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Child-Centered Play Therapy for Children with Autism: A Case Study

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Dedication

Since the first time I worked with her, Mary was an inspiration to me, both professionally and personally. Her family has been a major support to her personal development and this research along the way. I dedicate this research to Mary and her family.

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Abstract

This dissertation evaluated archival data from the implementation of a child-centered approach to play therapy with a young girl diagnosed with autism. Goals of treatment included promoting spontaneous symbolic play and increasing verbal communication skills. Young children with autism who engage in early intervention often receive behavioral interventions, such as applied behavior analysis (ABA), on a regular basis. However, the use of child-centered play therapy as an intervention is not as common, as play is frequently viewed as being a deficiency for children with autism. In psychological theory, play is often regarded as a child's work, and his or her primary mode of communication. Play, of any type, is vital for the healthy development of all children. Through a review of the literature, the importance of play interventions for children with autism is argued. Next, the use of child-centered play therapy with the goal of enhancing both spontaneous symbolic play and functional language for children with autism is examined. Methods for how the intervention was implemented and evaluated will be described. The results of the coded sessions are reviewed and explored. Results are then discussed through a traditional narrative case study method, highlighted by examples that occurred during therapy sessions. Information from an interview with the parents is narrated to illustrate their perspective on the implementation of the intervention, as well as their own experiences with the diagnosis. Limitations and challenges to the research are explored, followed by recommendations for future research. Finally, who should receive this type of intervention as well as when CCPT should be considered is discussed.

Keywords: child-centered play therapy, autism, case study, symbolic play, communication, language

Child-centered Play Therapy for Children with Autism: A Case Study

Chapter 1: Literature Review

Throughout the past few decades, the increase in diagnoses of autism spectrum disorders (ASD) has been substantial. However, many aspects of autism remain misunderstood. It is unclear whether the rise in the diagnosis of autism is due to better identification or an increase in the disorder's prevalence. According to Baio (2014), the rate of autism is now one out of every 68 individuals. While the exact number is unknown, it is clear that the rate of autism spectrum disorder diagnoses has drastically increased over the past two decades.

Statement of the problem. Chawarska, Klin, and Volkmar (2008) explain that the initial signs of autism can often be seen in the first or second year of a child's life. However, the majority of children affected with ASD are neither diagnosed, nor receiving proper interventions until early school age. This discouraging fact provides more reason to study autism with young children in order for educators and clinicians to be more informed about diagnosis of the disorder and how to properly intervene. Early intervention approaches, such as psychotherapy and behavioral treatments, allow children with autism to build on their own strengths, as well as provide caretakers with resources and support. While some recent research has been conducted utilizing nondirective approaches, such as child-centered play therapy (CCPT), with children with autism, the research is substantially lacking. Most studies utilizing nondirective play therapy interventions have later introduced more directive interventions, thus making the effects of pure nondirective therapy indefinable.

It is commonly thought that differences in the play of children with autism are related to problems in communication (Hobson, Lee, & Hobson, 2009). The act of play itself, can be

interpreted as a form of communication. Through this research, the effects of CCPT on the development of communication within symbolic play is examined.

Current research study. This research study examines archival data collected during CCPT with a young child diagnosed with autism, during the span of two consecutive school years. After a review of the literature regarding autism, discussion on the importance of play and communication during play, and a look at the theory behind CCPT, the intervention, data collection, and analysis will be described. Currently, the majority of research on children with autism is conducted through quantitative research methods (Wolfberg, 2009). However, qualitative research is necessary to provide a richer understanding of those diagnosed with autism (Mertens, 2009; Smith & Osborn, 2008). By using a mixed method of analysis of coding archival data and interpreting it through qualitative methods in a case study design, greater understanding of the play and communication experiences of children with autism is provided. Archival data was analyzed through a coding system adapted from Wolfberg and Schuler's (2003) Framework for Observing Children's Developmental Play Patterns. In order to protect the identity of the child involved in this research, the pseudonym "Mary" is used when referring to her.

What is Autism?

Defining autism. In Dr. Leo Kanner's first report on Autism, he stated that the "syndrome" was a congenital disorder (Kanner, 1943; Volkmar, Chawarska & Klin, 2008). In the report, *Autistic Disturbances of Affective Contact*, Kanner explained how the lack of social interest in a child with "autistic disturbances" can be seen within the first few weeks of life. He explained that children with autism do not relate socially to others in the same way as typically developing children. While there have been many modifications to his research findings since the

mid-1900s, Kanner's direction of looking at the social communication of children with ASD was at the forefront of autism research (Volkmar et al., 2008).

At the time, Kanner described physical movements in the body and difficulties dealing with change, that are listed as major symptoms in the DSM-5's diagnosis of ASD (American Psychiatric Association, 2013; Kanner, 1943; Volkmar et al., 2008). While many other clinicians during the mid-1900s believed that there was a parallel between what is now known as ASD and the diagnosis of schizophrenia, Kanner emphasized the distinct differences (Kanner, 1943). Until recent changes in the DSM-5, the term *autism spectrum disorder* included autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder, all of which shared fundamental features (American Psychiatric Association, 2000; Neufeld & Wolfberg, 2009). Rather than being diagnosed with one of the previously mentioned disorders, an individual is now diagnosed with an "autism spectrum disorder" with one of three different severity levels: (a) Level 1 – Requiring Support, (b) Level 2 – Requiring Substantial Support, and (c) Level 3 – Requiring Very Substantial Support (American Psychiatric Association, 2013). Autism spectrum disorder still remains under the heading of neurodevelopmental disorders, along with: (a) intellectual disability, (b) communication disorders, (c) attention-deficit hyperactivity disorder, (d) specific learning disorder, (e) motor disorders, and (f) tic disorders. Currently, some of the most common signs of early ASD detection are: (a) speech and language development delays; (b) low social interaction with others; and (c) some difficulties relating to sleeping, eating, and attention span (Volkmar et al., 2008). Impairments in creative thought are often seen as a distinctive feature of autism (American Psychiatric Association, 2013), which can interfere with certain types of play, such as symbolic play. Additionally, many children with autism show differences in "gaze, imitation,

joint attention, conventional gestures, attention to speech and faces, and interest in sharing interests and feelings" (Paul, 2008, p. 91). However, according to Paul, deficiencies in the method and amount of communication are often seen as one of the central symptoms of ASD. Echolalia (nonfunctional repetition of words) and self-directed and repetitive speech, along with difficulty engaging in typically developing, age-appropriate play, can often be found (Paul, 2008). As a neurodevelopmental disorder, autism can also affect many features of cognitive functioning.

Language and communication. There are three areas of detectible symptoms that distinguish an ASD: (a) obstacles in social relationships, (b) difficulties with imaginative thought, and (c) problems with social communication (Sicile-Kira, 2004). This section will focus on problems with social communication, as it exists in young children with autism. A large number of children with autism experience difficulty with mutual communication (Greenspan & Wieder, 2006). However, impairments in communication within this population vary greatly. For some, this is displayed through difficulty with back-and-forth conversation (American Psychiatric Association, 2013). Some children have difficulty with cohesive verbal and nonverbal communication, as well as irregularities with eye contact and social engagement. Many children with ASD develop speech, and later lose the ability to speak. Others never develop speech, or do so at a much later age than typically developing children (American Psychiatric Association, 2013; Sicile-Kira, 2004). If verbal communication is a difficulty, many children establish other systems of communication, such as pointing and signaling to indicate what they desire (Sicile-Kira, 2004).

For young children with autism, especially those who are nonverbal, behaviors are often a primary mode of communication (Sicile-Kira, 2004). Greenspan and Wieder (2006) explain

that when a child struggles with two-way communication, other areas of development, such as play, can be interrupted. Therefore, in order for progress in areas such as social skills and academics to occur, communication must be a primary focus. When psychologists (or other adults in a child's life) work with children with autism to develop two-way communication, the child's verbalizations can eventually become more meaningful and understood by others (Greenspan & Wieder, 2006). This can be accomplished through actions such as conversational modeling, or reflecting back what the child is doing or saying.

Communication of any form helps children with autism bridge the gap in understanding what they say and what someone else says to them, or the way they are feeling in relation to how someone else is feeling (Greenspan & Wieder, 2006). Communication that occurs during social play helps children form a more cohesive understanding of reality and their fantasy world. Greenspan and Wieder explain that the initial action in developing the desire for verbal communication is using physical gestures. When a child with autism uses physical gestures, and are responded to with the use of words, it can help children feel part of a relationship where they begin to learn how to act within that relationship. As this continues over time, children may begin to enjoy using verbal communication, as it becomes a way to connect to other people (Greenspan & Wieder, 2006).

Imitation. Dawson and Adams (1984) found that the development of cognitive abilities and social skills are closely linked with imitation abilities. It has been found that children with autism have a reduced capacity to imitate common gestures. Consequently, children on the autism spectrum who are seen as introverted have been noted to have extreme problems with motor imitation (Dawson & Adams, 1984). Piaget (1962) believed that the evolution of representational thinking was closely aligned to imitation abilities in childhood. In his famous

book *Play, dreams, and imitation in childhood* (1962), Piaget explained that when an infant was able to differentiate actual imitation from what the action represented, representational thought had begun. It can therefore be presumed that the significantly impaired ability of imitation often seen in autism is a deficiency of representational performance (Dawson & Adams, 1984).

Many studies have confirmed that children with autism have problems with multiple areas of symbolic functioning, which can also be linked to imitation (Bartak et al., 1975; Ricks & Wing, 1975; Riquet et al., 1981; Ungerer & Sigman, 1981; Wing & Gould, 1979). Bower (1977), has shown that the ability to imitate serves various social functions as well. He found that in the first few months of life, typically developing infants could often be seen communicating with their primary guardians through mutual imitation. Furthermore, this research found that imitation between infant and caregiver generates shared understanding through which language can develop. Although early research concluded that children with autism are unable to develop the ability for imitation (Dawson & Adams, 1984), more recently it has been shown that most children with autism are able to develop this ability (Greenspan & Wieder, 2006). As imitation is so closely linked to symbolic functioning and communication, interventions used when working with children with autism should include imitation and modeling.

Play and Autism Spectrum Disorder

Previous ideas about the ability to engage in symbolic play. It is often thought that children with autism have a deficiency in the ability to engage with creative thought and symbolic play (Hobson et al., 2009; Wolfberg, 1995). Hobson and his colleagues (2009) explain that many people believe that children with autism: (a) have an insufficient ability to generate ideas, such as those required for creativity in play; (b) cannot easily shift from real world thinking to a "pretend world;" and (c) do not have the motivation to participate in pretend play.

Many theorists and educators still frequently hold the idea that children with autism are unable to engage in an imaginary world. Hobson (1993) disagrees, explaining that although children with autism can develop the ability to engage in symbolic thought during play, they are often reliant on adult motivation. Following will be a discussion of how children with autism *can* engage in symbolic thought and play, and how the developmental projection of these actions often takes place.

The development of symbolic play. The development of play for typically developing children often follows a similar pattern and course (Thomas & Smith, 2004). However, the developmental trajectory of play for children with autism varies greatly from child to child (Thomas & Smith, 2004). Although typically developing children regularly display symbolic play skills around the age of two years-old, children with autism frequently begin to show these skills much later in their development (Marcu et al., 2009; Wolfberg, 2009). Wolfberg (1995; 2009) explains that without proper intervention, it is rare to observe children with this diagnosis engaging in the transformation of objects through symbolic play at any age.

Images of symbolic play for children with autism. While there are many symptomatic differences apparent among different children diagnosed with autism, the overall quality of play among children with autism tends to exhibit many consistencies (Wolfberg, 2009). In play, children with autism are often seen as experiencing difficulties in both pretending and synchronizing their social interests with peers (Wolfberg, 2009).

When children with autism play, the actions are often seen as solitary, repetitive, concrete, and devoid of innovation and imagination. Additionally, it is common to see a lack of flexibility during play. According to Wolfberg (2009), one of the most commonly found attributes of play for children with autism is the predictable manipulation of objects. These

predictable behaviors can include “banging or shaking objects, to more complex acts, such as stacking or lining up objects according to physical attributes or category” (Wolfberg, 2009, p. 46). It is common to see activities such as stacking to be more developmentally progressive than typically developing children of their age-range. Many children with autism develop significant attachments to specific objects (Sicile-Kira, 2004). Others struggle a great deal with any alterations in routine or their surroundings.

When alone and engaging in free-play, children with autism will often use repetitive gestures which can last for hours (Wolfberg, 2009). Repetitive gestures can include hand clapping, arm flapping, and spinning. At times, when these repetitive actions are established, a child may become highly frustrated if one attempts to alter or disrupt the behavior. Within toy play, children with autism are often observed lining up, stacking, or spinning objects. Additionally, there is often difficulty surrounding the detachment of play activities from a real event.

According to Wolfberg (2009), children with autism often have “specific impairments in spontaneous symbolic play that may extend to functional play” (p. 3). In other words, idiosyncrasies in symbolic play can extend into daily functional play. When children with autism engage in pretend play, supplementing other objects as real props is not often seen (Hobson, 1993). For example, it would be rare to see a child with autism using a block to pretend it is a telephone while playing. When engaged in symbolic play, the dialogue and context is often unintegrated when compared to peers. Children with autism tend to show less magical thinking than typically developing children of the same age (Wolfberg, 2009). Without the proper intervention, it is rare to observe a child with autism participating in and producing his or her own symbolic play (Hobson et al., 2009; Wolfberg, 2009).

Researchers frequently highlight the lack of interactive qualities within the play of children with autism. Often, children with autism will not automatically engage in spontaneous play with others; when a child with autism does engage in spontaneous play, it is often short-lived (Wolfberg, 2009). Children with autism often find it difficult to understand communicative signals from other people. Along these lines, they may misunderstand or fail to focus on other individuals' facial expressions and emotions. It is typical to observe a child with this diagnosis avoiding peers who are engaging in play, preferring to play alone.

Despite a difficulty with initiating connection, children with autism have the same overall desires to play and share the same need for acceptance and friendship as most typically developing children (Wolfberg, 1995; 2009). Misunderstanding social cues is a common reason for social isolation among many children with autism. More and more barriers are created between children with autism and typically developing peers through the failure of peers to accept children with autism, as well as the general misinterpretation of individuals with this diagnosis. Due to a lack of understanding interpersonal relations along with communication deficits, social and symbolic play are rarely seen or acknowledged (Hobson, 1993; Wolfberg, 1995; 2009).

Many children with autism are unintentionally deprived of their rights to "participate fully in the culture of play with peers" (Wolfberg, 2009, p. 51). This is due to the intense structured interventions that are frequently utilized when working with children with autism. It is also likely that when considering some of the more nonfunctional symptoms of the diagnosis, children with autism have generally been lacking the *opportunity* to attempt engagement in this form of play. Instead, interventions are regularly geared towards daily life skills and communication. Some therapists believe that structure and modeling are necessary for children

with autism to engage in symbolic play. However, incorporating a child-centered environment is becoming a more popular and considered idea for intervention. Considering all of the shortcomings regarding research in the combined area of communication, play, and autism, further understanding of the experience children with autism have during play must be more fully researched.

Play Theory

In *Emile*, Rousseau (1792/1930) discussed the significance of observing children during play in order to begin to understand their lives. Early on, he observed that children were wrongly being treated as miniature adults. Almost two centuries later, Froebel (1903/1955) investigated the representative elements of play in *The Education of Man*. He explained that play has both a conscious and unconscious purpose, no matter who is doing the playing, and how they are involved. Froebel intelligibly described that play is *full* of meaning. To this day, American culture still struggles to consider the individual lives of children and treat them as distinctive people. Whether it is in everyday life, or the therapy room, children are frequently approached without recognition of their place in development. The play of children is often seen as a background activity and not considered to be significant.

The developmental functions of play. In contrast to those who do not believe in the significance play has on development, many theorists consider play to be one the most important acts in a child's life. For example, Winnicott viewed play as the "benchmark for the entrance into a life of health and vitality" (Tuber, 2008, p. 119). He believed in the importance of play, as it allows children to engage in a magical "to-and-fro" (p. 121) with both objects and individuals (Tuber, 2008). Winnicott (1971) described play as a transitional area that is neither inside, nor outside the individual. Developmental psychologist Susan Engel (2005) looks at play as a

universal action involving an activity that is in some way inherently significant to the player, and is noted in some way as being fictional. When engaging in play, children learn about the emotional states of other people, and how to navigate in the real world (Wolfberg, 1995). It is through play that a child is able to discover and understand the true self (Tuber, 2008; Wolfberg, 2009). Within the act of playing, a young child can experience both solitude and relatedness to the other (Tuber, 2008). Therefore, play can be seen as being especially important for children who have difficulty relating to others, such as children with autism.

The irregular nature of play makes the act itself a phenomenon (Tuber, 2008). The representational aspect of play can aid a child in feeling connected with the outside world (Tuber, 2008). As life is about relating to others, play can be seen as helping children understand and experience both the sense of aloneness and togetherness. Furthermore, it is through play that a child learns he or she is not alone in the world. In play, children act out the types of interactions they have experienced with other people (Tuber, 2008). The people, objects, and stories represented in a child's play, evoke the types of affect with which he or she is familiar. Due to the spontaneity of play, the act does not have "a specific end goal, nor is it a means of conformity or compliance" (Tuber, 2008, p. 133). The meaningfulness of play derives from the creativity of a child.

In his book *Mind in Society*, Lev Vygotsky (1978) expressed his beliefs on play, describing it as one of the most important activities for a child's social development. He described play as a time when a child can experience life as different characters and be in imaginary situations. When engaging in symbolic play, children develop an ability to understand guidelines and truths of the real world as well as the worlds they create in play. Vygotsky

explained that one of the most vital factors in any child's development of social growth is play-based interactions with the self, other children, or adults.

In play, children are able to acclimate to the world and generate novel adventures of learning (Elkind, 2007). It is a critical element in one's development, which allows people to make sense of their experiences and desires (Schiller, 1967). By engaging in play, children become "active consumers and producers of their own symbolic culture" (Corsaro, 2003, p. 91). In play, children use their images of the culture around them, and fabricate stories related to their own lives, in order to understand their experiences.

Experiences of symbolic play: The child's right to play. Piaget (1962) explained that the act of playing links experiences in reality to abstract thought. The representational functions in play are the most important to understand (Landreth, 2012; Piaget, 1962). Landreth explains that "play represents the attempt of children to organize their experiences and may be one of the few times in children's lives when they feel more in control and thus secure" (p. 16). Through play, children can express their inner feelings and lives. Experiences and feelings in the real world that may appear to be unmanageable and difficult to express through verbal language, can often be expressed more readily through symbolic play (Landreth, 2012). Moreover, this experience models self-directed examination as a coping strategy in the "real world."

When children play in a pretend context, they incorporate daily activities with a working imagination to make meaning of their daily experiences (Segal & Adcock, 1981). Children's symbolic play is not necessarily meant to be a replication of the world (Sutton-Smith, 1997). A child's make-believe world can be seen as a fabricated reality that lies alongside the real world. When children begin to pretend, their thoughts often become symbolic in form (Segal & Adcock, 1981). As this process continues, the distinction between fantasy and reality begins to be

understood.

Symbolic play lays the preliminary outline for a child's personal creative development (Singer & Singer, 1977). "Pretending is a form of thinking and learning as well as a form of play. It is not easy to create a pretend reality-both concentration and inspiration are needed to keep the illusion alive" (Segal & Adcock, 1981, p. 30). When children engage in symbolism through play, they begin to develop adaptive skills that will be useful throughout the entire lifetime.

According to Casby (2003), typically developing children develop the capacity for symbolic thought throughout the first four years. However, he explains that the first signs of pretense can often be seen between 12 and 18 months. Before a child is verbal, adults will often captivate children with games of joint attention (Casby, 2003). Around the age of four or five, typically developing children will often talk about pretending to help themselves establish what is real and what is make-believe (Engel, 2005). Talking about the act of pretending is a signifier that young children are concerned with their own thoughts and experiences. In addition, by engaging in symbolic games, children are able to apply rational skills to help them later on in adult life (Singer & Singer, 1990).

Symbolic play includes actions such as object replacement, visualizing missing objects within play, and giving new qualities to absent objects (Lewis & Boucher, 1995). This form of play can be explained as a child's utilization of objects, motions, or stories indicating the representation of other objects or ideas. In symbolic play, children use fictitious objects without tangible stimuli (Marcu et al., 2009).

Play therapy. In 1909, the first published case of therapeutic work through play with a child was Sigmund Freud's famous case of "Little Hans" (Freud, 1909/1955; Landreth, 2012). Little Hans chronicles the phobia of a five year-old boy. To this day, it is the first recorded case

in which a child's psychological symptoms were attributed to emotional causes. Succeeding the work of Little Hans, Hermine Hug-Hellmuth began to draw attention to play as being crucial to psychoanalysis with children (Landreth, 2012). She emphasized the importance of providing play materials to children in therapy to help them express themselves. Hug-Hellmuth did not formulate her own approach to play therapy, but discussed the trouble with applying adult therapy methods when working with children in therapy. She was one of the first theorists to recognize that unlike adults, many children are unable to verbalize their struggles and experiences, and can more easily express themselves through play.

