how the therapist narrates their facilitation of “fit” through the treatment.
- d. This coding will use green highlighting. I will also use **bold font** within this coding category to specifically note sentiments that highlight a gaming perspective informing the therapists’ interventions.

C. Outcomes:

- a. I will code for how therapists narrate the outcomes of treatment, such as the therapeutic goals that are planned and how they are met by clients over the course of therapy.
- b. The aim is to understand how the therapist narrates what “fit” would even look like for the client, if they were to experience it in session and in the outside world.

“There is just this great debunking of core assumptions in ASD like ‘theory of mind’. I’ve only worked with one or two guys who had a hard time entering the fantasy world and couldn’t quite get into real time. **But theory of mind is not really the root of that challenge though, the challenge is attending to facial expressions** in real time. But if I **describe the character’s expressions** in the **game as the Dungeon Master**, **they are good at guessing at it... they are good at trying to assign motives through story elements....**you just see these supposed ‘social deficits’ just melt away in game play. Theory of mind is bullshit.”

“The idea that **Autism is less ‘reciprocal’** can completely disappear in certain contexts. **Like in [gaming system]** where **there is a connection in a shared interest, shared imaginative world,** and a **rich connection** is developed. **A genuine back and forth reciprocal conversation”**

“Let the **child play through it and talk about it later.** **Let the play go on and let the person stay immersed, not be overwhelmed with how you are fucked up or what your issue is.**

I’ll give you an example of a kid who was **working on his impulsivity,** and he needed to **play through it.** After making impulsive moves in the game, **I would try to help him think of a different strategy.** **We came upon this door one day in the game** and instead of **opening it immediately,** **he said he might try something different,** like looking through the keyhole of the door first. ‘Wait! I see what you are doing...’ he said to me with a smile. He got it. **I’m not beating you over the head that ‘this is therapy’.** You know, **I’m putting your goals and your skills in,** **but I’m going to respect you individually.”**

After completing this coding, I will compile the coded sections into lists by the three categories.

An example can be seen below, using the TRPG therapist anecdotes again from above:

Case Conceptualization:

- **Theory of mind is not the root of the challenge**
- **The challenge is attending to facial expressions**
- **Autism is said to be less reciprocal**

- **Working on impulsivity** and needing to play through it

Interventions:

- I describe the character's expressions
- **In the game as the dungeon master**
- **Like in a gaming system when** there is a Shared interest, shared imaginative world
- Play through it, talk about it later
- **We came upon this door in the game one day**
- Let the person stay immersed
- Not to be overwhelmed with how you are fucked up and what your issue is

Outcomes:

- Rich connection
- A genuine back and forth reciprocal conversation
- Guessing character expressions and trying to assign motives to characters
- Try something different

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