In 1919, psychoanalyst Melanie Klein (1955) began to utilize play in child therapy as a way of analyzing children under the age of six. Klein believed that the play of children could be compared to free association in adults. According to Landreth (2012), Klein was convinced that play therapy allowed the therapist to enter into the child's unconscious. She used play as a way to motivate children to express their desires and struggles. Klein (1955) extracted symbolic meaning from play, and later interpreted the meaning. She believed that the unconscious was the most important aspect of a child's experience, and that through examining the transferential relationship between the therapist and child, the unconscious could be reached. She believed that desires and anxieties surfacing in the therapist-child relationship could be traced back to the child's parents as his or her first "love objects" (Klein, 1955; Landreth, 2012). Klein surmised that by re-experiencing and understanding early emotions, "gaining insight through the therapist's interpretations, diminished the child's anxieties" (Landreth, 2012, p. 30).

As play materials, Klein (1955) used small wooden people, cars, animals, houses, balls, marbles, and craft materials. To symbolize the private relationship between the child and therapist, Klein delegated a locked drawer to each child client where they could store play

materials. Although she maintained physical boundaries of safety in the therapy room, Klein allowed children to act out any aggressive fantasies, both verbally and physically (Landreth, 2012).

Around the same time Klein began practicing play therapy, Anna Freud employed play as a way to stimulate the alliance between the child and therapist (Landreth, 2012). She used play as a way to promote positive emotional attachment between the child and therapist and "as a way to gain access to the child's inner life" (Landreth, 2012, p. 30). Like Klein, Freud believed that play was the mechanism through which children could understand and express their environments freely (Landreth, 2012). In contrast with Klein's beliefs, Freud emphasized the importance of creating an emotional bond in the therapeutic relationship, before interpretations of play could be made (Freud, 1965). She seldom made direct interpretations of a child's play, and believed that not all actions in play were symbolic (Landreth, 2012). When play exhibited parroting of recent experiences in a child's life, Freud believed that it had little emotional significance. She never provided direct interpretations of a child's play until she had gathered substantial insight from observations of play and background history from the parents.

Following her father's footsteps with free association, Anna Freud supported her child clients in verbally expressing daydreams or fantasies (Freud, 1965; Landreth, 2012). If the child displayed difficulty verbally disclosing emotions, she offered the option of "seeing pictures" (Landreth, 2012). In using this technique of engaging the child in a "feeling-level experience," Freud believed that the child would be able to learn how to verbalize underlying thoughts and begin to discover the meaning and significance behind the thoughts, thus gaining access into the unconscious. As the therapeutic relationship developed over time, Freud would begin to shift the

emphasis of play during sessions, to an emphasis on more verbal communication (Landreth, 2012).

During the middle of the 1900s, Virginia Axline developed the concept of CCPT (Bohart, 2003). As a student and colleague of Carl Rogers, Axline believed that the client was the primary agent of change, not the therapist. Axline (1969) created eight basic principles to help guide the child-centered play therapist: (a) the therapist should develop a trusting and affectionate relationship with the child, (b) the therapist must accept the child where he or she is, (c) the therapist should be lenient enough that the child experiences freedom in fully expressing his or her emotions, (d) the therapist recognizes the feelings and reflects them back to the child in a genuine manner, (e) the therapist truly believes that the child is able to solve his or her own problems, (f) the therapist refrains from directing any actions, speech, or play for the child, (g) the therapist has patience with the gradual therapeutic process, and (h) the therapist only creates limitations necessary to anchor the relationship in the world of reality. The thinking behind CCPT was that instead of the therapist leading therapy, children would now be in charge of the pace, direction, and content of the therapeutic journey.

The importance of nondirective play therapy for children with autism. A child's world is one of tangible realities filled with experiences that are understood and expressed through daily play (Landreth, 2012). To begin to scratch the surface at understanding a child's reality, psychotherapists must let go of their own idea of what truth is, and enter into the abstract, subjective world of the child. As a child's natural mode of communicating is through play, utilizing this activity in therapy is of utmost importance. In therapy, playing acts as a way for children to unconsciously communicate their experiences (Landreth, 2012).

Through self-initiated, nondirective play, children are able to more thoroughly and directly communicate their experiences (Landreth, 2012). Landreth believes that a child's play is the most organic and therapeutic practice in which they can process their feelings and experiences. If play is not an option in therapy, and children are limited to verbal expression, an immediate barrier is constructed within the therapeutic relationship. Limiting children to using only verbal language in psychotherapy sends the message that they must enter the adult therapist's world, as opposed to the therapist entering the child's reality. It is the responsibility of the therapist to communicate with the client through the mode in which the child feels most comfortable.

A therapeutic alliance with child clients can be most thoroughly created through play (Landreth, 2012). The alliance and therapeutic relationship are essential for the process of therapy to move forward. When a strong therapeutic alliance exists, "play provides a means through which conflicts can be resolved and feelings can be communicated" (Landreth, 2012, p. 10). Young children often do not have the developmental capacity to verbally express their emotions and feelings, which can result in a great deal of frustration (Landreth, 2012). When experiences and feelings are frightening for a child to express directly through language, they may be communicated through playing.

Due to the recent drastic increase in the diagnosis of autism in children, there is a heightened need to develop effective intervention strategies to address difficulties such as play, symbolic thought, social relatedness, and problems with communication. In the past, many researchers and those directly working with children with autism disregarded the importance of strengthening play for children within this population. The belief was that play had a fairly small

impact on treatment and education within this population (Thomas & Smith, 2004; Wolfberg, 2009).

On average, children with autism are proven to show a lower degree of symbolic play than typically developing children (Marcu et. al., 2009). Thomas and Smith (2004) explain that a possible reason for this is that play is difficult to both define and measure. However, as a result of an increasing understanding of the importance of play on child development for typically developing children, the focus on the importance of this topic for children with autism has increased. Consequently, more and more play interventions are being created for children with autism, including both directive and nondirective approaches (Thomas & Smith, 2004).

Interventions for Children with Autism

Currently, psychotherapeutic interventions based on behaviorism are most commonly used when working with children with autism (Dawson & Adams, 1984). Behavioral interventions for children with autism include, but are not limited to: (a) cognitive behavioral therapy, (b) social skills training, (c) systematic desensitization, (d) applied behavioral analysis, and (e) early intensive behavior intervention. Although behavioral interventions are extremely successful in removing self-destructive behavior and strengthening language abilities and social behavior, there are many qualities that remain untouched (Dawson & Adams, 1984). New behaviors that have arrived through the inclusion of behavioral interventions frequently fade once the reinforcement has ended.

In their article about intervention strategies for individuals diagnosed with autism, Yoder and Calculator (1981) looked at the degree to which behaviorally taught responses have both conceptual and expressive significance for children. As opposed to behavioral interventions, developmental interventions produce an organized, yet unconfined environment where

appropriate behavior is more likely to be yielded by children at their own pace and comfort (Dawson & Adams, 1984). "Because the learning is child-initiated and therapist-facilitated, rather than therapist-initiated, the behavior is more likely to make conceptual sense to the child and be incorporated into a spontaneous repertoire in a range of settings" (Dawson & Adams, 1984, p. 212).

Behavioral interventions and play therapy can supplement one another. According to Dawson and Adams (1984), research that has been completed with typically developing children shows the ability for imitation is a necessity for symbolic formation to be achieved. Additionally, through imitation, a child has the chance to practice communication and social skills (Dawson & Adams, 1984). These skills are vital for children with autism to gain symbolic functioning.

There are various play interventions that can be used when working with children with autism. Although there is a common belief that children with autism do not know how to play "as well" as typically developing children, play interventions with this population are becoming more and more research and utilized. In a study looking at play abilities of children with autism in comparison to intellectually disabled children, Wing and her colleagues (1977) found that all play they witnessed in these populations could be catalogued into three groups: (a) symbolic play, (b) stereotyped play, and (c) non-symbolic play. There were 108 children involved in the study who ranged from five- to 14-years of age, 61 of whom were diagnosed with autism. They found that none of the participants diagnosed with autism displayed symbolic skills in their play activities, while 33% illustrated some evidence of stereotyped play (Wing et al., 1977). Additionally, 67% of the participants with autism exhibited non-symbolic play. Through the proper play-based interventions, children with autism may begin to develop the skills to engage with a symbolic play environment.

Theoretical Foundations: Child-Centered Play Therapy (CCPT)

Part of the humanistic family of psychotherapy, the foundation of CCPT comes from person-centered theory, originally called nondirective or client-centered psychotherapy (Sweeney & Landreth, 2011). Developed by Carl Rogers (1951), person-centered therapy (PCT) was adapted into nondirective (or child-centered) play therapy by his mentee and colleague, Virginia Axline (1969). Focusing on the therapeutic relationship, CCPT relies on play as a major method of communication. Axline's child-centered approach to play therapy follows the fundamental premise of PCT by focusing on the process of therapy for the individual client (Axline, 1969). Within this theory, the therapist is seen as a contemporary explorer engaging in the journey of self-discovery alongside the child (Bohart, 2003).

Diagnoses and techniques in CCPT are viewed as secondary, while the therapist's empathy and unconditional positive regard toward the client are of primary importance (Guerney, 2001). Therefore, a strong and intact therapeutic relationship is vital for growth to occur (Bohart, 2003). Therapists working from this frame accept the child's reality without challenging it (Guerney, 2001). In fact, it is the job of the therapist to create a safe space where the child is free to unveil his or her unique world.

Arthur C. Bohart (2003) explains that over time, child clients learn to self-heal as they become more empowered and confident. In CCPT, the child-client is seen as the primary agent of change, not the therapist (Bohart, 2003). One of the most prominent innovators of CCPT, Louise Guerney (2001), explains that play therapy is most influential when the child has authority over the direction of play. In CCPT, the child is able to direct both the content and the direction of play (Guerney, 2001). Instead of focusing on behavior or the source of symptoms, CCPT places priority on the child in the present moment (Sweeney & Landreth, 2011). In other

words, the CCPT therapist works alongside the child throughout the therapeutic process. The theory posits that whether or not the child verbally discusses the reason for referral in session, it will eventually be acted out through a play medium (Guerney, 2001).

Main aspects of CCPT include total acceptance of the client, empathic understanding, and genuineness from the therapist (Sweeney & Landreth, 2011). According to Rogers (1951), there are six major conditions needed to result in personality changes for a client: (a) a strong relationship between the therapist and client, (b) balance between the client's experience and awareness, (c) genuineness on behalf of the therapist, (d) unconditional positive regard, (e) empathic understanding, and (f) the client's perception of the therapist's unconditional positive regard and empathy. In addition, Axline (1969) created eight basic principles to help guide the child-centered play therapist: (a) the therapist should develop a trusting and affectionate relationship with the child, (b) the therapist must accept the child where he or she is, (c) the therapist should be lenient enough that the child experiences freedom in fully expressing his or her emotions, (d) the therapist recognizes the feelings and reflects them back to the child in a genuine manner, (e) the therapist truly believes that the child is able to solve his or her own problems, (f) the therapist refrains from directing any actions, speech, or play for the child, (g) the therapist has patience with the gradual therapeutic process, and (h) the therapist only creates limitations necessary to anchor the relationship in the world of reality. While all of Rogers' conditions and Axline's principles are necessary for therapy, the heart of a child-centered approach to play therapy is meeting the child where he or she is, and accepting his or her reality (Guerney, 2001).

According to the theory behind CCPT, an individual's personality is reasonably flexible and forever evolving (Bohart, 2003). Personality traits may continue to grow over time, while

continually maturing. Most personality changes occur in fairly small, subtle adaptations (Bohart, 2003). CCPT views the evolving nature of personality as a process (Guerney, 2001). Founder of the Center for Play Therapy, Garry L. Landreth (2012), explains that the child-centered play therapist believes in, and is able to have confidence in, the *self-concept* of the child. Every child has his or her own view of the world and the self (Landreth, 2012). The self-concept is the child's perceptions about him or herself in relation to the outside world (Landreth, 2012). Landreth describes each child as living in an ever-changing world in which what the child experiences as reality, *is* their reality. Children create ideas and form beliefs about themselves and the environment through their own experiences and relationships (Landreth, 2012). As these created beliefs become a reality for each child, the development of a positive self-concept becomes a major goal through the implementation of CCPT. The positive self-concept is hoped to be observed in the child's daily life outside of therapy.

The theory's idea of *self-actualization* is grounded in the idea that children have an inherent need to develop and mature over time (Landreth, 2012). Landreth explains that children are thought to be forever striving for self-actualization, which is achieved through autonomy, self-direction, and natural maturing. With a positive self-concept, and a sense of complete acceptance in the world, a child can become fully adjusted and eventually reach self-actualization (Landreth, 2012). The child's view of him or herself, whether healthy or maladjusted, is the basis for understanding a child-centered approach's conceptualization of personality structure (Landreth, 2012). Therefore, the ideas of the *self-concept* and *self-actualization* are two of the most important concepts in CCPT.

Interventions. "The process of nondirective therapy is so interwoven that it is difficult to tell where one principle begins and another ends. They are overlapping and interdependent"

(Axline, 1969, p. 89). As a result, specific interventions within a child-centered approach are often difficult to outline. CCPT is a philosophy of therapy, not a string of techniques or interventions that live only in the playroom (Landreth, 2012). The approach is a "complete therapeutic system" (Landreth, 2012, p. 53), which relies on the child's ability to be self-directing. To be a successful child-centered play therapist, one must believe that children are capable of maturing on their own (Landreth, 2012). Therefore, CCPT interventions can be understood as support from the therapist towards the client. Primary child-centered interventions include: (a) unconditional positive regard, (b) accurate empathic understanding, and (c) congruence (Landreth, 2012; Rogers, 1986).

Unconditional positive regard. The idea of unconditional positive regard is a trademark in many theories of psychotherapy. However, this idea is one of the major features of CCPT (Landreth, 2012). A child is often referred for therapy because his or her guardian, teacher, or caretaker is looking to change something about the child's behavior or personality (Axline, 1969). The child may enter therapy feeling a sense of defeat. As a result, complete acceptance on the part of the therapist is vital. This absolute acceptance is an important aspect of building a trusting therapeutic relationship (Landreth, 2012). Within CCPT, the therapeutic relationship is demonstrated as an extension of a positive relationship that may be seen in the outside world (Landreth, 2012).

Along with other CCPT interventions, displaying unconditional positive regard is not done in a prescribed manner (Landreth, 2012). It is a perspective that should always be applied when working with children. Unconditional positive regard is a therapist's positive attitude toward the child that remains nonjudgmental (Axline, 1969). This attitude can also be looked at as a sense of confidence in the client that seeps into the therapeutic relationship (Landreth,

2012). In other words, this form of acceptance is seen as absolute respect from the therapist towards the child (Axline, 1969).

Accurate empathic understanding. For accurate empathic understanding to occur in therapy, the therapist must understand the child's subjective world, and join him or her in that space (Hobson, 2002). Appreciation of the child-client must be displayed by the therapist's approach towards the child (Axline, 1969). Through accurate empathic understanding, children are given the freedom to process their own feelings and experiences of the world, often occurring through play (Landreth, 2012). The therapist enacts accurate empathic understanding when he or she joins children on their level, and in their individual world (Axline, 1969). Utilizing accurate empathic understanding means that the therapist must never shame the child. The stories and histories created in the playroom belong to the children, and when invited, the therapist is often able to enter their subjective world (Landreth, 2012).

Congruence. Congruence is displayed as complete genuineness on the part of the therapist (Sweeney & Landreth, 2011). When a child enters therapy, a child-centered play therapist believes the client is in a state of incongruence (Rogers, 1951). As a result, it is the therapist's job to aid in the reversal process. The therapist can model an overall sense of genuineness in the session, displayed through words, actions, and body language (Axline, 1969).

In order for congruence to exist, the therapist must have insight and be in harmony within the therapeutic relationship (Landreth, 2012). In addition, Landreth explains that the therapist should be aware of, and accept, his or her own feelings towards the therapy. Complete genuineness within the relationship allows the child to experience the therapist as a human with feelings, instead of as a professional (Axline, 1969).

Child-centered play therapy with children with autism: A new approach. "Children do not need to be taught how to play, nor must they be made to play" (Landreth, 2012, p. 7). CCPT does not *teach* children to play, but allows children to explore their own mode of playing at their own pace while developing communication skills. When a nondirective approach to play therapy is used with children with autism, it allows for the child to engage in spontaneous imitation (Dawson & Adams, 1984). In this approach, the therapist is not required to prompt the child to imitate. Instead, the child is given as much time and space as needed to explore the environment and the play possibilities within it. The therapist is present to be as involved as much or as little as the child-client wishes. In this way, the child-centered play therapist can be seen as an equal participant in the therapeutic relationship.

Unlike behavioral interventionists, the child-centered play therapist's job is to participate in a relationship with the child client through his or her organic method of communication through play (Ray, Sullivan & Carlson, 2012). Behavioral interventions do not typically address the developmental trajectory for children with autism. However, CCPT provides a space for the therapist to meet the child where he or she is developmentally. CCPT is a method of working with children in therapy that underlines the importance of the therapeutic relationship and communication in that relationship. The relationship between the therapist and child is the main therapeutic factor in CCPT. Despite the initial research stating that CCPT can be utilized with any children other than those diagnosed with and autism or schizophrenia, the philosophy behind this theory actually makes it exceptionally suitable in addressing some of the core difficulties seen in children with autism (Ray, Sullivan, & Carlson, 2012), such as limited social relatedness and communication difficulties.

Benefits of a relationship-based intervention. Greenspan and Wieder (2006), distinguished three fundamental relational limitations for children with autism: (a) difficulties in creating close relationships, (b) problems using emotional gestures, and (c) trouble with using words or symbols with desire. These three core relational challenges can be improved through CCPT over time (Ray et al., 2012). Lack of communication within primary relationships in a child's life, is often viewed as a predominant concern about those properly diagnosed with autism. As children with autism form close relationships with their child-centered play therapist, they will later be able to demonstrate this closeness with other significant individuals outside of the therapy room, such as caregivers and friends.

As a relationship-based intervention, both the relationship itself and ways in which communication occur contribute to therapeutic growth (Ray, Sullivan & Carlson, 2012). Therefore, it can also be theorized as a "relational communication intervention" (Ray et al., 2012, p. 166). The primary goal of using CCPT as an intervention for children with autism is to present a relationship to the clients where they are able to progress towards self-enhancing acceptance (Ray et al., 2012). This occurs through the opportunity to engage in child-directed play and use of communication within the security of a safe therapeutic relationship. A child-centered play therapist works to address the primary relational challenges of autism by contributing to a safe and secure relationship.

CCPT allows the therapist to enter the world of the child and use the relationship as an intervention, rather than "training" children to engage in behaviors that conflict with their natural ways of being. Often, children with co-morbid diagnoses are treated with interventions that focus on specific symptom management and negative behavior reduction, instead of working with the individual as a whole. According to Kanne (2013), diagnostic overshadowing is the bias that can

ultimately influence a psychologist's therapeutic judgment in regard to clients with co-occurring disorders, such as autism and ADHD. Often, symptoms or behaviors the client may be exhibiting are attributed to a diagnosis, as opposed to possible other life occurrences. CCPT allows the therapist to approach the child from a place of wonderment and joining. Therefore, child-centered play therapists work with the individual child as a whole, and do not place much focus on specific symptoms or behavior management.

Essential elements of CCPT and their relation to autism. There are three crucial components of CCPT that result in the enhancement of play and communication behaviors associated with autism: (a) full acceptance of the child by the therapist, (b) the nonverbal focus of the intervention, and (c) focus being placed on the child for who he or she is and where he or she is in the moment (Ray et al., 2012). Ray et al. (2012) explain that children with autism are frequently not fully accepted due to a myriad of behavioral factors. Many methods of intervention for this population target problem behaviors and aim to "fix" the behaviors (Ray et al., 2012). Therefore, children with autism rarely experience affirmation and appreciation of who they are. Moreover, interventions designed for this population often require children to enter into the typically-developing adults' world. With CCPT, the child is given a distinct experience where the adult therapist enters the child's reality on the child's own terms (Ray et al., 2012). Full acceptance of the child, or unconditional positive regard, shows the child that he or she is seen as an equal. When children experience feelings of safety and mastery, self-confidence grows and they may feel more motivated to interact with others in their world. Additionally, over time, this acceptance often permits children to engage in two-way communication and joint play with the therapist, thereby resulting in new relationship capacities outside of the therapy room.

In CCPT, children are not obliged to communicate verbally or "socialize" with the therapist (Ray et al., 2012). However, the therapist remains engaged with the child client through verbal reflections of behaviors and communication, as well as nonverbal reactions. Accompanying children through therapy with this form of modeling, gives children with autism the stepping-stones to begin communicating in whatever ways they may feel are most comfortable.

Previous research on CCPT with children with autism. In recent years, research has been conducted using CCPT with typically developing children, in addition to a plethora of research on treatment interventions for children with autism spectrum disorders. However, very little research has been carried out using CCPT when working with children with autism in therapy. More often than not, research on children with autism focuses on behavioral treatments. However, more recently, psychodynamic play therapy has been utilized in autism treatment research (Josefi & Ryan, 2004; Kenny & Winick, 2000). I believe that utilizing a CCPT approach with children with autism will help promote pretend play skills and language development. As using nondirective play as the primary method of intervention with CCPT, children with autism are able to decide on the rate and content of their therapy (Josefi & Ryan, 2004). The therapeutic relationship established through CCPT later can be seen as enhancing other important relationships outside the therapy room (Ray et al., 2012).

In Kenny and Winick's (2000) study with a young girl with high-functioning autism, they used nondirective play therapy along with directive intervention techniques. The initial phase of treatment utilized CCPT, to form a relationship between the client and the therapist (Kenny & Winick, 2000). More directive techniques were used later in the therapeutic process to focus on specific behavior reductions. Kenny and Winick found that the client responded more

emphatically to the CCPT, and they credited her behavioral alterations and emotional progression to nondirective play therapy. They found that when directive interventions were introduced, the progress she had made through CCPT began to slow down.

In a 2004 research article, Josefi and Ryan looked at the effects of CCPT on therapeutic relationships, attachment behavior, autonomy, and pretend play with a young boy with autism. The goal of their research was to find out if nondirective play therapy could be used successfully in conjunction with behavioral treatments for an all-around treatment plan for children with autism (Josefi & Ryan, 2004). They found that CCPT was effective in areas that behavioral interventions fail to address, such as helping to build the client's sense of autonomy, joint attention, concentration, relationship with the therapist, and in the growth of symbolic play.

Summary

Throughout the past few decades, there have been extraordinary promotions in the research and understanding of children with autism (Wetherby & Woods, 2008). The growing number of autism diagnoses made during this time has prompted this growth in research. Creating and learning about interventions for autism and their effectiveness is vital at this time. The inclusion of play in interventions for children with autism has been scarcely used in the past (Wolfberg, 2009). However, because play is of central importance to the development of all children, and the deficiencies in play are significant in children with autism, it is important to look at the methods of using play in future interventions for this population. If researchers and clinicians do not have a complete understanding of the obstacles children with autism encounter in play and communication, proper interventions are not likely to be utilized even though the necessity is clearly apparent. Utilizing CCPT as an adjunctive therapy is likely to help promote communication skills and spontaneous symbolic play for children diagnosed with autism, as it

taps into areas of behavior not reached in behavioral interventions such as applied behavior analysis.

Research Questions

1. Will a child-centered approach to play therapy with a young girl with autism be associated with spontaneous symbolic play?
2. Will a child-centered approach to play therapy with a young girl with autism be associated with improvements in verbal methods of communication and language?
3. Will other symptoms improve during the course of CCPT with a young girl with autism?

Chapter 2: Method

This dissertation sought to expand the research on the effects of child-centered play therapy on the symbolic play and communication skills of children with autism. The study aimed to expand on ideas gathered from previous research on utilizing CCPT as a psychotherapeutic intervention with a young child diagnosed with autism. Based on the research findings described above (Josefi & Ryan, 2004; Kenny & Winick, 2000), this study used a child-centered approach to play therapy with minimal therapist encouragement with Mary (a pseudonym), who was diagnosed with autism. The overall goal of this study was to see if CCPT could be used as a therapeutic intervention to help promote spontaneous symbolic play as well as communication skills. To evaluate the usefulness of the intervention, a mixed methods study using both quantitative and qualitative measures was used.

Research Design: Case Study

When using a case study design for research, it is important to note that findings within groups are not always more extensive than findings acquired from an individual case (Kazdin, 2003). In almost every area of psychology, including child psychology, individual subject research has supplied critical details about human behavior and development. Additionally, Kazdin explains that the field of psychology often learns a great deal from extensive research on individuals conducted over time. Case studies can be used to examine individuals, groups, or cultures. Within the realm of clinical psychology, Kazdin explains that case studies typically pertain to unstructured and narrative cases. Due to the nondirective and uncontrolled nature of CCPT, as well as working with one individual, a case study is an appropriate research technique to follow.

As a rule, case studies indicate methodical and in-depth examinations of an individual (Kazdin, 2003). For a case study to be considered a valid research method, four different characteristics must be present: (a) it must be an in-depth examination of an individual, (b) the information presented should be thoroughly detailed, (c) the individual involved should be distinctive or unique in some way, and (d) the case study should begin in the present moment and not focus on information gathered from other researchers in the past (Kazdin, 2003). Case studies regularly emphasize details, and as a result, incorporate written descriptions, narratives, and vignettes. To accomplish this, the present study chronicles experiences and behavioral changes over time with a cohesive description of details about the individual, the intervention, and the ways in which the treatment transpired.

Despite the potential for a lack of objectivity, the realistic qualities of case studies make this method of research a valuable source of information drawing on diverse theories and practices (Kazdin, 2003). Case studies in psychological research (a) give us ideas about development and behavior, (b) typically aid in the development of intervention techniques, (c) allow for research on unique cases, (d) are beneficial in contributing contradictions to ideas and interventions previously known as truths, and (e) can be extremely convincing (Kazdin, 2003). Additionally, many developments in the field of psychology were brought to the forefront through well-known case studies. For instance, Sigmund Freud's case of Little Hans is one of the most well-known case studies still cited in the psychodynamic community (1905/1955).

While using a case study research design was most fitting for this long-term project, some limitations to using this approach have been noted. Due to the young age and communication difficulties of the participant, her subjective experience cannot be fully understood. However, through her play, we begin to understand parts of her experience as

interpreted by myself. Typically, case studies depend on narrated information in which subjective perception plays a critical role (Kazdin, 2003). However, this study used coded information gathered from videotaped sessions, to more objectively observe the symbolic play and communication skills acquired over time. To gain a more objective point of view, the information gathered was watched and analyzed by both myself and another graduate student. This brought another perspective to light, instead of that solely of the primary researcher (Kazdin, 2003). Additionally, it is hard to attribute changes in behavior as a direct result of the intervention, as other factors such as development and external life events can result in change.

One of the most concerning limitations when using a case study is that the information acquired cannot always be generalizable to other individuals, even those with similar symptoms. While this can be interpreted as a shortcoming to the design of the current study, the purpose of this research was to demonstrate that the utilization of CCPT in therapy with children with autism should not be automatically ruled out. Rather, the intervention should be considered as an adjunctive therapy along with other traditional interventions (e.g., applied behavior analysis) provided for children with autism. Additionally, this research is aimed at adding to evidence indicating that children with autism have the ability to engage in symbolic play and that engaging in play can help to improve their utilization of language and communication skills. Despite the limitations, using a case study design with quantitative analysis gives an objective look into the subjective experience of a child with autism as her symbolic play and verbal communication skills increase over time.

Intervention

Participant. During the intervention, the young child involved in this study, Mary, was a student at a public elementary school in a rural town in the United States. She was in

psychotherapy with me for two consecutive school years (See Appendix A). Due to the importance of tracking therapeutic progress for Mary's Individualized Education Plan (IEP), her parents agreed to allow videotaping of the sessions (see Appendix B). After consent was obtained, these videotapes, along with session notes, were archived for the present case study. She participated in CCPT with me, once per week for about 45 minutes each session for 52 sessions.

The therapy began when Mary was six years old and continued until she was eight years old. She was formally diagnosed with autism spectrum disorder at the age of five years. Additionally, while her parents and medical doctor believed she had ADHD, her parents decided not to go through with a formal diagnosis, for fear they would be pressured to put Mary on medication. At the onset of therapy, Mary's symptoms included little-to-no verbal communication, infrequent play with others, very little symbolic play, high energy, difficulty staying on task, and frequent tantrums. When we began working together, she was considered to be nonverbal, and communicated by using the applied behavior analysis (ABA) picture exchange communication system (PECS), and through frequent tantrums and some aggressive behaviors. Little to no symbolic play was present at the beginning of therapy.

At the onset of CCPT, Mary received interventions through ABA, as well as speech and language therapy and occupational therapy, all of which continued throughout our therapy together. ABA is a skill-based treatment that is often viewed as the most successful method of instructing young children with autism (Sicile-Kira, 2004). Behavioral skills are enforced by using small steps, such as encouraging through prompting, conditioning, and rewarding (Sicile-Kira, 2004). CCPT was used as an adjunctive intervention in conjunction with ABA in order to facilitate the skills of symbolic play and communication.

School setting. The setting for this research project took place in a rural elementary school within the United States. The town where the school resided was small, with a low socioeconomic status. Many individuals who were residing in the town lived below the poverty line and received financial assistance from the government.

All videotaped therapy sessions were conducted in a school psychotherapy office, which became familiar to Mary very quickly. However, there were times when portions of the sessions took place playing in the hallways and looking at artwork throughout the school. Only time spent in the therapy office was videotaped. During the first year of work with Mary, the psychotherapy office was approximately 30 feet by 30 feet. After a renovation, the space became about 10 square feet smaller. The office was formerly a school classroom, and maintained the bulletin boards and shelving of a classroom. The office had three desks and chairs; each in its own corner of the room. There was a small corner of the office designated for play therapy, with a tall shelf full of toys and art supplies. Typically, Mary only used the space where my personal desk sat. However, she also utilized multiple parts of the room, and directed the therapy. At times, Mary utilized my supervisor's desk by playing with the phone or lamp. Although the therapy was aimed at client self-direction, appropriate boundaries were set in place. Boundaries included not hurting herself or the therapist on purpose, and no purposeful destruction of toys or property. It is important to note that due to the nature of working in a school setting, there were times when my clinical supervisor and a practicum student were present in the room during therapy. However, no other adults or children were present for reasons of confidentiality.

Play materials. Play materials in the psychology office varied weekly, as toys were consistently donated to the school. Despite my best efforts to keep the toy selection consistent, this was not entirely possible. This is not consistent with a pure CCPT approach, as typically

play materials should not change from week to week. Play materials frequently used by Mary included: (a) wooden blocks of various shapes, sizes, and colors; (b) marbles; (c) paint and paint supplies; (d) markers; (e) glitter glue; (f) clay and Playdoh, (g) crayons, and (h) the dollhouse with dolls and furniture. Often, art supplies were used as substitutions for characters such as people and animals. For example, crayons and paintbrushes were often used as people and identified by Mary as having feelings and emotions.

Psychotherapy. Psychotherapy with Mary continued for 52 sessions over the course of 20 school months, with a break after the first 10 months for summer vacation. The therapy was based on the premise of CCPT. As such, Mary directed the goals of the sessions and play within each session. Over time, she engaged with me more often, in both play and verbal communication. Additionally, she developed the skills to verbally express what she wanted to engage in during the sessions, when she was unable to do so at the start of therapy.

Data Collection

Videotapes, clinical notes, and privacy. To gather objective data about the psychotherapy as well as to analyze progress over time, sessions were videotaped using a Flip MinoHD Video Camera. After each session, the videos were immediately dated and transferred onto a confidential, password-protected file on my computer. Within the password-protected file, there was a folder with chronologically dated videos, and another folder with chronologically dated clinical notes from each session with the participant. Viewing and analyzing videotapes of therapy sessions with Mary allowed for observation of spontaneous symbolic play and the use of communication in sessions as the behaviors progressed over time. As the study included one participant, results are discussed as progress over time, rather than a comparison of multiple participants.

Additionally, any pertinent information gathered from Mary's parents, teachers, or other school staff was documented and placed into the same password-protected file. Although Mary's parents granted verbal permission to conduct this research, formal written consent was obtained after the termination of therapy (See Appendix C). Additionally, I conducted a postintervention semistructured interview with her parents to gather any additional information needed and to learn about their experience regarding Mary's diagnosis and the intervention (See Appendix E). Information from this interview was used as a way to document progressions seen outside of psychotherapy. Information about the changes noticed in Mary's behaviors from her parents was gathered. Whereas the videotapes reviewed were gathered prospectively while conducting psychotherapy with Mary, the data from her parents was collected retrospectively. Once the data was collected and analyzed, all identifying information about Mary was removed to ensure the participant's and the family's privacy.

When I received notice that I would be working at a different school the following year due to internship requirements, and could no longer work with Mary, I immediately contacted her parents. Her mother relayed sadness that we could not continue our work together, and explained that she had noticed tremendous gains in Mary's symbolic play skills and ability to verbally communicate. We discussed future psychotherapy for Mary and some of the progressions her mother noticed in Mary's behavior over time. I also mentioned the idea of using Mary's case, along with videotapes and case notes to analyze, as part of my dissertation for school. She agreed, and explained that she agreed to "anything to help people learn how to work with a child like [Mary]." I asked if she would agree that I keep the session recordings and clinical notes on a thumb drive in a locked cabinet, and she agreed. I explained that all identifying information in the final document would be removed. Mary's mother offered to speak

to me at any point during the research, and agreed to meet for the postintervention semistructured interview.

Data Analysis Procedures

For purposes of this study, I used a case study method to narrate the findings. Additionally, the videotaped sessions were coded to track progress over time. Due to the large number of sessions videotaped, one session per month was chosen at random to be reviewed by a second coder and myself. The second coder and I separately viewed 10 minutes randomly selected out of each of the 20 chosen sessions. The 10-minute segments all had the inclusion criteria that both Mary and I were present for the entire 10 minutes. The segments were not chosen for quality in the interactions, but for the quantity of minutes interacting in the session. The second coder and I documented the frequencies of behaviors of interest over time. These behaviors were within the realms of symbolic play and verbal communication skills, and included: (a) object substitution, (b) incorporating imaginary objects, (c) role-playing scripts with self, others, or toys, (d) interactive play, (e) facial expressions, (f) eye gaze, (g) gesturing, (h) noise mimicking, (i) narration of play, (j) verbal directing, and (k) asking questions (See Appendix D for definitions of categories of behaviors coded). These target behaviors were chosen as they are all within the scope of what most typically developing children should be able to do at the age of six. As Mary was six years old when the intervention began, her behaviors and activities can then be compared to what a typically developing child does in play at the same age. As supplemental material from sessions, handpicked vignettes heard from the coded segments were utilized in order to demonstrate behaviors that are later explored in the Discussion section. One picture of toys taken after a therapy session with Mary, demonstrating one of the target behaviors, was utilized in the discussion to illuminate the findings.

Framework for coding. Data was analyzed by watching videotapes of chosen segments of sessions. The second coder and I used an adapted version of the Framework for Observing Children's Developmental Play Patterns (Wolfberg & Schuler, 2003), called the Framework for Observing Data (See Appendix D), which addressed both spontaneous symbolic play and the use of communication. Under the Framework for Observing Symbolic Dimensions of Play Patterns (See Appendix D), coded behaviors included: (a) object substitution, (b) incorporating imaginary objects, (c) role-playing scripts (real or invented) with self, others, or toys, and (d) interactive play, such as initiating social engagement, and sharing and taking turns. Object substitution can be explained as utilizing one object to represent another (Wolfberg & Schuler, 2003). Incorporating imaginary objects into play can be seen when an absent object is used as if it were present. Role-playing scripts occur when a child verbally plays out scenarios that can occur in a real or imaginary context. This can happen between two or more people, or if characters or toys are given human qualities and play out interactions. Interactive play occurs when a child involves another person in his or her play world.

Under the Framework for Observing Communication Patterns of Play (See Appendix D), coded behaviors included: (a) facial expressions, (b) eye gaze, (c) gesturing, (d) noise mimicking, (e) narration of play, (f) verbal directing, and (g) asking questions. The utilization of facial expressions in play can be seen through actions such as smiling and frowning (Wolfberg & Schuler, 2003). Eye gaze includes eye contact that is made with another person, with the aim of redirecting the other person's gaze in an alternate direction. Gesturing encompasses movements such as waving, pointing, and head nodding (Wolfberg & Schuler, 2003). Noise mimicking is creating words to sound like noises, such as "splat." Narration of play is when a child narrates what she is doing, while the action is being completed. Verbal directing occurs when a child tells

another person what to do verbally during play. Lastly, asking questions can include any type of question, as long as it is relayed verbally and directed at another person. The Framework for Observing Symbolic Dimensions of Play Patterns, and the Framework for Observing Communication Patterns of Play was laid out in a chart format on one sheet of paper for convenience (See Appendix D). At the bottom of the sheet, was an additional space where the coder could write down any play themes, topics, or quotes that arose during the segment watched.

The second coder and I had the Framework for Observing Data present as the therapy film clips were watched. Each time one of these behaviors was noted, a tally mark was produced under the designated section. When all of the sessions were reviewed, the tallies were added up and each scheme was charted over the two-year period of time. The segments were watched separately to ensure coding tallies and notes would not be discussed until the end. Changes in the frequency of the target behaviors over time was noted. The findings are later discussed and narrated through a traditional case study style. Examples from actual sessions are used and discussed in the Results and Discussion sections of this research.

Reliability and validity. Parallel to reliability and validity in a quantitative sutdy, the qualitative researcher must obtain dependability (Mertens, 2009). Dependability is applied when the participant and researcher engage in assessing the information gathered from the participant. However, due to the inability to engage in this assessment with the participant herself, dependability was obtained by using a second rater to review the information gathered. As disprepancies in tally numbers between two coders was likely, it was necessary to consider this factor and plan for resolving discrepancies. As I considered micro moments in behavior, either the behavior was there, or it did not happen. Therefore, any discrepancy in tallies between the

second coder and I was discussed and resolved. Clips with discrepant tally numbers were rewatched and subsequently any discrepancies were resolved. Although it was not used, a plan was put in place in case the discrepancy could not be resolved between myself and the second coder. If this had happened, a third coder (member of the dissertation committee) would have been brought in to watch the clip and resolve the discrepancy.

Before the segments were coded, I reviewed the Framework for Coding with the second coder. All behaviors and their definitions were fully understood and agreed upon before the actual coding began. In order to maximize inter-rater reliability, myself and the second coder reviewed 10 minutes of a videotaped session together (chosen segments were not used for research coding), and practiced applying the coding system. This was practiced multiple times with different clips (that were not used in the actual research) until there were no discrepancies between coding.

The coded data was interpreted through qualitative and quantitative means. The coded data was analyzed through quantitative means by being graphed over time. This information was then qualitatively interpreted through a traditional case study narrative. All information gathered, from the coded sessions and semistructed interview, was helpful in contributing to a wider understanding of the complex intricasies of symbolic play and verbal communication for Mary.

Conceptual Hypothesis

I hypothesized that with the inclusion of CCPT as an adjunctive intervention, the participant would make gains in both spontaneous symbolic play and verbal communication methods. These gains would be observable in increases in the incidence of symbolic play and communication both in therapy, and outside of sessions. It was also hypothesized that the

increased incidence of spontaneous symbolic play and verbal communication would be retained during the remainder of my work with Mary, and after the termination of psychotherapy.

Chapter 3: Preliminary Findings and Results

Results

The main goal of this study was to see if CCPT increased the incidence of spontaneous symbolic play behaviors and communication patterns in a young girl diagnosed with autism. In this section, Mary's coded behaviors are explored and analyzed. I hypothesized that the inclusion of CCPT with a young child diagnosed with autism would be associated with an increase in spontaneous symbolic play behaviors and an increase in communication patterns within play over time. The spontaneous symbolic play behaviors measured were object substitution, incorporating imaginary objects, role-playing, and interactive play. The communication patterns measured were facial expressions, eye gaze, gesturing, noise mimicking, narration of play, verbal directing, and asking questions.

To test my hypothesis, I coded the above-mentioned behaviors using the Framework for Observing Data (see Appendix D). Ten-minute coded segments were chosen from 20 randomly selected psychotherapy sessions conducted over two school years. The initial therapy sessions were not recorded via videotape, and therefore could not be analyzed. For purposes of this data analysis, the first session coded (session 12 overall) was considered the baseline session. The first 12 sessions can be considered an introductory phase, as Mary had not been involved in psychotherapy before CCPT took place. The data were analyzed by looking at behavioral trends across the 20 subsequent coded sessions.

A second coder and I coded the videotapes independently, and subsequently through discussion, resolved the few discrepancies between scores. Discrepancies only occurred in three out of the 20 coded sessions and were one point off from each other. The second coder and I were able to re-watch the recordings and discuss the behaviors observed to come to an

agreement. Figures 1-11 show the occurrence of each behavior during the sessions, as well as trend lines representing changes in each behavior over time (See Appendix F for additional visual representations; Kazdin, 2003). To analyze the trends of behavior change over time, the slopes of the raw data were calculated using regression analysis in Microsoft Office 2008 (see Figures 1-11; See Appendix F for additional visual representations).

These figures were then visually analyzed to determine the rate of behavior change (see Table 1 for rates of change). The raw data obtained from the two observers were then analyzed using the points range guide presented in Table 1, to determine the degree of change in behavior over time. The term "points" refers to change in the occurrence of behavior over time. Eleven out of the 12 target behaviors in both categories of symbolic play behaviors and communication behaviors displayed with increased incidents over time. Gesturing displayed no change over time.

Table 1

Points Range for Description of Visual Analysis – Over 20 Coded Weeks

Descriptive Term	Change in Frequency of Behavior
Neutral	<1 Point
Small	1 – 2 Points
Modest	3 – 6 Points
Moderate	7 – 14 Points
Significant	15 – 26 Points

Symbolic Dimensions of Play Patterns Over Time

Notable increases in target behaviors were observed in both symbolic play and communication skills over the course of the treatment (see Appendix F [Figures 12 and 13] for additional visual representations). Spontaneous symbolic play was the behavior that increased most during the intervention. Role-play behavior within the category of symbolic play showed the most profound increase over the course of treatment. The change in role-playing behavior ranged from 0 points at baseline to 25 points at the end of the intervention, as seen in Figure 1. Mary displayed an increase in interactive play behavior ranging from 1 point at baseline to 14 points at the end of the intervention (see Figure 2). The overall changes in object substitution throughout the intervention were moderate, ranging from 0 points during the baseline session, and increasing to 12 points in the last session (see Figure 3). Mary's inclusion of incorporating imaginary objects into her play was modest, ranging from 0 points at baseline to 4 points at the end of the intervention (also see Figure 4).

Figure 1. Symbolic Dimensions of Play Patterns Over Time: Role-Playing

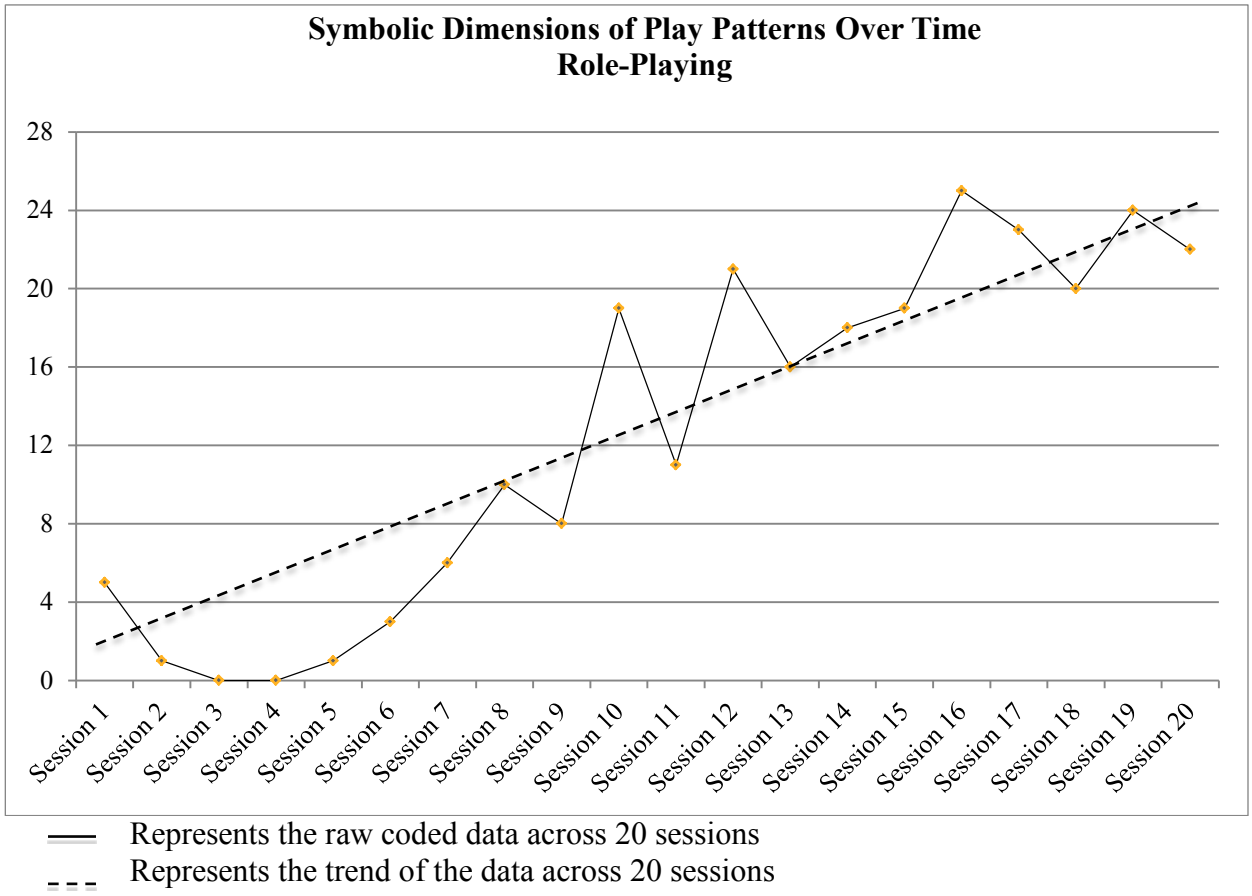


Figure 2. Symbolic Dimensions of Play Patterns Over Time: Interactive Play

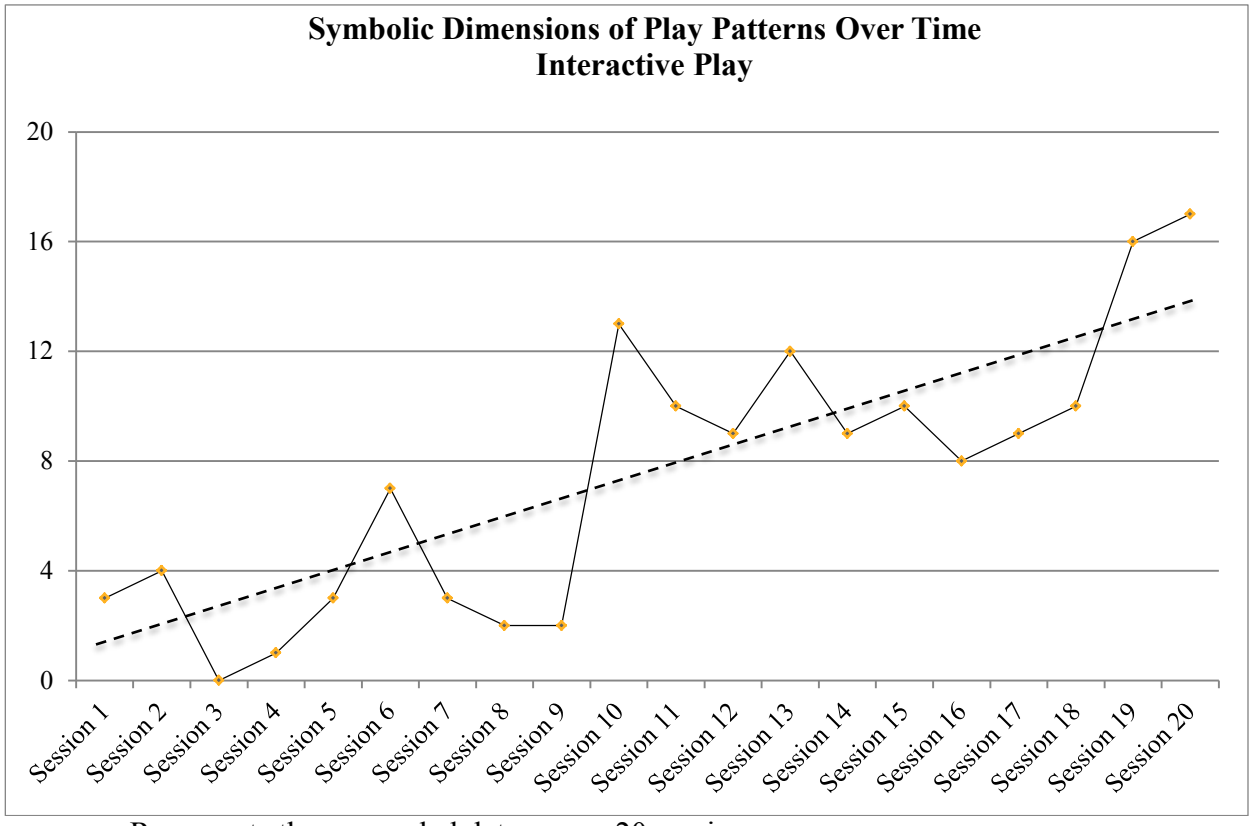


Figure 3. Symbolic Dimensions of Play Patterns Over Time: Object Substitution

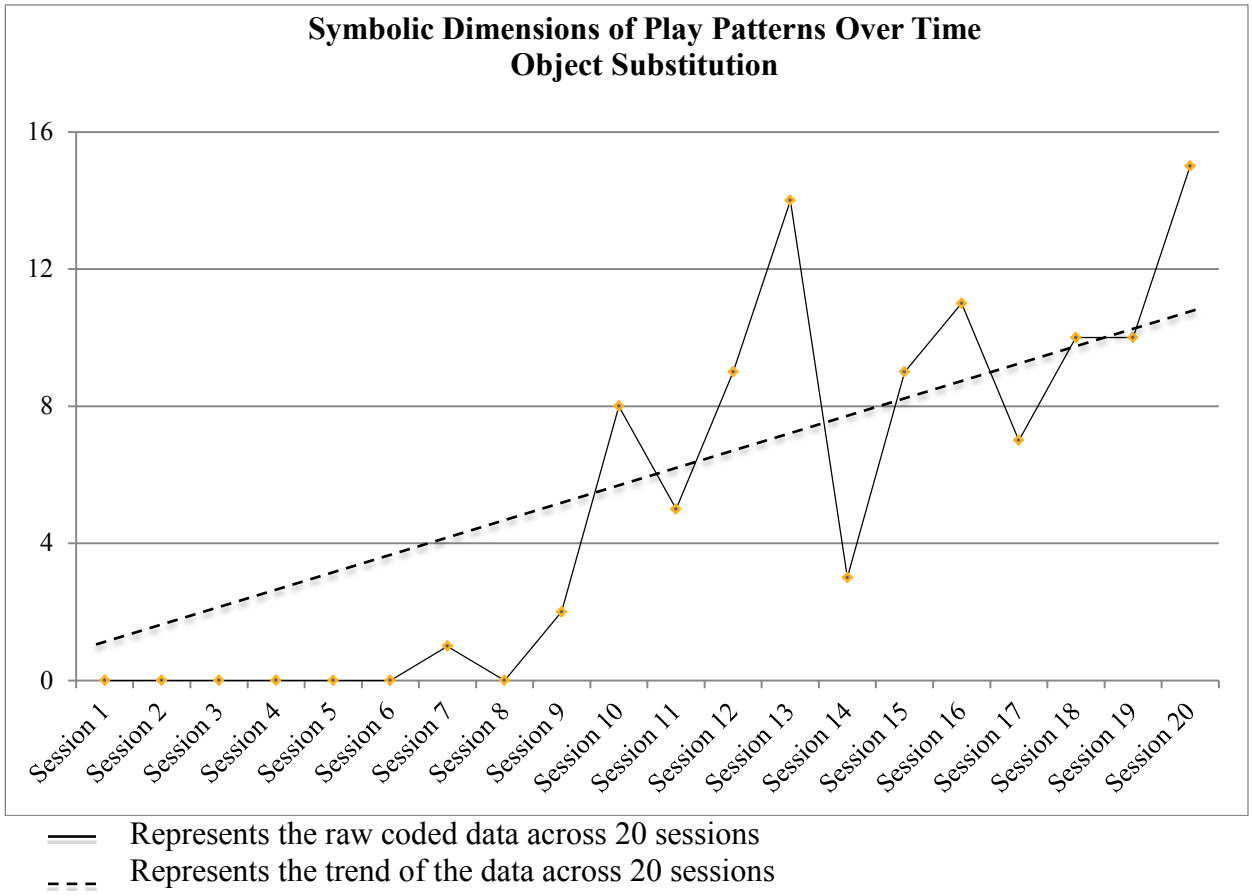
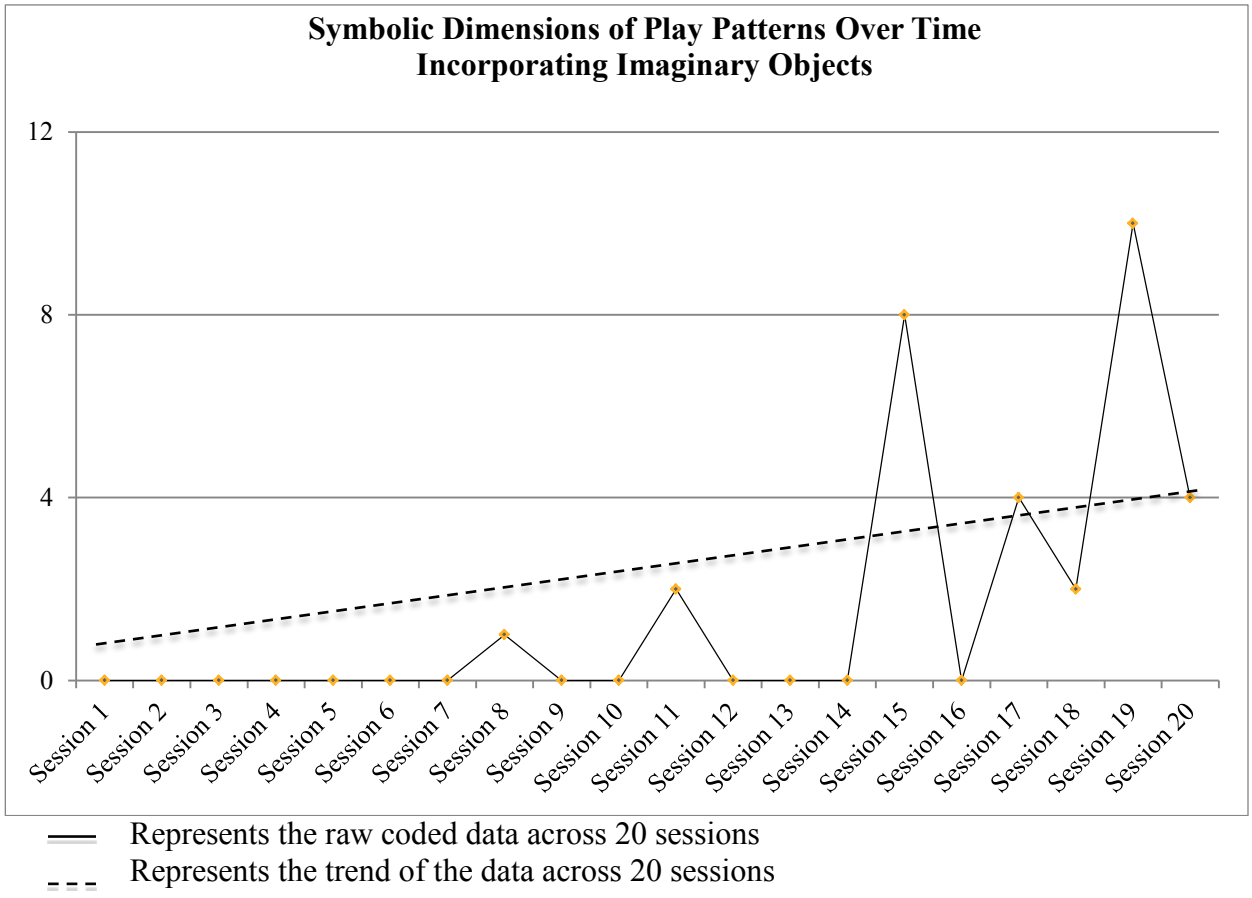


Figure 4. Symbolic Dimensions of Play Patterns Over Time: Incorporating Imaginary Objects



Communication Patterns of Play Over Time

Noteworthy and interesting trends were also found when analyzing Mary's communication patterns during play (see Appendix F [Figures 14.1, 14.2, 14.3 and 15] for additional visual representations). Narration of play showed the most increase of all behaviors within the communication patterns of play over time. Figure 5 shows that changes in narration of play moderately increased ranging from 0 points at baseline to 9 at the end of the intervention. Verbal directing was another moderate increase in behavior over time, with changes from 1 point at baseline to 9 at the end of the intervention (see Figure 6). Asking directions showed a modest increase in behavior, with changes ranging from 0 points at baseline to 3.75 at the end of the intervention (see Figure 7). Figure 8 shows a modest increase in noise mimicking behavior, with changes ranging from .5 points at baseline to 3 points at the end of the intervention. Behavior changes in Mary's eye gaze during play were also modest (see Figure 9), ranging from 0 points at baseline to 3 points at the end of the intervention. As seen in Figure 10, facial expressions only showed a small increase in the behavior over time, ranging from 0 points at baseline to 2 points at the end of the intervention. Gesturing remained neutral over time and showed no change; that is, the trend remained at .25 points throughout the 20 sessions (see Figure 11). Changes in gesturing behaviors ranged from 0 points at baseline to 3 points at the end of the intervention.

Figure 5. Communication Patterns of Play Over Time: Narration of Play

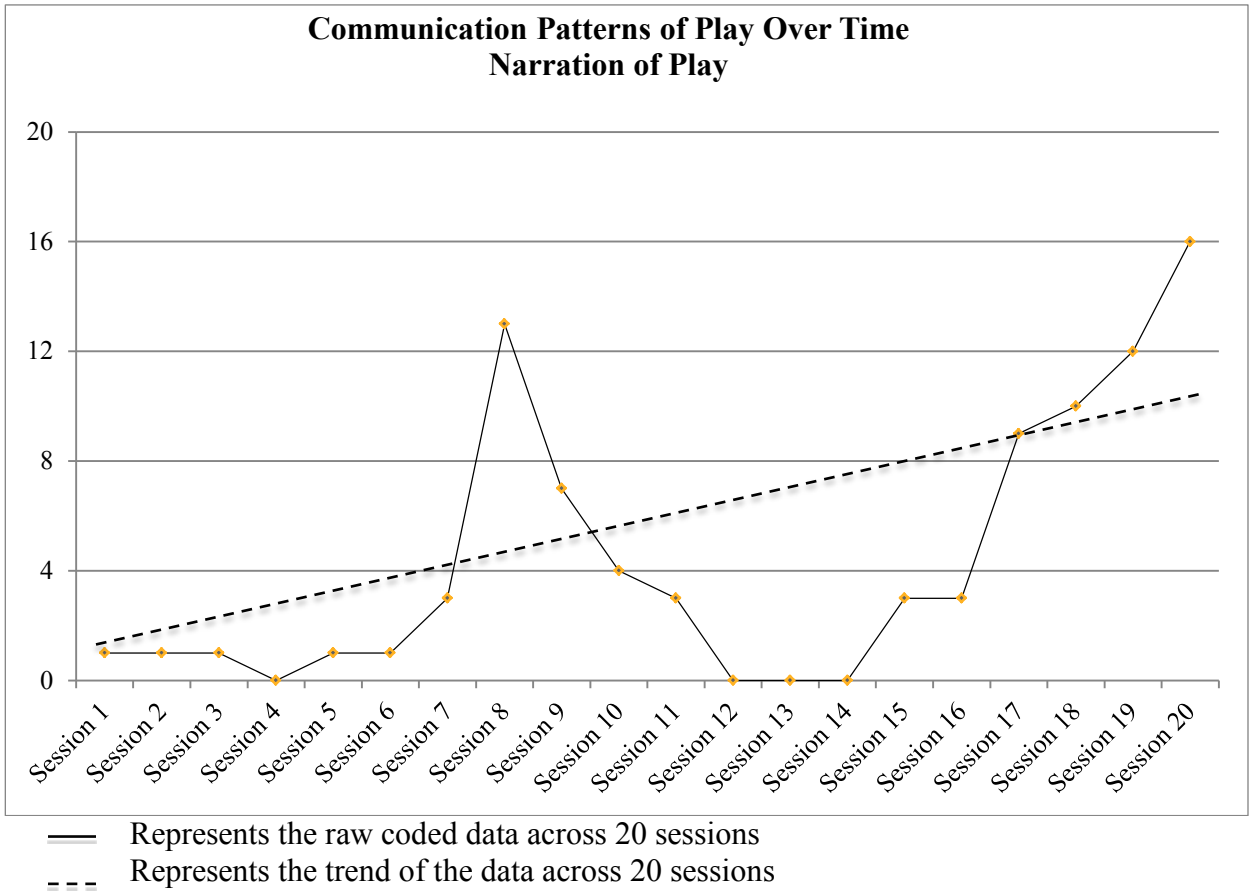


Figure 6. Communication Patterns of Play Over Time: Verbal Directing

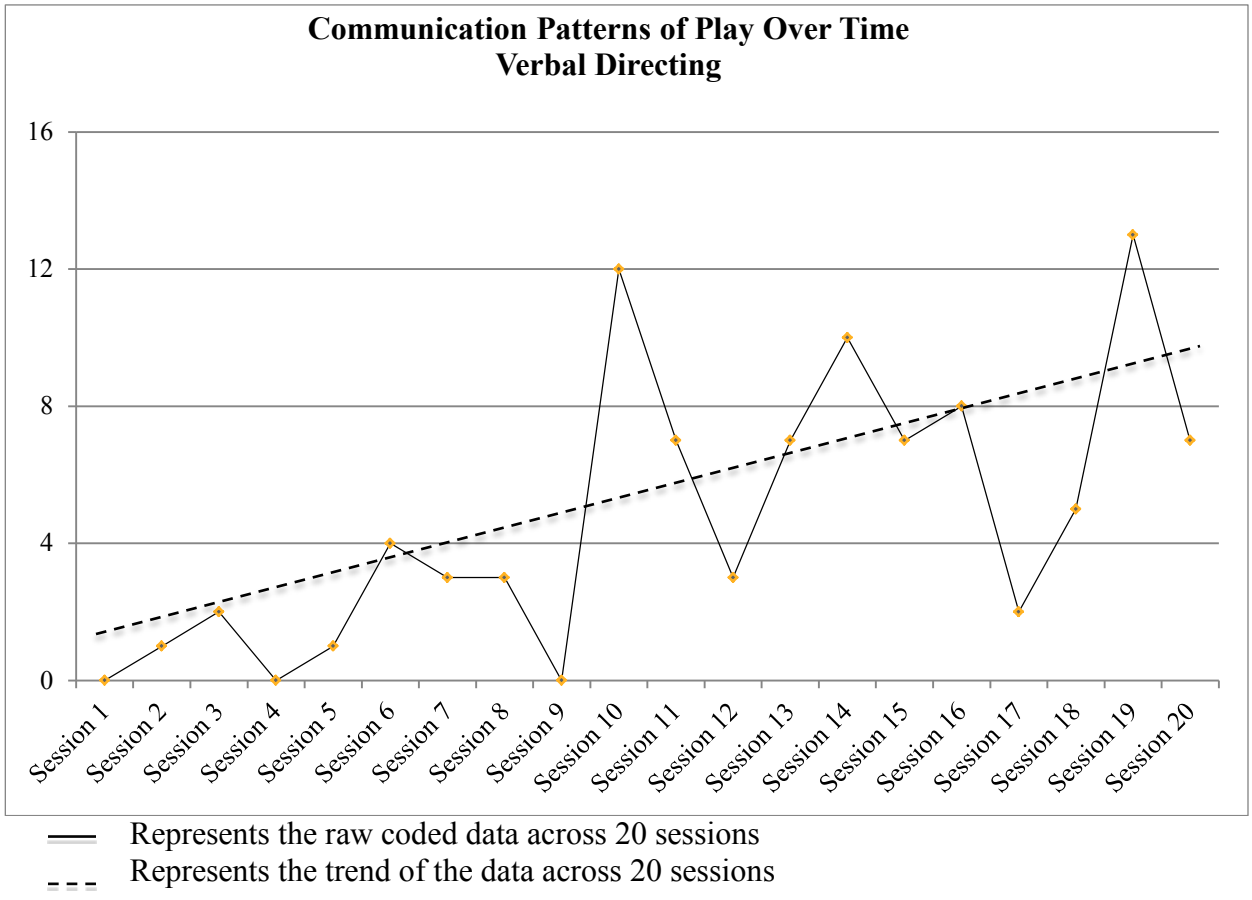


Figure 7. Communication Patterns of Play Over Time: Asking Questions

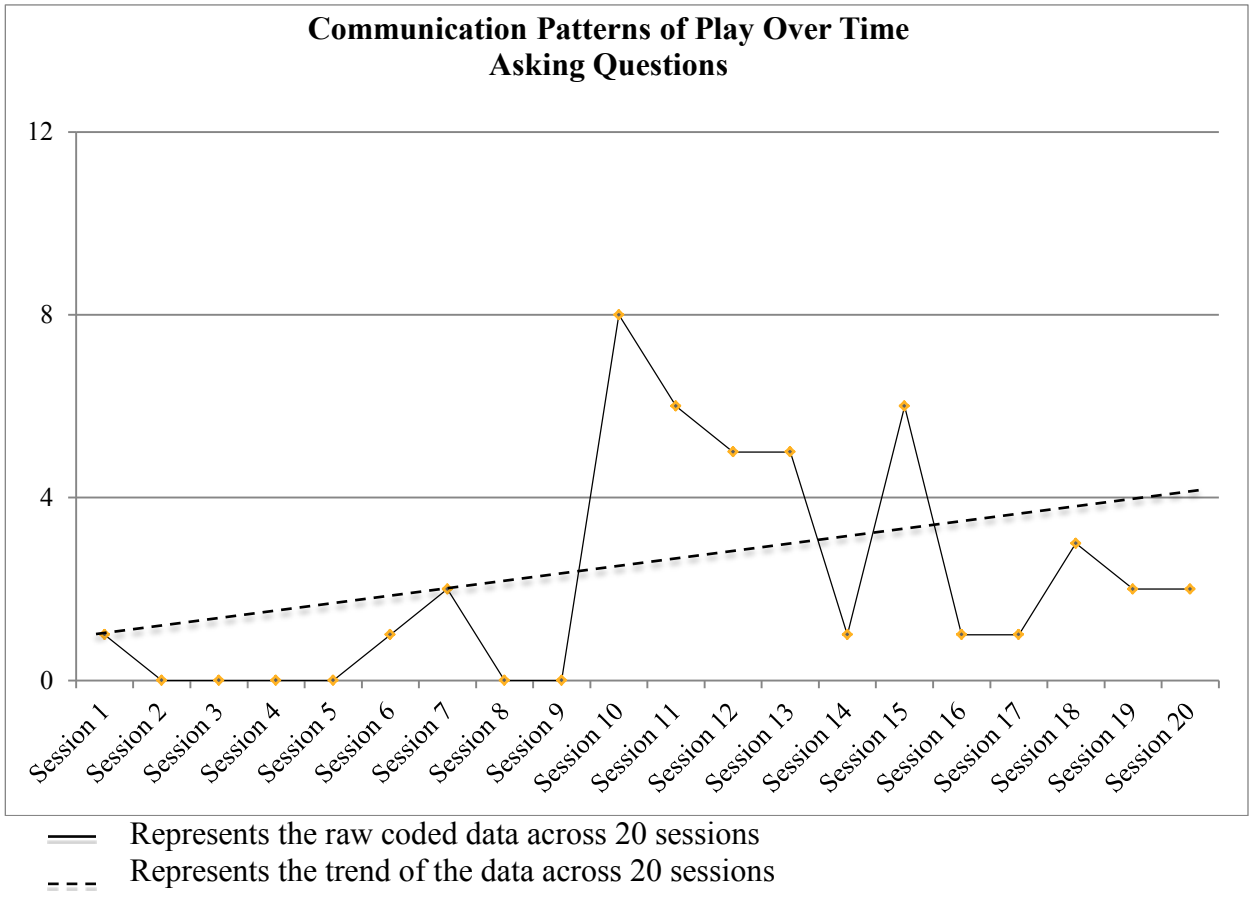


Figure 8. Communication Patterns of Play Over Time: Noise Mimicking

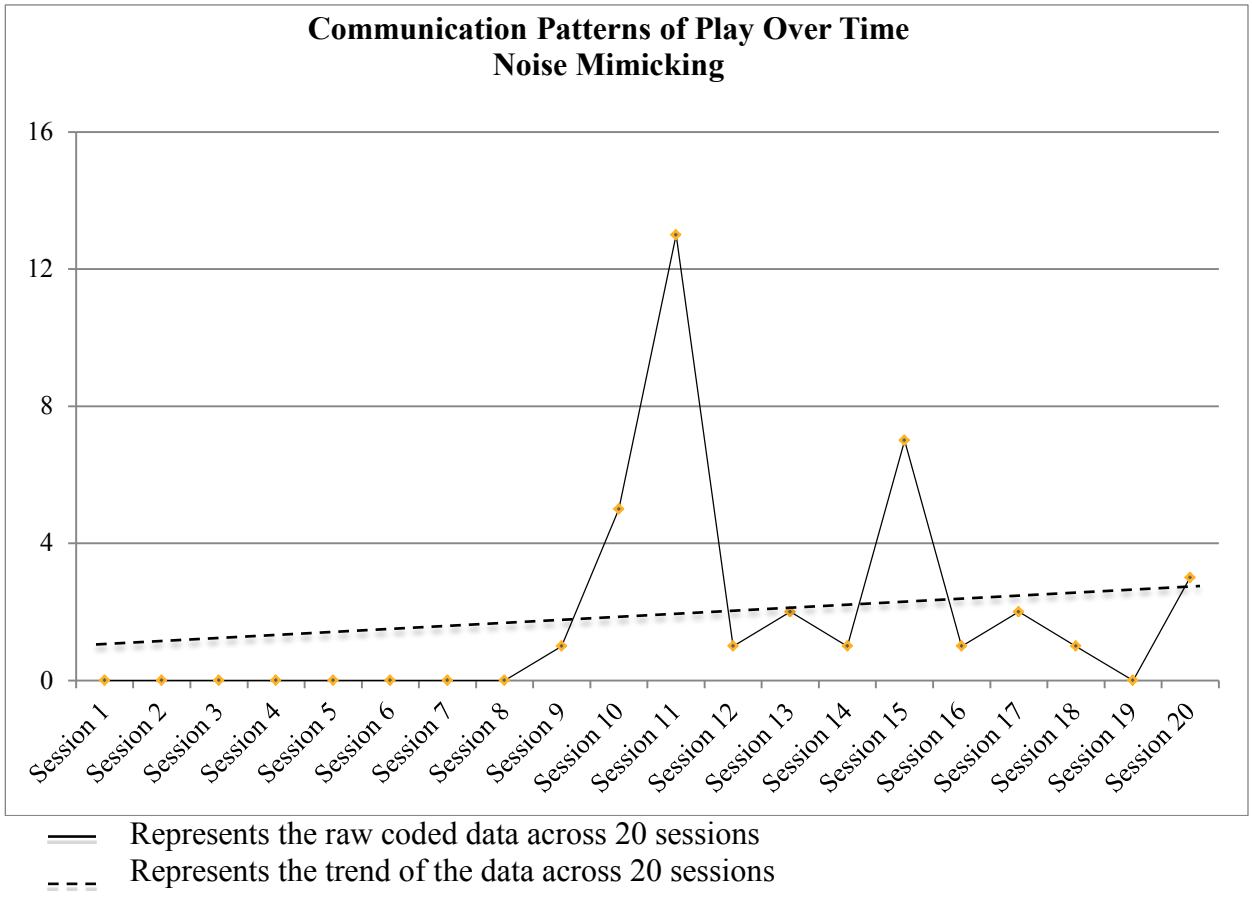


Figure 9. Communication Patterns of Play Over Time: Eye Gaze

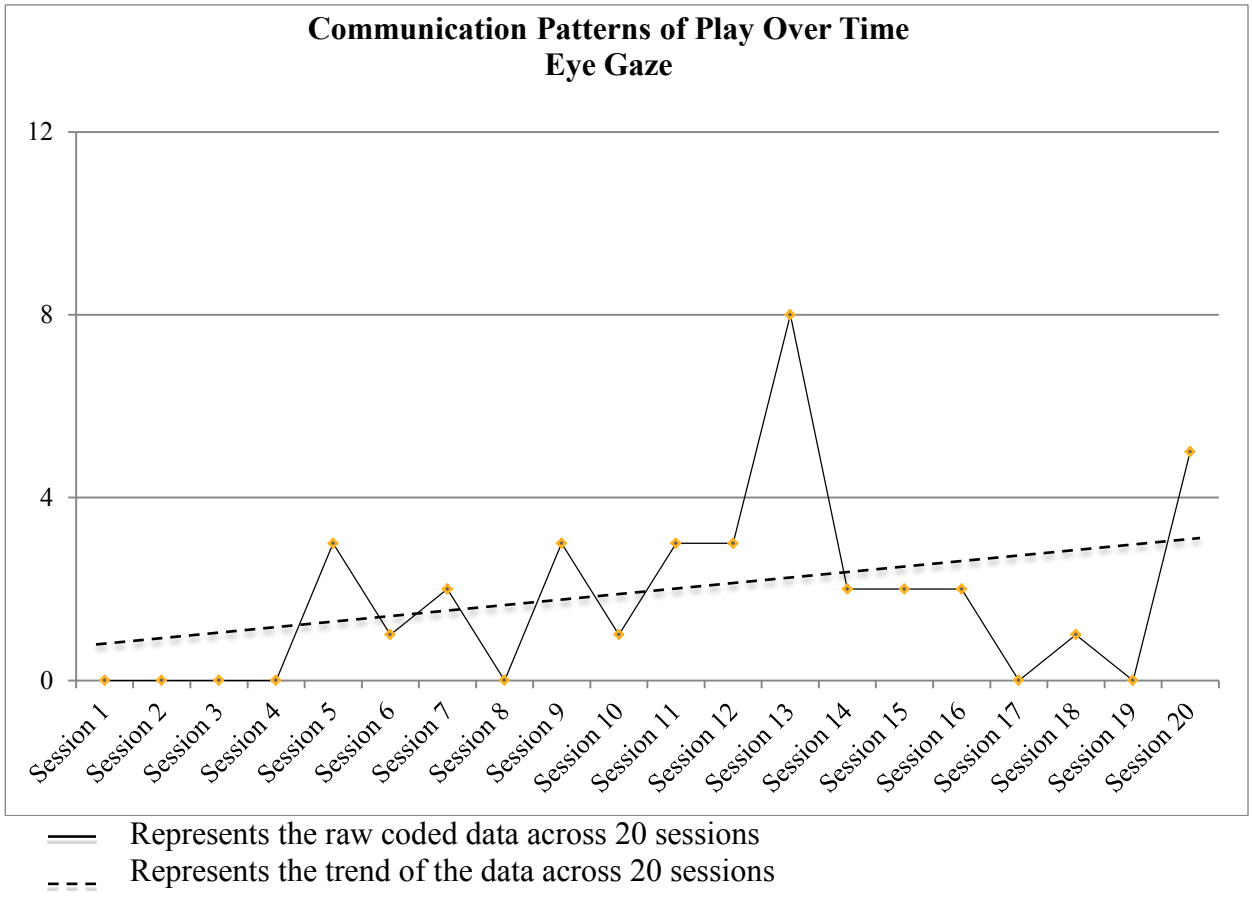


Figure 10. Communication Patterns of Play Over Time: Facial Expressions

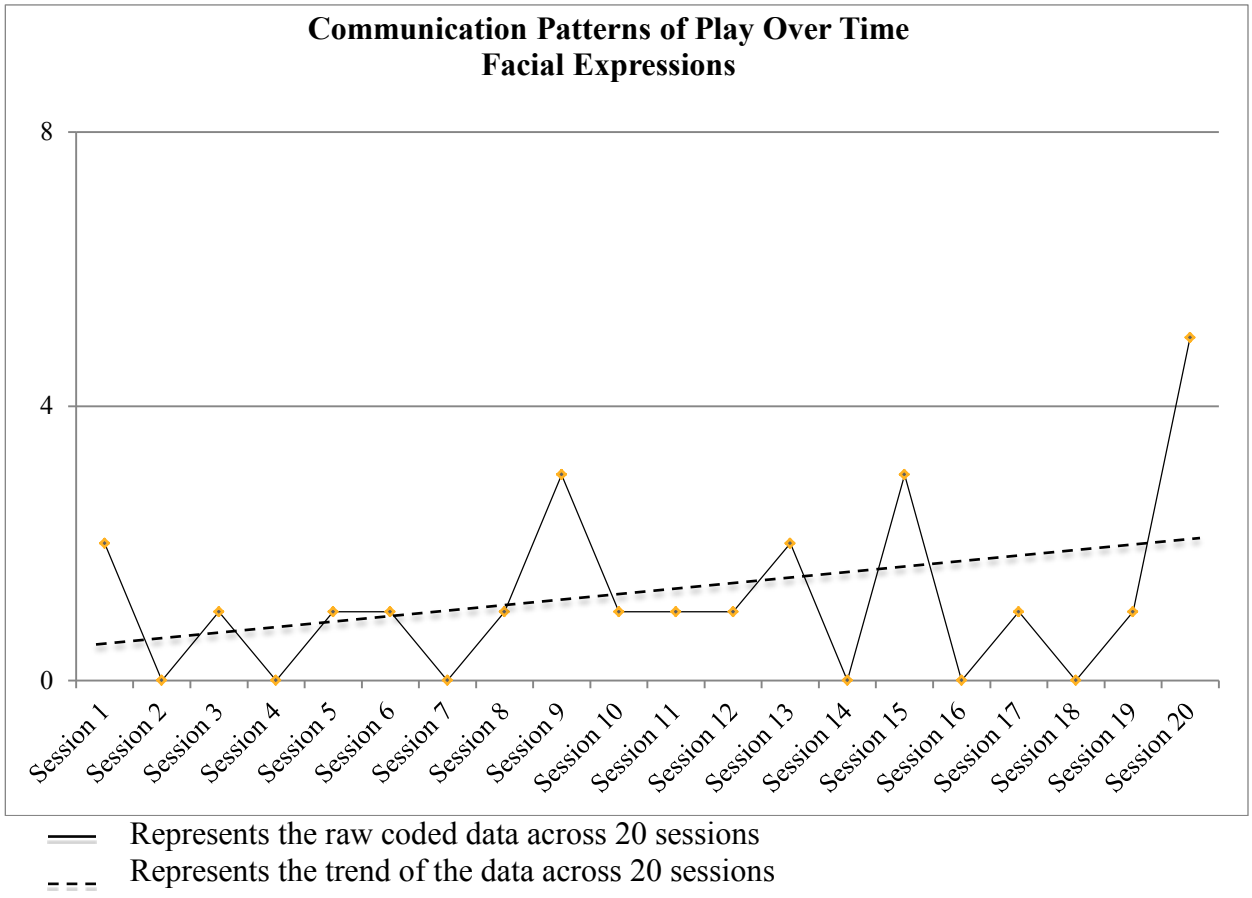
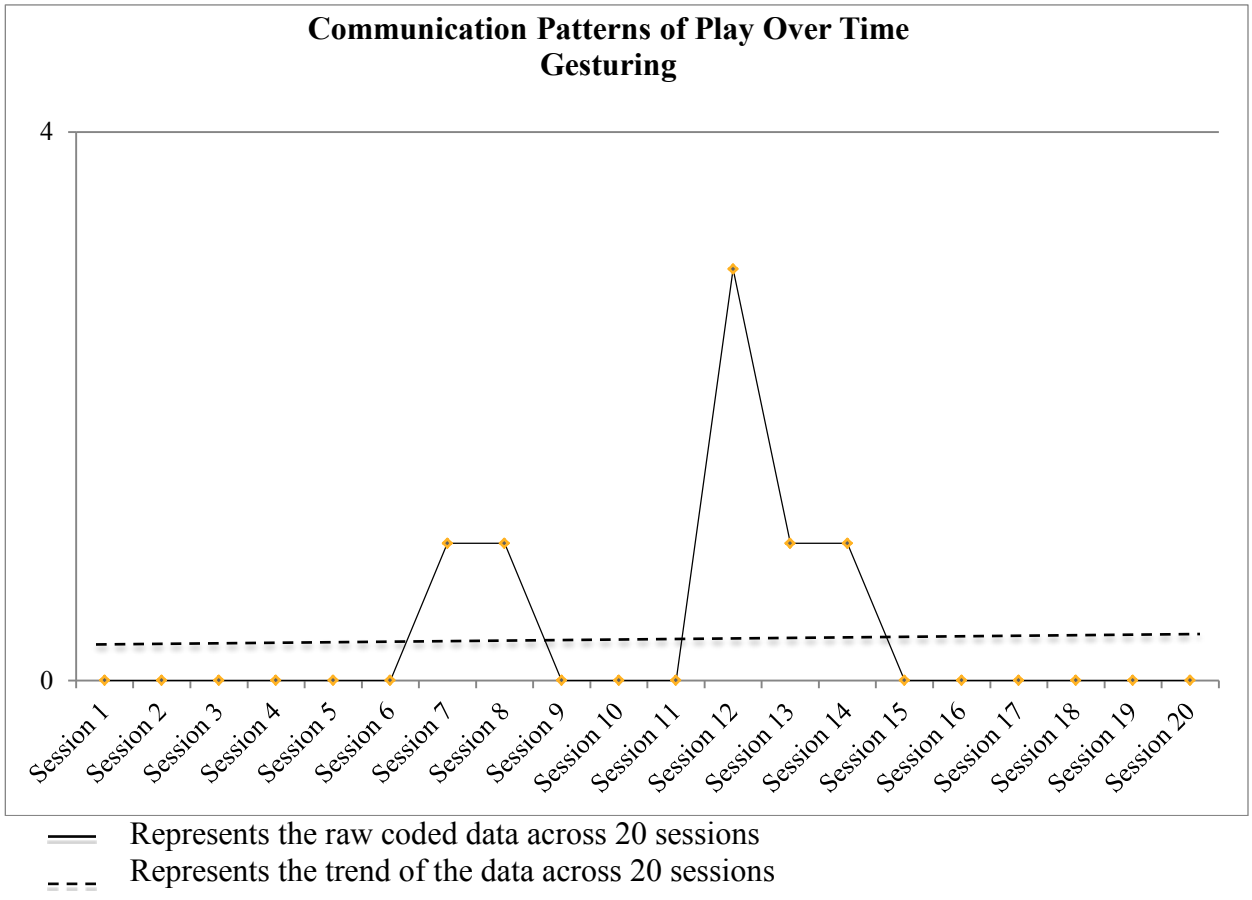


Figure 11. Communication Patterns of Play Over Time: Gesturing



Interview with Mary's Parents

To gain more background information and to assess Mary's parents' perceptions of the effects of the intervention, I met with her parents about 6 months after the therapy had terminated and conducted a semistructured postintervention interview (see Appendix E). It was apparent that they were pleased with the outcome of the addition of CCPT to Mary's treatment program. They described noticing positive changes in Mary's play skills as well as her communication, which continued after the intervention was terminated. For more detail about the interview, see the Interview with Parents section in the Discussion chapter.

Summary of Results

Overall, the findings of this study revealed that the intervention of CCPT with a young girl with autism was associated with an increase of spontaneous symbolic play behaviors and communication skills. Ten out of the 11 behaviors examined showed increased occurrences over time. Gesturing was the only behavior that showed no change in frequency over time, remaining neutral with infrequent occurrence throughout the study. The most drastic increase was in Mary's role-playing behavior, which increased drastically over the course of our treatment together. From these results, it appears that the intervention of CCPT was associated with an increase in the target behaviors over time.

Chapter 4: Discussion

This dissertation explores changes in spontaneous symbolic play and communication behaviors concurrent with CCPT for Mary, a young child diagnosed with autism. The purpose of this study was to examine spontaneous symbolic play and communication skills over time, during the course of CCPT. Utilizing a narrative case study along with plotting behavioral data points allowed for a multidimensional view of the outcome of CCPT with Mary. In this discussion, I begin by presenting the findings for each of the research questions, including information gathered from the postintervention parent interview. I then consider some of the limitations and challenges to this research, as well as challenges in the implementation of the intervention. Lastly, I discuss recommendations for treatment and future research within the field, along with whom this intervention would best serve.

Hypotheses Considered

Hypothesis 1. The first question considered in this dissertation was whether a child-centered approach to play therapy with a young girl with autism would be associated with an increase in spontaneous symbolic play behaviors. The coded data show that the intervention of CCPT was associated with an increase in Mary's spontaneous symbolic play. Measured behavior increased over the 20 sessions in all four areas of symbolic play: (a) role-playing, (b) interactive play, (c) object substitution, and (d) incorporating imaginary objects.

Role-playing. The symbolic play behavior with the highest rate of change over time was role-playing, with a significant rate of change over the 20 coded sessions. Role-playing is acting out a play scene with the self, other people, or toys (Wolfberg & Schuler, 2003). This action can occur between two or more people, or when toys are given humanistic qualities and interactions transpire between the toys. Role-playing is often mastered by the age of three years for typically

developing children (Howes, Unger, & Matheson, 1992). At the beginning of therapy, when Mary was six years old, she showed no signs of role-playing. Over time, Mary's ability to initiate and engage in role-playing with both myself as the therapist and objects, became part of her daily play therapy repertoire. In one session, when Mary and I were playing with the dollhouse, she used object substitution to replace the dolls with crayons so that each color represented a different figure. Mary directed me to play with the yellow-green crayon, while she played with the blue crayon. The yellow-green crayon accidently dropped off of the second story of the dollhouse and onto the floor. With the blue crayon, Mary quickly swooped up the yellow-green crayon and exclaimed, "Are you okay? I'll get a Band-Aid for you. I'm sorry." She then prompted me to respond for the yellow-green crayon and explain that this crayon was safe and not hurt. In this instance, Mary initiated an interaction between the blue crayon and the yellow-green crayon. It is possible that Mary showed recognition of the crayon's pain in this vignette, as the yellow-green crayon had fallen to the ground. It is also possible that Mary displayed the socially acceptable response of asking if the hurt character was okay. Mary enacted what the blue crayon could do to help the yellow-green crayon recover. The dialogue between the crayons in this context is an example of Mary's participation in role-playing behavior.

The high rate of change in this behavior over time can be attributed to many different factors. Mary was regularly engaged in the therapy sessions, and used the time to explore her own reality in session. Her role-playing behavior can be seen as a way of making sense of her daily life, and acting out scenes with which she was familiar. Children often engage in play in order to make sense of their daily lives and environment in a tangible way. Mary was also able to take perspective and show empathy, which is not commonly observed in individuals with autism (Sicile-Kira, 2004). Role-playing requires a level of perspective taking, as it entails the child to

consider at least two sides of a relationship, as two sides are required in order for role-playing to take place (Wolfberg, 2009). Perspective taking is grounded in the idea of theory of mind (Mastrangelo, 2009), which is the capacity to attribute emotions and feelings to people and make sense of their behavior in relation to their mental state (Broekhof et al., 2015). During symbolic play, a child is able to play out a real life story with pretend elements, with the awareness that the story is not real (Morgan, Maybery, & Durkin, 2003). A great deal of research shows that children with autism have a delayed development of theory of mind, while typically developing children often show evidence of theory of mind around the age of two (Broekhof et al., 2015). In Brown and Whiten's (2000) study, they found that children with autism struggle with empathy due to their difficulty with theory of mind. Mary's interaction between the crayons, focusing on the potential pain of one crayon and what it may need to recover, shows a great deal of empathy, and therefore application of theory of mind. This interaction also required advanced perspective taking skills. As Mary frequently displayed this behavior, it is likely that she simply enjoyed role-playing. She may have felt a sense of mastery with role-playing, and therefore, continued to engage in the behavior.

Interactive play. Interactive play was another behavioral area in Mary's play that showed a moderate increase over the 20 coded sessions. This form of play occurs when a child involves another person in their world through some sort of social engagement (Wolfberg & Schuler, 2003). Mary was frequently able to engage with me and direct my play during our sessions. Without my initiation, she would regularly hand me a piece of paper when giving one to herself, or give me a crayon when she was using crayons. There were also times when she was more directive in her interactions with me, such as using my name and gesturing to invite me to join her activity. Continuing to use the dollhouse play as an example, Mary regularly gave me a

specific colored crayon to "be" during the play. She initiated conversations between our crayons as well as interactions in the dollhouse. As a result, Mary and I interacted through the actions of the crayons.

For typically developing children, interactive play can be witnessed as early as during the first year of life (Howes et al., 1992). Interactive play in a symbolic context is often seen at three years of age in typically developing children. At the beginning of our work together, Mary engaged in interactive play infrequently. However, over the course of our work together, this behavior grew rapidly. As is with most school environments, the other professionals working with Mary regularly encouraged her to engage with other people. When passing Mary in the hallway, the professional with her always encouraged Mary to engage with me by saying, "say, 'Hi, Miss Ashley.'" In class, engaging with other peers and teachers was often required. Whether academic or play-based, interactions are often initiated in a school setting, and therefore were frequently modeled for Mary. This also provides a chance for children to practice engaging with other people. It is likely that as Mary's natural course of child development grew, interactive play would be an area that would grow along with it. The nondirective nature of CCPT allowed Mary to engage in these interactions at her own pace without any initiation from the therapist.

Object substitution. Mary engaged in a high level of object substitution, with a moderate increase in the behavior throughout therapy. Object substitution is utilizing one object to represent another (Wolfberg & Schuler, 2003). It is often observed in typically developing children between the ages of three to four years (Wolfberg, 2009). Hobson (1993) explains that children with autism do not frequently engage in substituting objects in play. However, each time Mary played with the dollhouse in session, she engaged in this behavior. When the dollhouse was chosen in session as a play interest, Mary consistently placed all of the dollhouse people

onto my desk. She would then grab all three containers of crayons and dump them in front of the dollhouse, choosing different colors to represent different individuals. Although this action was never verbally discussed, it remained consistent throughout the therapy. Mary exhibited many other examples of object substitution throughout the sessions.

While Mary never directly played with the dollhouse people, she regularly substituted crayons for people. In her play, the crayons were used in the same way that another child might use the dolls in the house. By substituting crayons for people, Mary used her imagination to give the crayons aspects of a personality and even a life story for that day. When meeting with Mary's parents for the postintervention semistructured interview (see Appendix E), they reported that after hearing about Mary's frequent use of the dollhouse in therapy, they purchased a dollhouse for the home. Mary's mother disclosed that at home, instead of using the people to enact play scenarios, Mary always chose to use crayons or markers. While this form of object substitution was likely never modeled for Mary, she seemed to generalize the behavior to environments outside of the therapy. The desired behavior of object substitution continued to grow in Mary's

play even after the intervention ended. It is possible that Mary's consistent substitution of dolls with crayons was perseverative, or repetitive over time, as it frequently occurred when playing with the dollhouse in session. However, it is also possible that crayons were a preferred toy for Mary, as children often gravitate towards similar toys in play therapy.

Incorporating imaginary objects. Incorporating imaginary objects was the symbolic play behavior with the smallest rate of change over time, with a modest increase over the 20 coded sessions. Incorporating imaginary objects is described as pretending an absent object is present and real (Wolfberg & Schuler, 2003). In typically developing children, this can often be seen in play at four years old (Wolfberg, 2009). An example of this is pretending that one is talking on the phone, when there is no phone or object representing a phone. In session, Mary did not often pretend that there were purely imaginary objects present; that is, she more often engaged in object substitution.

It is possible that the advanced symbolic nature of incorporating imaginary objects was not impacted by the intervention. To pretend that an absent object is present, one must be able to fully engage in imaginary thought, which is typically difficult for individuals with autism (Wolfberg, 2009). This advanced form of symbolic thought was not yet mastered by Mary at the time the intervention took place, yet, it is possible that it could have been improved even more if the therapy continued beyond the end date. Alternatively, it is possible that if this behavior were modeled in play for Mary, she may have engaged in it.

Summary of symbolic play behaviors. Overall, Mary's engagement in the behaviors associated with symbolic dimensions of play increased over the 20 coded sessions. While some of the behaviors seemed to change greatly during the intervention, such as role-playing, other behaviors showed less change, such as incorporating imaginary objects. It seems possible that if

the intervention had continued longer, Mary's engagement with all of the symbolic dimensions of play, including role-playing, interactive play, object substitution, and incorporating imaginary objects, would have continued to grow. It is possible that more change in the area of incorporating imaginary objects would require more of a behavioral intervention.

For typically developing children, the earliest forms of symbolic play can be seen as early as 15 months (Howes et al., 1992). By three years of age, the basic elements of symbolic play are often mastered. However, for children with autism, developmental trajectory is varied and symbolic play skills are often greatly delayed. Symbolic play skills, such as role-playing and interactive play, are important because they help expand social skills, as they both require interaction with another person or toy, and perspective taking (Wolfberg, 2009). Social skills and perspective taking are noted areas of difficulty for many children with autism, as they are heavily grounded in theory of mind. Observational data supported increases in these interactive behaviors, and in the postintervention semistructured interview, Mary's parents confirmed that she frequently engaged in role-playing after the intervention took place. They explained that postintervention, Mary regularly played with her dollhouse at home, and invited her family members to join in the play. Her play became less rigid and repetitive, and was more focused on exploring her daily life and activities, as the content of her play became more reality-based. Mary's parents also reported that she often acted out scenes from her life while role-playing.

Mary's parents reported that before CCPT took place, they sensed that she had a desire to engage with other people, but did not know how to relate to others. While she still struggled with relating to other people at times after the intervention, Mary developed friendships and was able to play with peers. She became more involved with other people and could carry out brief

conversations. The content of Mary's play became more consistent with that of typically developing children as the intervention continued.

Other symbolic play skills, such as object substitution and incorporating imaginary objects, were not as greatly affected by the intervention, although some change was observed. As with all symbolic play skills, these skills require a high level of abstract thought (Wolfberg, 2009). As thinking abstractly is often difficult for children with autism, observing a child with autism using abstract thought within play is noteworthy and important. Mary was able to utilize these skills, especially with object substitution, which demonstrates that she was able to use abstract thinking at times. Mary's parents shared that she was still substituting crayons and markers for people in her dollhouse play at home after the intervention was terminated. Incorporating imaginary objects requires an even higher level of abstract thought than for object substitution, as the child must pretend that an absent object is present. As incorporating imaginary objects was not as regularly seen with Mary, it is apparent that this is a skill that was not as well developed through the intervention. Although this may have been idiosyncratic to Mary, it is possible that skills requiring significantly high levels of abstract thought may need to be directly modeled and reinforced for children who struggle in this area. Behavioral techniques and other forms of play therapy may allow the therapist to show the child client how to engage in this form of play, and provide a place where the child client can mimic these actions.

While research shows that children with autism struggle with the integration of symbolic thought with play (Marcu et al., 2009), the current study shows that it is possible for some children with autism to engage in this form of play with the correct intervention. The increase in the occurrence of symbolic play behaviors over time in this research suggests that CCPT is a promising intervention for play and symbolic thought for children with autism. We do not know

the specific meaning of play to children with autism. However, play in general, and especially symbolic play, allows typically developing children to use their imagination to integrate their daily life within a make-believe context, in order to understand their daily experiences (Segal & Adcock, 1981). This study shows that this may also be true at times for some children with autism, as was the case with Mary. Findings in this study support previous research (Josefi & Ryan, 2004; Kenny & Winick, 2000) indicating that a nondirective approach to play therapy with children with autism can be highly beneficial. This research extends the existing literature on the advantages of CCPT by focusing on an in depth look at play therapy with one child over the course of two school years.

Hypothesis 2. The second question considered in this research was whether a child-centered approach to play therapy with a young girl with autism would be associated with an increase in verbal methods of communication and language. Based on the findings of this case study, it seems that the majority of the target communication behaviors increased during CCPT. As problems with language and communication are often seen as central symptoms of autism (Paul, 2008), seeing any positive trend in these behaviors over time is remarkable. It is important to note that changes in communication can also be achieved through behavioral interventions such as ABA. In this instance, CCPT was used as an adjunctive therapy, as Mary was also receiving ABA at the onset of CCPT. Overall, Mary's patterns of communication increased in six out of the seven communication behaviors considered in this study.

Narration of play. Of all the communication patterns of play behaviors, narration of play was observed the most over time, and displayed a moderate increase throughout the 20 coded sessions. Narration of play can be described as the child narrating what she is doing, while the action is being completed (Wolfberg & Schuler, 2003). This behavior occurred in the majority of

the sessions, and was seen more over time as Mary became more verbal. When she engaged in this behavior, it typically occurred throughout the entire session. Narration of play is a behavior that can only occur when a child is at least partially verbal, as it requires a good use of verbal language. Additionally, it requires the child to make a connection between what they are saying and what is happening in the moment.

After the first few sessions, Mary readily engaged in narration of play. This occurred at various times, including while engaging in symbolic play together in the dollhouse, and when playing more simplistic games such as rolling marbles. Mary's ability to narrate her play ranged from simply stating what was happening at the moment in her play, to it being used as a way of initiating a response from me. There were times when she would explain what was happening, and then repeat it again until I had verbally reflected what was happening in the play. In this way, she engaged in communication with me through her narrations. During one session, Mary and I were playing with the paint and paintbrushes. She referred to the paint as "mud" and the paint water as a "bath," during this particular session. As Mary's grey brush traveled along the table, she narrated, "Grey is in the mud. Now it goes to take a bath!" This vignette is a clear example of Mary's ability to explain and narrate her play during therapy sessions. Her symbolic play skills, such as referring to the paint as mud, and the paint water as a bath, were noted in this instance as well.

Narration of play was often observed throughout Mary's play, and regularly increased when typical CCPT reflections were made. It is possible that this behavior increased throughout the intervention due to the frequent reflections required of CCPT, as Mary responded well to reflections during sessions. Frequent reflections may have been a sign to Mary that I was engaged and paying attention to her throughout our work together. They also likely modeled a

way of narrating what was occurring, a style which Mary could have mimicked. Additionally, as she did not frequently engage in back and forth conversations in therapy, narration of play may have been a way for her to verbally engage with the therapy environment and myself as the therapist.

Verbal directing. Mary engaged in a great deal of verbal directing, with a moderate rate of change throughout the 20 coded sessions. Verbal directing is explained as verbally telling another person, or object, what to do (Wolfberg & Schuler, 2003). This behavior requires a great deal of verbal language, a skill which Mary continued to strengthen throughout our work together. As Mary was virtually nonverbal at the onset of therapy, this behavior would not have taken place.

Mary was often observed verbally directing toys or objects in my possession, through her own toy's action. For example, there were many sessions that we spent painting with watercolors and glitter glue. The paintbrushes used often assumed identities, complete with emotions and rules for playing. In our play, the paintbrushes were referred to by their color as if it were their name. For example, the name of "Blue" was given for the blue brush and "Purple" for the purple brush. Sometimes the brushes would paint, and sometimes they would interact with each other and go on adventures. During one particular brush adventure, Mary's blue brush encouraged my purple brush: "Purple! Come on, it's time for breakfast!" The brushes then "walked" together across the table for some paint water for breakfast. Other examples of verbal directing were seen when Mary would direct my actions by saying something such as, "Ashley, put dollhouse away." In both of these instances, Mary verbally directed my play and actions within the play therapy environment.

Verbal directing is another behavior that requires sophisticated verbal language skills, which Mary continued to develop throughout the intervention. Additionally, since Mary's nonverbal communication skills were not as well developed, she relied more heavily on verbal communication, such as verbal directing. This behavior likely strengthened throughout the intervention alongside Mary's verbal language skills. Furthermore, the frequent therapist reflections that were made during sessions may have been a good model for verbal language. It is likely that if the intervention continued, Mary's ability to engage in verbal directing would have continued to grow.

Asking questions. Asking questions was another communication behavior that increased modestly over the 20 coded sessions. This type of behavior can include asking any form of question, as long as it is relayed verbally and is directed at another person or an object (Wolfberg & Schuler, 2003). Verbal directing requires the child to relate to another person, as the question is directed at someone else. Additionally, at times it requires perspective taking to understand how the question may affect another person.

At times, Mary directed questions to the toys, and at other times, she engaged with me by asking a question. A clear example of asking questions occurred while painting one day, when Mary handed out different colors of paint. She asked, "what color do you want, Ashley?" In this instance, Mary was able to verbally engage with me, and use my name to draw even more attention to the task at hand. It is possible that Mary engaged in verbal directing more frequently as the intervention continued due to modeling of asking questions both in and outside of therapy. She may have also responded to the typical CCPT reflections beginning with statements such as, "I wonder…" Although the wonderment in nondirective, this may have been another form of modeling asking questions for Mary.

Noise mimicking. While noise mimicking had only a modest positive change in the behavior over time, there were some coded sessions when noise mimicking was a frequent part of the play (see Figure 3.2). Noise mimicking is described as creating words to sound like noises, such as "splat" (Wolfberg & Schuler, 2003). Noise mimicking can be looked at as taking a sound heard in a child's everyday life, and relaying during play. This behavior requires a great deal of imaginary thought, as the sounds, such as "splat," are often preconceived notions of what the sound should be like.

Mary infrequently engaged in noise mimicking in her play therapy sessions. When she did engage in this behavior, it often occurred many times throughout one session. During these moments, it was apparent that Mary was relaying noises that she had heard recently and was including them in her play that day. This did not typically extend across sessions. As stated above, considering the nondirective nature of CCPT, Mary was not asked to engage in any specific behavior. Therefore, unless she wanted to engage in noise mimicking in session, it simply would not occur. However, if she were to engage in this behavior, the therapeutic environment was one that supported this form of play and communication. Overall, it is possible that noise mimicking is another area that is not easily affected by an intervention such as CCPT, and may be a behavior that would more easily increase with directive and behavioral interventions.

Eye gaze. At the very beginning of our work together, Mary rarely made eye contact with me. However, throughout the 20 coded sessions, there were sessions with several apparent spikes in the number of times she made eye contact. Eye gaze had a modest rate of change over the 20 coded sessions. Eye gaze is described as eye contact that is made with another person, with the goal of connection (Wolfberg & Schuler, 2003). Along with other nonverbal methods of

communication, eye gaze is infrequently seen among children with autism. Additionally, lack of eye contact is regularly considered one of the most common symptoms when diagnosing autism and a frequent target of early intervention.

Due to the limitations of the video recording equipment, the actual number of times Mary made eye contact was not measured precisely, and this may have affected the findings in this area (see section on Limitations and Challenges to Research). It is conceivable that if the intervention had continued, Mary may have developed this desired behavior more fully. Through modeling in session, as well as modeling and initiating eye contact from individuals outside of the therapy environment, she may have engaged in this behavior more frequently over time. It is also possible that this is an area that is not easily altered and may not be greatly affected by a nondirective intervention such as CCPT. Fortunately, this is an area that is greatly impacted by ABA, and can be a target behavior in behavioral interventions.

Facial expressions. Over time, the behavior of displaying facial expressions showed a small rate of change over the 20 coded sessions. Facial expressions are considered any nonverbal communication that is displayed on the face, such as smiling or frowning (Wolfberg & Schuler, 2003). Typically developing children can often be seen recognizing facial expressions and mimicking them anywhere between nine to twelve months (Guerra, Williamson, & Lucas-Molina, 2012). Nonverbal communication, such as making facial expressions, in response to another person, is generally less commonly seen in children with autism than in typically developing peers. Professionals working with children with autism often highlight the deficiency of responsive qualities, such as facial expressions (Wolfberg, 2009). Children with this diagnosis can be frequently seen misinterpreting other peoples' facial expressions, as well as lacking their own facial expressions.

Mary was rarely seen making facial expressions in session, as she typically displayed flat affect. Additionally, due to the stationary camera, there were times when the camera was not directed at Mary's face for an extended period of time (see section on Limitations and Challenges to Research). Therefore, it is important to note that the coding of facial expressions may be somewhat inaccurate. Another possibility for the small improvement rate could be due to Mary's ability to communicate through other modes. As she began to use verbal language more over time, she did not need to rely on nonverbal communication methods as much. As various forms of nonverbal communication seem to be difficult for many individuals with autism, including Mary, she may have been more likely to use communication methods she felt she had mastered, such as narration or verbal directing. It is also possible that Mary would have used more facial expressions if the therapy were more behavioral and focused on reinforcements. However, due to the nondirective nature of CCPT, therapist encouragement and reinforcements were not used.

Gesturing. Gesturing was the only desired behavior that displayed a neutral rate of change over the 20 coded sessions. According to the trends over time, this behavior remained consistently low and stayed neutral during the entirety of the intervention. Gesturing is described as movements such as waving, pointing, and head nodding (Wolfberg & Schuler, 2003). In typically developing children, gesturing can be witnessed as early as nine months and will occur in order for the baby to gain attention from a caregiver (Guerra et al., 2012; Wolfberg, 2009). Gesturing is another form of nonverbal communication, which, as stated above, is less commonly seen in children with autism than in typically developing children.

Instead of gesturing, when Mary wanted something, she either verbalized what she wanted, or simply did it for herself. Sicile-Kira (2004) explains that occasionally, children with

autism develop gesturing systems for communication if verbal communication is a difficulty. It is possible that her nonverbal communication, such as gesturing, did not increase during the intervention because it was not required for communication, due to her rapidly increasing verbal language skills. It is also possible that due to the nondirective nature of CCPT, and a complete lack of initiating any behavior in the therapy, Mary did not engage in behaviors that were not required, such as gesturing. Instead, she engaged in behaviors that were more conducive to play, such as narrating her play and verbal directing.

Summary of communication methods. Overall, Mary's engagement in communication patterns of play grew as the intervention continued. Six out of the seven behaviors accelerated over the 20 coded sessions, and one did not change. The behaviors of narration of play, verbal directing, noise mimicking, and asking questions grew drastically over time. However, the nonverbal communication patterns of play, such as facial expressions, eye gaze, and gesturing, changed the least throughout the intervention. It is possible that if the intervention had continued, Mary would have engaged in all of the communication patterns of play beyond what was seen during the coded sessions. The frequent therapist verbal reflections and modeling of verbal language use in CCPT may have aided in the growth of communication behaviors if the intervention had continued longer.

Typically developing children often speak their first words between the ages of 13 to 18 months (Guerra et al., 2012). Two or more words are often combined by two years old. This is vastly different for children with autism, and the communicative developmental trajectory for each child with autism is varying. When Mary and I first began working together, she was using occasional single words and the majority of her communication was through PECS. Communication of any type is very important for children, as it allows for other people to

understand the child's perspective, wants, and needs. As a nondirective therapy, CCPT provides a space for children to explore their own methods of language and communication, which was seen throughout the implementation of the intervention with Mary. Mary displayed increasing verbal communication throughout the intervention through narrating her play and verbally directing.

Verbal communication skills, such as narration of play and verbal directing, show that a child can make the connection between the current action and thought. Additionally, both of these skills require the use of verbal language. In the postintervention semistructured interview, Mary's parents reported that before the inclusion of CCPT, she displayed a lack of verbal communication. While PECS had been introduced, she was rarely utilizing the system. Instead, Mary often communicated through tantrums, single words, and some gesturing. After the intervention, Mary no longer used PECS, and the majority of her communication was through verbal language. Language skills such as narrating play and verbal directing can only occur if the child has some verbal skills. As Mary's language skills grew during the intervention of CCPT, her ability to engage in both narration of play and verbal directing drastically grew as well. This was supported by her parents' reports that CCPT radically affected Mary's verbal language skills.

Asking questions also requires verbal language use, as well as perspective taking. Throughout the intervention, Mary's ability to ask questions grew, as she was able to direct questions towards the therapist, as well as towards toys. Although the change in this behavior was not substantial throughout the intervention, Mary's parents reported seeing great change at home. They explained that before CCPT, she used tantrums to communicate, and after the intervention, she was able to directly ask for what she needed. This is a skill that likely becomes

better developed as verbal language skills develop further. Although Mary easily accessed imaginary thought in sessions, she rarely utilized the skill of noise mimicking during therapy, which is closely connected to imaginary thought. As change was not great in this area, it is possible that growth of noise mimicking and asking questions would require more of a behavioral intervention, such as ABA. In an instance such as this, the therapist could model the behaviors, and reinforce the child after they imitated the action.

Children with autism often display difficulty in the area of nonverbal communication (Greenspan & Wieder, 2006). Throughout the intervention, Mary displayed very little growth in the nonverbal areas of communication, including facial expressions, eye gaze, and gesturing. Mary's parents reported that before the intervention, Mary displayed very little eye contact, and showed a "blankness" on her face. Despite seeing little growth among the coded sessions, after the intervention, Mary's parents reported that she often used eye contact when communicating with other people, especially when she wanted a direct answer to a question. They also reported that after the intervention, she displayed some facial expressions, and they were able to tell when she was upset, happy, or angry. Nonverbal communication is more abstract than spoken language, and is often used when children do not communicate verbally (Sicile-Kira, 2004). Mary developed strong skills in verbal communication over time, and therefore may not have needed to rely on her nonverbal communication as much as verbal language. The area of nonverbal communication is another area that may require more of a behavioral intervention, with modeling and reinforcements to recognize growth. However, given the increase in this behavior for Mary at home, additional research on CCPT for children with autism is warranted.

As children communicate through play, using play in therapy is very important. Landreth (2012) explains that when children play in therapy, their daily experiences can be communicated.

Play therapy also provides a space where children can explore different methods of communication, free of judgment. In CCPT, children are not required to communicate or interact with the therapist, and communication frequently occurs through therapist reflections (Ray et al., 2012). Mary responded well to the constant engagement and frequent therapist reflections of both her actions and communication throughout therapy, resulting in her comfort exploring her own methods of communication.

Hypothesis 3. The last question considered in this research was whether other symptoms would improve during the course of CCPT with a young girl with autism. Mary's parents noted many improvements in her behavior over time, including a rise in her grades and ability to complete work, her ability to socially relate to other people, and a decreased frequency of tantrums. What is unclear is whether or not behavior changes such as these were solely due to the implementation of CCPT, the utilization of other interventions, or Mary's developmental trajectory over time. No other symptom improvements were noted by Mary's parents in the postintervention semistructured interview. To highlight various symptom improvements, this section will focus on the postintervention semistructured interview with Mary's parents.

Interview with parents. I met with both of Mary's parents before coding the data to gain written consent to this project, answer any questions, and conduct a postintervention semistructured interview (see Appendix E). Upon meeting with me, her parents first expressed how sad they were that I no longer worked with Mary. Her mother disclosed that she tried to reenact the type of therapy I did with Mary, at home. I noted this as important clinical data about the usefulness of the intervention. It also demonstrated how the intervention began to generalize in other settings and over time. We then began the interview process by first discussing their experience of Mary in relation to her autism diagnosis, and continued to talk about any shifts in

behavior or symptoms they observed with Mary during our work together. Mary's parents also mentioned that while they, as well as Mary's doctor, believed she had ADHD, her parents did not want to follow through with an official diagnosis for fear that they would be pressured to put her on medication.

To begin, we talked about her parents' experience of the process when Mary was diagnosed with autism. Mary's parents disclosed that they chose to have Mary tested when she was five years old, as they had noticed behaviors that were vastly different from other children her age. They observed behaviors such as running in circles, a fascination with water, frequent tantrums, lining up toys, a lack of verbal communication, a lack of eye contact, and a "blankness" on her face. Both parents reported that before the diagnosis was made, they had a strong feeling she had autism. The diagnosis was made at a prominent hospital in the area. After the official diagnosis, Mary's parents reported great sadness, while also feeling a sense of relief. They disclosed considering seeking psychological services to help them go through this process, but ultimately decided against it.

Mary's parents spoke of the incredible changes they saw in Mary's behavior during CCPT, which they attributed to the intervention. They explained that before CCPT, Mary's play was very repetitive, such as spinning circular objects over and over again. They observed Mary wanting other children around, but not knowing how to relate to them. After the intervention, Mary still struggled with this sense of relatedness, but was more socially involved than she had been before. Before the inclusion of CCPT, Mary displayed hoarding behaviors and had a difficult time entertaining herself. Mary's mother recalled a time when she watched Mary engage with a toy farm set when she was a year and a half. She described Mary walking the cow across the farm. Mary's mother became teary eyed when explaining that for other parents this may not

have seemed like a big deal, but for her it was, as this was the first time she observed her daughter playing. After this moment, Mary did not display this type of play behavior again.

Her parents explained that while she still struggled to entertain herself after the intervention, Mary engaged in some solitary play with encouragement, and many of the hoarding behaviors subsided. They reported observing drastic changes in her play over the course of CCPT. They believed that Mary's play made more sense after the intervention and appeared to be reality based. They disclosed, "We know that what you did made a difference."

Mary's parents described believing that every aspect of her communication was better after the intervention, as compared to before the intervention took place. They explained that after the intervention, she verbalized how she felt and what she needed without having a tantrum. It was also apparent that she better understood what adults were saying to her, and often responded accordingly. Additionally, they reported that her eye contact improved compared to preintervention. They reported that when Mary really wanted an answer to something, she learned to make direct eye contact and patiently waited for an answer. Mary's parents also explained that her ability to cope with difficult situations improved. They stated that while she did not say what was wrong while she was upset, she almost always disclosed the problem after the fact. I found this feedback from Mary's parents to be crucial to understanding the changes that occurred for Mary and her behaviors over the course of the treatment.

Her parents explained that along with scheduled "free play time," they noticed that strict routine helped. They used a lot of charts around the house for Mary's behavior. Mary's parents reported that overall her behavior became more controlled and focused after the intervention. Her play made more sense and her communication and language was more accurate. When directly asked if they would recommend this type of intervention to another child diagnosed with autism,

Mary's mother replied, "one thousand percent, yes." She explained feeling saddened that Mary did not continue to receive the intervention. She continued to express to me how much of a difference it made in Mary's life, and in the lives of all her family members. Mary's mother disclosed that she "guaranteed" it would make a difference in the lives of other children with autism as well. Her feedback was not only validating, but I found it to be essential when considering the impact of the intervention for Mary.

Overall, when considering all eleven of the coded symbolic play and communication behaviors, it is clear that the majority of the behaviors showed a positive increase over time. Mary's parents reported noticing many of these behavioral changes, and were supportive of the intervention for Mary. Furthermore, they recommended the intervention for other children diagnosed with autism. Considering the results of this research, as well as Mary's parents' perspective, the intervention of CCPT should be considered for children diagnosed with autism as an adjunctive therapy.

Limitations and Challenges to Research

Despite the overall positive behavioral increases seen through this intervention with Mary, there are several limitations to the findings noted and challenges while conducting the research. Due to the implementation of the videotapes three months into my work with Mary, it is impossible to account for the first three months of therapy and the progress made during this time. Because the original sessions were not video recorded at the initiation of CCPT, this research cannot address the beginning of therapy and associated behaviors at the exact onset of the intervention.

Many of the challenges that surfaced during this study were due to the limitations of the recording equipment. The quality of the sound in the videos was poor and depending on where

Mary and I were in the room, at times it was hard to hear during coding. Additionally, due to the stationary camera, it was difficult to see some nonverbal cues and facial expressions in many of the shots. Therefore, coding behaviors such as eye gaze and facial expressions was difficult. It is likely that the coding for nonverbal communication may be somewhat inaccurate due to these issues.

Due to the case study design of this research, the results cannot be generalized beyond the case of Mary. Therefore, the upward trends that were found for symbolic dimensions of play and communication patterns have limited implications. Due to the varied developmental trajectory of play for different children diagnosed with autism, it is almost impossible to know which behavior changes were made due to Mary's natural developmental trajectory, which resulted from other concurrent interventions, and which were due to the CCPT intervention itself (Thomas & Smith, 2004). Wolfberg (1995; 2009) explains that without genuine play-based interventions, children with autism are unlikely to engage in any form of symbolic play. Nonetheless, while it can be surmised from this research and analysis that CCPT was associated with an increase in target behaviors for Mary, it cannot yet be assumed that it would be beneficial for all children diagnosed with autism, nor can a cause-and-effect relationship be assumed. Additional empirical investigation is necessary to generalize the findings of this case study.

Lastly, due to the nondirective nature of CCPT, integrating the intervention with other forms of directive behavioral interventions typically used when working with autism can be difficult. This may be especially difficult when interventions such as discrete trials are being used alongside CCPT. The nature of CCPT is child-directed, and the purpose is to move at the child's pace. If discrete trials were conducted during the intervention of CCPT, it would remove

any potential benefits of ABA and CCPT. Additionally, it may be confusing for the child in the session, as he or she may not be able to identify when directive interventions would occur, and when the child would direct the session. For these reasons, it is recommended that discrete trials not be conducted during CCPT sessions. Although Mary was involved with ABA during the beginning of our work together, none of the ABA interventions took place during our therapy sessions. Although involvement in two opposite interventions such as ABA and CCPT at the same time could be potentially difficult, in the case of Mary it did not seem to affect either therapy negatively. Overall, I see CCPT as a compatible intervention for many children diagnosed with autism.

Challenges in implementation of the intervention. The challenges of doing psychotherapy with Mary permeated all of our sessions. As a client, she was engaged and sessions were always exciting and new. However, implementing play therapy with a child with autism is vastly different than with a typically developing child. This is primarily due to the themes and content of therapy. Often, in a CCPT session with a typically developing child, it is common to see a larger number of both symbolic play and communication behaviors, than compared to a child with autism. As children make sense of their environment through play, CCPT can be a valuable place for a child to direct the play where they can engage in symbolic thought and communicate in whichever ways they feel most comfortable. However, Mary's play initially looked very different, as it was repetitive, rigid, and she rarely engaged in the target behaviors. Engaging in CCPT over time gave Mary the opportunity to explore the world of symbolic play as well as try out different methods of communication within her play.

When working with any child in psychotherapy, it is vital to reevaluate expectations for individual sessions and for the outcome of therapy. Therapists must greet each new session with

an open mind, as it is almost impossible to predict where the therapeutic journey will go from session to session. Additionally, when doing psychotherapy in a school setting, the therapeutic environment is not consistently controlled, as other factors, such as standardized testing and reorganization of scheduling must be considered. When working in a school setting, many therapeutic conditions may not remain stable from session to session (e.g., available toys). Additionally, due to the nature of the therapy room being the psychology office, there were many times when individuals other than Mary or myself needed to enter the room during our sessions. Along with the setting and materials, in a school there are a larger number of individuals involved with the child than there would be in individual therapy outside of the school system. Therefore, negotiations and conversations with all of these individuals are necessary for the child's benefit, so that everyone is in agreement about interventions that are conducted throughout the child's day.

Recommendations for Future Research

More research on beneficial psychotherapeutic interventions with this population is imperative, as the number of children with autism continues to grow. Considering the results of the current research, it is recommended that this research project be replicated in an environment that could provide more control in the research design. The environment should be complete with a playroom with a full range of therapy toys. The playroom should be a space where the toys remain stable and stay in the same place from session to session. Toys considered should be conducive to both symbolic play and interactive play. A suggested list of toys and supplies includes, but is not limited to: (a) dollhouse with dolls; (b) blocks; (c) Legos, (d) board games; (e) figurines, such as people, animals, and cars; (f) House and School sets; (g) paint and supplies; (h) drawing supplies; (i) board games; and (j) sand tray supplies. Video recording equipment

should have high quality sound and image capabilities, as well as the capacity to record from multiple angles.

Additionally, it would be important to attempt this research project outside of the school system. This would make it easier to keep the therapy room and materials consistent from session to session. It would be important that occurrences that could potentially interfere with the intervention, such as other professionals entering the room, would not take place and that the therapy be conducted in a secure environment. Overall, conducting the intervention in a more controlled environment would allow for treatment truer to the CCPT model and for empirically sound research.

Future research might examine whether a more directive approach, such as modeling and reinforcement, would increase the number of times a child incorporates imaginary objects within play. This could be completed through conducting this intervention with multiple children and an experimental design. Including comparison conditions would allow for more assurance that the intervention itself causes change. If multiple children were involved in the study, the groups could be split up by those receiving only CCPT, another group receiving CCPT and ABA, and another group receiving only ABA. To get a pure read on the effectiveness of CCPT, it is advised that children in the CCPT group not be involved in any ABA intervention outside of therapy. Additionally, those in the ABA group should not be receiving any outside CCPT. With comparison conditions such as these, there would be more confidence that behavior changes over time are due to the specific interventions as opposed to one individual's personal developmental trajectory.

To conduct CCPT with a child with autism, the child-centered play therapist must be well trained in autism and in CCPT theory and techniques. Without proper training and the correct

approach, CCPT would not be as useful as it could be. Efforts must be made to find a well-trained therapist and the proper environment for the therapy to take place.

To enhance effectiveness of the intervention, should it be replicated in the future, feedback from guardians, teachers, and other professionals working with the child would be important. During the therapy, the therapist and researcher only see the child during a specific amount of time, and therefore cannot bear witness to the ways in which the intervention may impact the child outside of therapy. A progress book could be used to follow the child, and would allow for any adult working with the child to write updates and learn about the child's day. This would provide a great deal of information about the child's entire week, which is vital for wrap around management of symptoms and behavior. Additionally, meeting with guardians before the therapy takes place to gather background information is helpful. Regular meetings can be set up in order to assess the guardians' perspective of the effectiveness of the treatment. Lastly, a meeting with guardians postintervention will give insight into the overall effectiveness of the intervention, and may give ideas for future work.

Who Should Receive this Intervention?

Without further research, it is nearly impossible to list all characteristics that would qualify children with autism for CCPT, as children with autism have vastly differing developmental trajectories. While Mary was virtually nonverbal at the onset of CCPT, she showed signs of her potential to communicate verbally. She used single words, and occasionally gestured and waved to communicate. Additionally, there were clear signs that she had a desire to engage in play and become associated with the world of symbolic play. Even without using verbal language, Mary engaged in dollhouse play. It is not clear how this intervention would work with children with autism who are much more impaired, or who are much higher

functioning, such as those who formerly would have been diagnosed with Asperger's Disorder. However, it can be speculated that children who are lower functioning, such as those who remain nonverbal, might not gain a great deal from this type of intervention. CCPT relies heavily on some sort of communication, which often occurs through play. Therefore, if verbal language and communication were a problem for a child, it is possible that CCPT would not be the best choice of interventions, and a behavioral approach such as ABA would be better suited. On the other hand, this study supports the possibility that for more verbal children with autism, CCPT might be a beneficial intervention.

Lastly, along with an extensive academic support team at school (e.g., autism program, speech and language pathologists, and occupational therapists), Mary had an incredible support team at home. As her parents noted in the semistructured interview, "We are Team Mary!" Mary's parents duplicated many of the interventions and goals that the school provided when she was home. Additionally, with a communication journal going back and forth from home to school each day, all individuals working with Mary were aware of how her day had been. Without the incredible support of her academic team and parents, it is possible that this intervention would not have been as successful. Still, the success of the current study reflects a need for additional research and exploration of more child-centered and play-focused interventions for children with autism.

While this form of therapy is not recommended for all children diagnosed with autism, it should be considered as an adjunctive intervention when working with this population. It is hard to pinpoint why all of the changes to Mary's symbolic play and communication behaviors occurred, as she was receiving a plethora of interventions throughout our work together. However, one certainty through the literature remains constant; play is too often disregarded in

the treatment of children with autism. While all children not only have the right, but the need to play, interventions for autism often place little emphasis on this right. CCPT provides the opportunity for children with autism to engage in symbolic play and communication in their own time, and in their own way. For children, daily life and their sense of reality is often expressed through play (Landreth, 2012). In order to begin to understand this reality, psychotherapists must enter the subjective world of the child. CCPT can be seen as a portal in which children with autism can explore play therapy and be understood, and all children deserve this opportunity.

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Appendix A

Permission for Therapy

Date

Parents of Client
Address
United States

Dear Parents,

My name is Ashley and I am a third-year doctoral student in clinical psychology at Antioch University. I am currently working as a practicum student at the _____ School with Dr. _____, Ph.D. throughout the 2012-2013 school year.

I have been speaking to ___'s case manager about working with _____. Specifically, I would like to support some of _____'s social/behavioral IEP goals, such as working on sharing, social play, and other socialization skills. I will be making an effort to minimize her time away from her core academic time. _____'s case manager and I have identified one 45 minute block during each week. This will not interfere with any of _____'s other services; rather, it will be a supplemental therapy.

I am writing to ask your permission to work with _____ under Dr. _____'s supervision. I will call you tomorrow or early next week (I'm here on Tuesday, Wednesday, and Thursday) to discuss this plan and answer any questions you might have.

Please feel free to contact me or Dr. _____ at any time if you have any questions or concerns. Our number is XXX-XXX-XXXX.

Thank you,

Ashley Morgenthal
Practicum Student

*This letter was used before working with the client. It has been adapted for purposes of this research to exclude any and all identifying information.

Appendix B

Permission to Videotape

Date

Parents of Client
Address
United States

Dear Parents,

I have been working with _____ in individual therapy for a month now, after having worked with her in the classroom during the beginning of the year. Over the past few weeks, she has made tremendous progress in social skills and play goals. _____ has been initiating sharing toys and taking turns with me. Additionally, she has been utilizing various forms of pretend play, while inviting me to join in the play with her.

I am writing to ask for your permission to allow me to videotape sessions with _____. Videotaping would help to track _____'s progress, and make it more possible to review gained skills over time. Additionally, they will be used for supervision purposes and only viewed by my supervisor, Dr. _____ and myself. I believe that this data will help us learn about the effect non-directive play therapy is having on _____'s overall IEP goals. The recordings will immediately be transferred onto a password-protected computer and will only be used for clinical purposes. All information will be kept strictly confidential. As soon as my work with _____ is complete, the videotapes will be destroyed.

If you grant permission for _____ to be videotaped, please fill out the following page and return to the school. This page should be kept for your own purposes. If you have any questions or concerns, please feel free to contact me, or Dr. _____ at any time. Our number at the school is XXX-XXX-XXXX.

Thank you,

Ashley H. Morgenthal
Practicum Student

*This letter was used before videotaping sessions with the client. It has been adapted for purposes of this research to exclude any and all identifying information.

Appendix C

Informed Consent

Dear Parents,

After working with _____ for the past two years in therapy, I am interested in using some of the information I have gathered as part of my dissertation research for my overall doctoral degree in clinical psychology at Antioch University New England.

The purpose of the study will be to gain insight into the effects non-directive play therapy has had as a supplemental therapy, on the symbolic play and communication skills for _____ over time. If you and _____ agree to be part of this research, I will select 10 minutes from one videotaped session per month, to be viewed by myself and another graduate student. The information viewed in the film will be coded in order to analyze _____'s progress over time. Additional, clinical therapy notes corresponding to the film dates may be used as supplemental material.

Although neither your daughter's nor your family name will be revealed, due to the nature of videotapes, the identity of _____ will not be anonymous to the second coder. However, all identifying information will be removed for the research proposal and final dissertation write-up.

By signing this document, you have given permission for me to use the videotapes and clinical notes gathered from previous sessions for research purposes. Additionally, verbatim vignettes may be utilized in the published report as examples of progress over time. There is a slight risk that your family could be identified based on the fact that there is only one person involved in this research. However, it is highly unlikely that any of this information will be able to be traced back to your daughter or your family. After the research is completed, all of the recordings and clinical notes kept in the confidential and password protected file will be destroyed.

Any questions can be directed to me by email or phone: email - amorgenthal@antioch.edu, cellular phone – (914) 263-9796. You may reach my clinical supervisor, Dr. _____ at (XXX)XXX-XXXX, and my dissertation advisor, Dr. Kathi Borden at kborden@antioch.edu or Don Woodhouse, Interim Chair of the Antioch University Institutional Review Board (603-283-2101 or dwoodhouse@antioch.edu).

You will be given a copy of this consent form for personal records.
Once this document is signed, it shows that you have consented to participate in this research study, have read the above information, and agree to all of the terms and conditions.

_____ _____ _____

Name of Participant *Signature of Researcher* *Date*

_____ _____

Name of Legal Guardian *Signature of Child Participant (optional)*

_____ _____

Signature of Legal Guardian *Date*

Appendix D

Framework for Observing Data

Framework for Observing Symbolic Dimensions of Play Patterns

Symbolic Play Scheme	Number of Times Enacted
Object Substitution: e.g. utilizing one object to represent another.	
Incorporating Imaginary Objects: e.g. absent object is used as if it were present.	
Role-playing Scripts (real or invented) with self, others, or toys: e.g. verbally playing out scenarios.	
Interactive Play: e.g. involving another person into fantasy world through initiating social engagement, and sharing, and taking turns.	

Framework for Observing Communication Patterns of Play

Communication Scheme	Number of Times Enacted
Facial Expressions: e.g. smiling and frowning.	
Eye Gaze: eye contact made with another person with the aim of redirecting attention.	
Gesturing: e.g. waving, pointing, and head nodding.	
Noise Mimicking: e.g. creating words to sound like noises such as “splat!”	
Narration of Play: when child narrates what he or she is doing, while the action is being completed.	
Verbal Directing: verbally telling another person what to do.	
Asking Questions: question must be directed at another person.	

Play Themes:

Play Themes:

Adapted from Wolfberg, P & Schuler, A. (2003). *Peer play and the autism spectrum: Integrated play groups field manual*. Kansas: Autism Asperger Publishing Co.

Appendix E

Semistructured Interview with Parents Postintervention

1. When was your child first diagnosed with autism? When was she first diagnosed with ADHD?
    a. What was your experience of the process of testing/assessment?
    b. How do you think your child experienced the process of testing/assessment?
    c. What was your reaction when you found out about the diagnosis?
    d. Did you ever receive counseling, support, or consultation regarding these findings?
        i. Have you considered joining a support group for parents of children with autism diagnoses?

2. At the time of diagnosis, what behaviors were you noticing?
    a. Did you notice any excess of behaviors?
    b. Did you notice any deficits in over behaviors?

3. Tell me about the changes you have seen in your child's behavior, in relation to symbolic play, over the last two years?
    a. What is her solo play like now, in relation to two years ago?
    b. How does your child relate to peers during play?
    c. Does she spontaneously engage with other people while playing?
    d. Have you noticed any changes in specific play characteristics, such as repetitive themes, rituals, or stereotyped behavior?

4. Tell me about the changes you have seen in your child's behavior, in relation to verbal communication, over the last two years?
    a. Have you noticed any changes in her ability to make or sustain eye contact?
    b. Does she spontaneously engage in communication with you or other people in her life?

5. Have you seen any changes in her coping skills, or her ability to handle frustrating situations?

6. What is your experience of your child's current pretend play and communication skills? Has this changed at all over the years?

7. Is there anything else you would like to add about your child's play or communication styles, or about any changes you have noticed over the past two years?

8. Would you suggest this form of therapy as a supplemental intervention, to parents of other children diagnosed with autism?

Appendix F

Figure 12. Symbolic Dimensions of Play Patterns Over Time: Raw Data

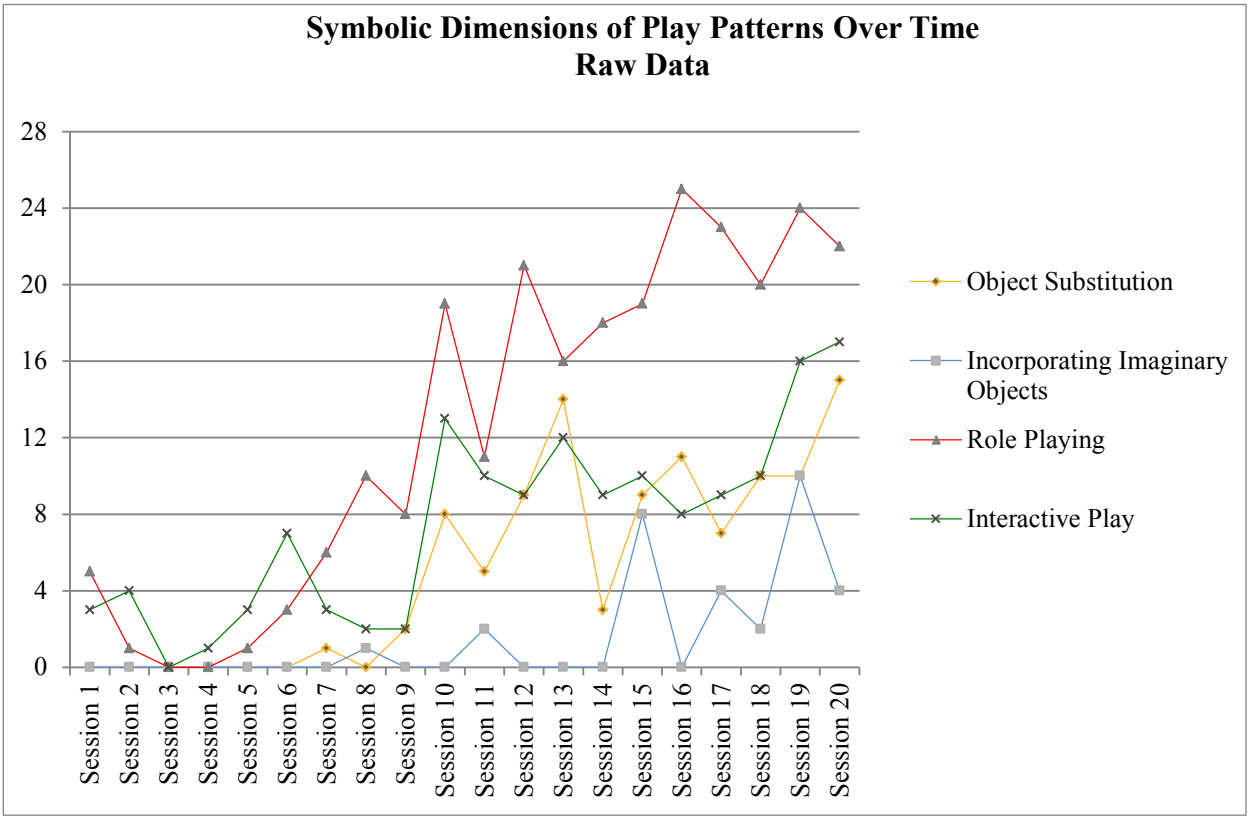

Figure 13. Symbolic Dimensions of Play Patterns Over Time: Trends Over Time

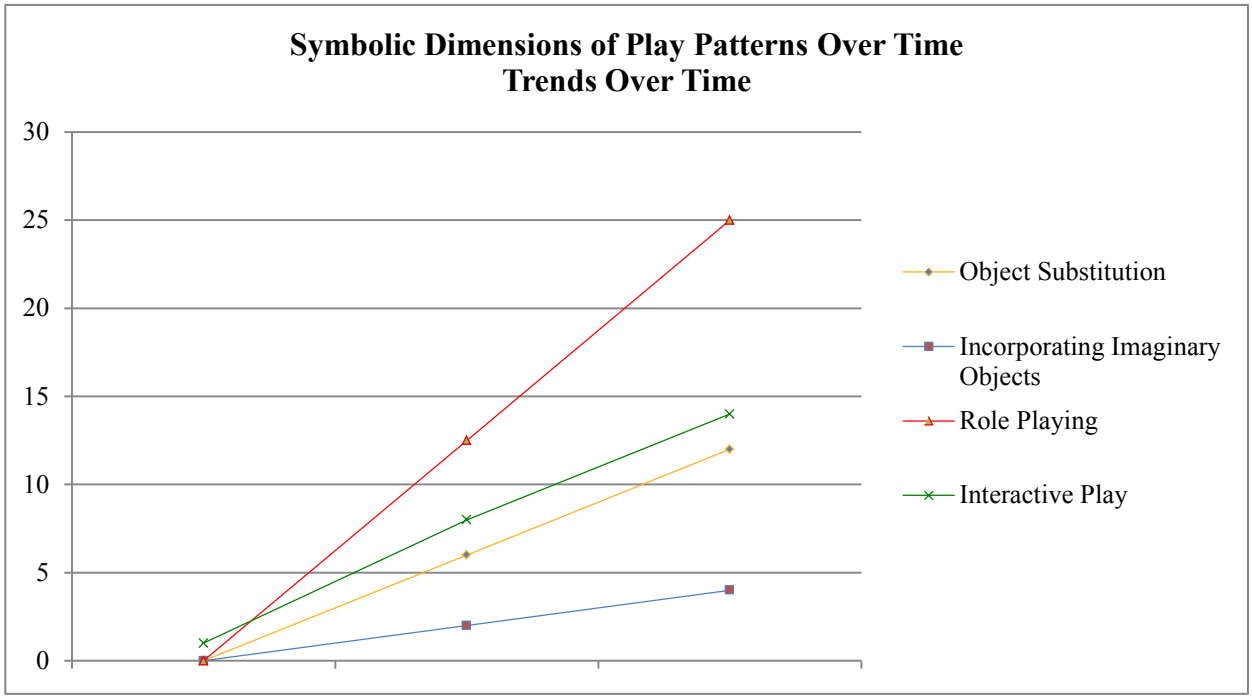

Figure 14.1 Communication Patterns of Play Over Time: Raw Data

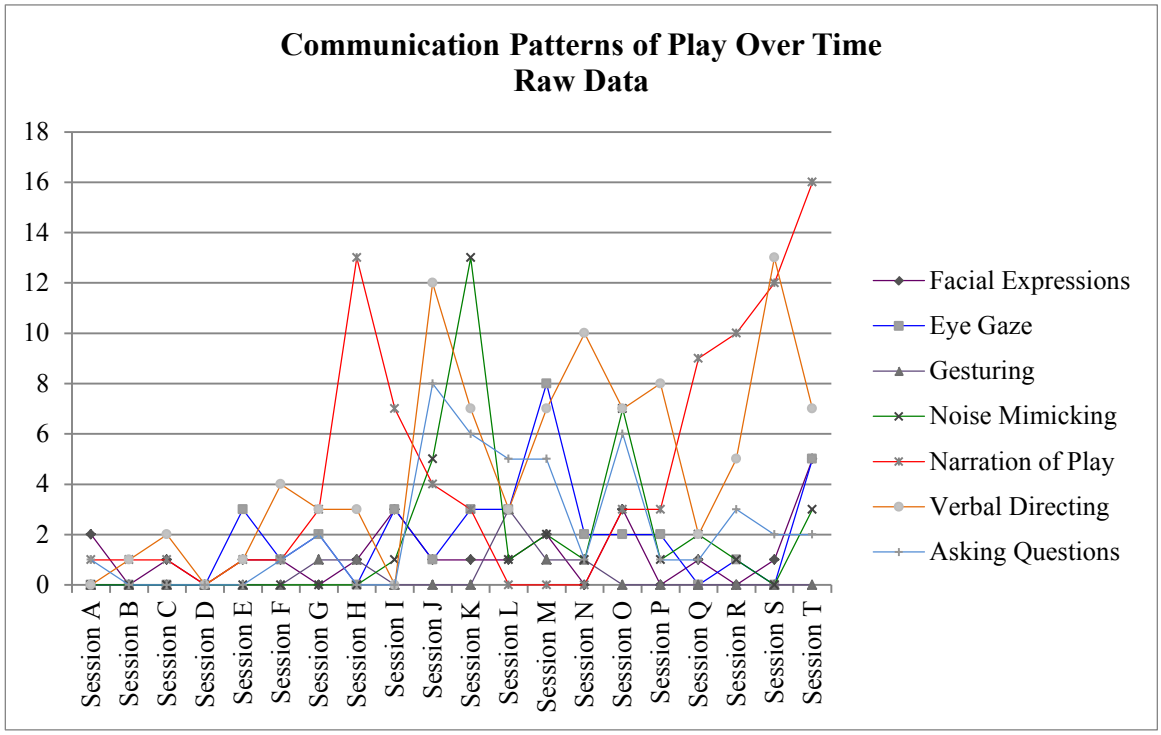

Figure 14.2 Nonverbal Communication Patterns of Play Over Time: Raw Data

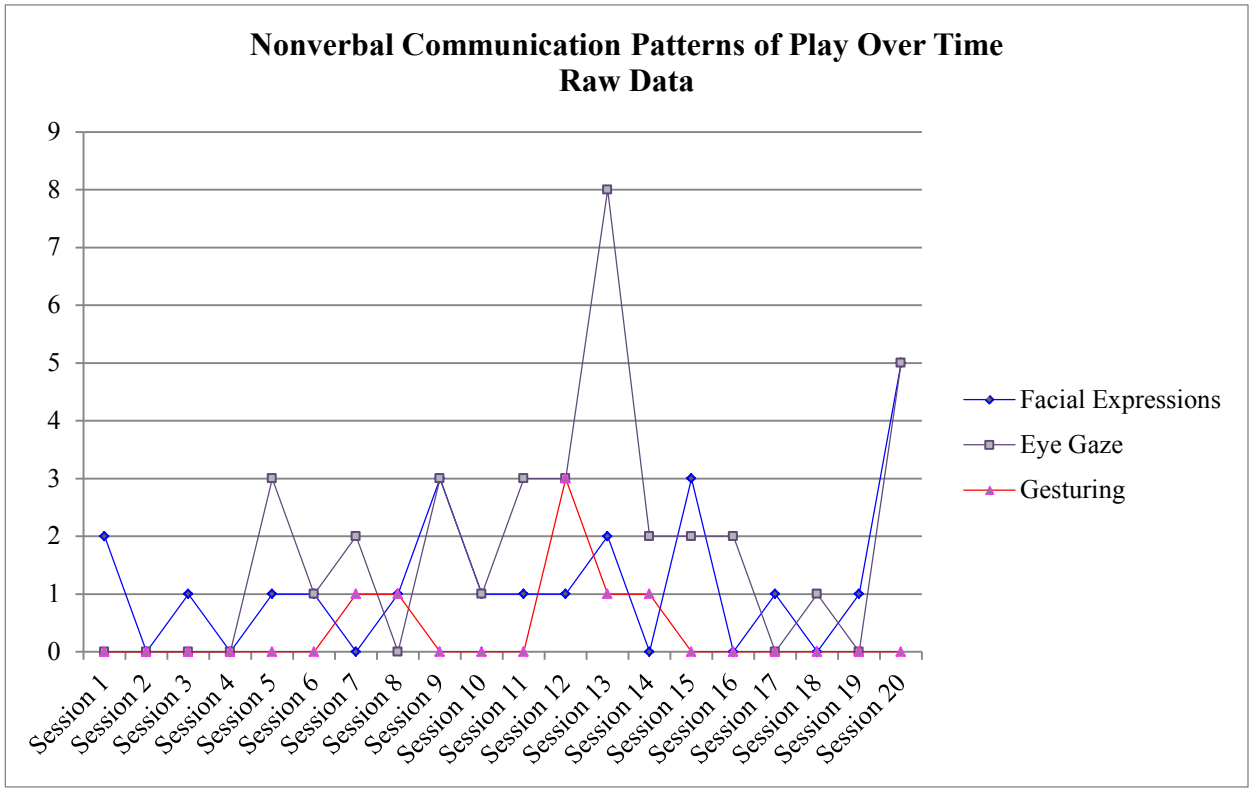

Figure 14.3 Communication Patterns of Play Over Time: Raw Data

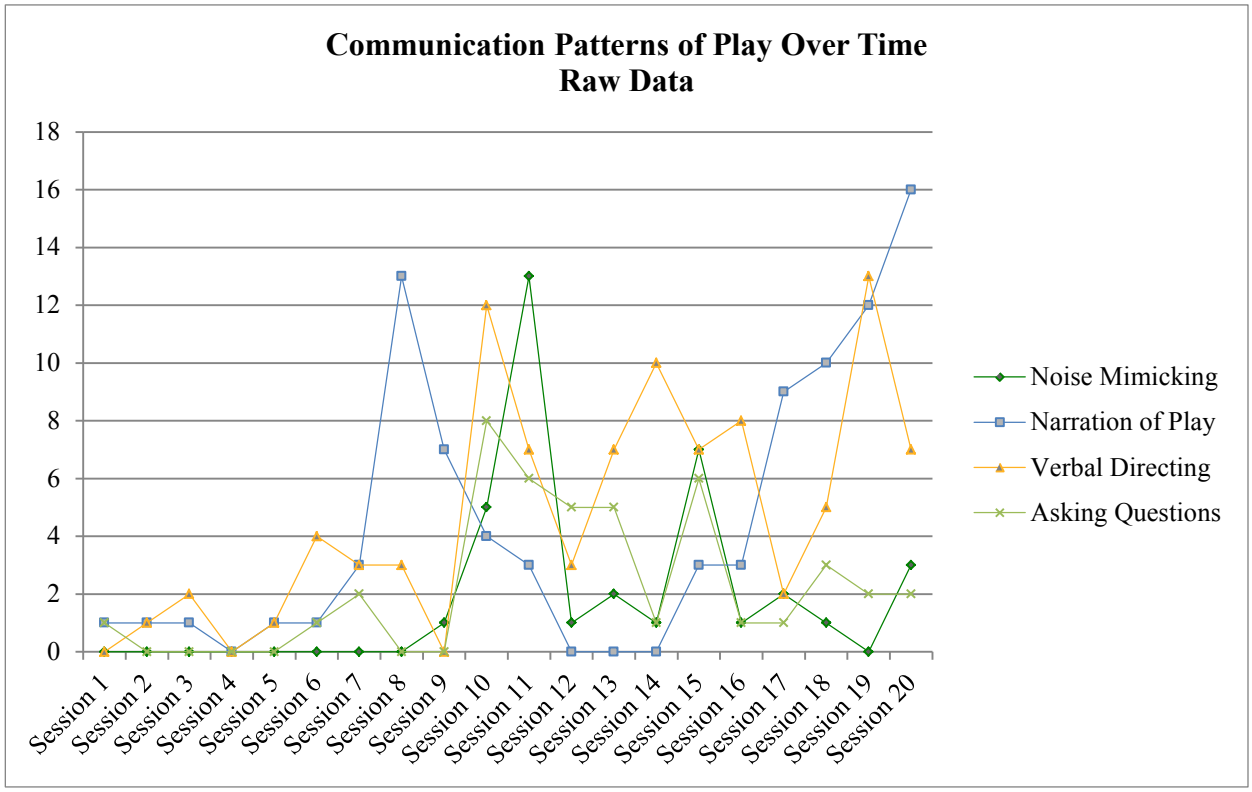

Figure 15. Communication Patterns of Play Over Time: Trends Over Time