A Qualitative Case Study: Stories of Healing Children with Disabilities and Play Therapy

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This dissertation titled
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Children with disabilities represent a marginalized population who confront many obstacles in achieving optimal health and social experiences (Laudan & Loprest, 2012). Specifically, children with disabilities encounter various obstacles towards adjusting to a different way of living. Many children with disabilities experience societal and attitudinal barriers that further exacerbate the disability adaptation process. As a result, clinical counselors hold a foundational role towards empowering children with disabilities (Henderson & Thompson, 2011). However, practitioners must maintain a level of competence and understanding of the common challenges that children with disabilities encounter. Unfortunately, there remain significant limitations in the counseling research for serving children with disabilities. Considering the diversity of cognitive, verbal, and motor functioning of children with disabilities, clinicians must explore more innovative treatment modalities for serving children with disabilities.

The purpose of this study was to gain a greater understanding of the play therapy experience for children with disabilities who participated in play therapy services at The Child Protection Center of Ross County. Since it is common that counseling professionals serve children with disabilities, this study offers professionals additional insight into the potential benefit of play therapy for children with disabilities. This dissertation provides a rich thick description of the experiences of five children who
participated in play therapy intervention with a child advocacy center in south central, Ohio.

This dissertation employs qualitative research that uses naturalistic inquiry. This qualitative study utilized separate semi-structured, open-ended interviews with five children with disabilities who were served by a child advocacy center in southern, Ohio. Additional interviews were conducted with three of the caregivers of these children, and two play therapists who were responsible for delivering play therapy services. All of the children who participated in the study are residents of southern, Ohio and were referred for play therapy intervention in through the local child advocacy center. Each interview provides an avenue to generate and describe the play therapy experience for children with disabilities. Data was collected through digitally recorded semi-structured interviews, field notes, and observations.

This qualitative inquiry addressed one research question. What are the experiences of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County? The analysis of interviews, observations and field notes generated eight emerging themes. These emerging and salient themes were then compared and contrasted with prior literature that explores the use of play therapy for children with disabilities. In addition to the descriptions provided from the data of this discovery, outcomes from this investigation further offer implications for a variety of professionals who work with children with disabilities. Findings from this examination have provided valuable data that can enhance services for children with disabilities who are served by a variety of professional. However, specific recommendations are
delineated for clinical counselors and rehabilitation counselors. Recommendations for future research are also discussed within the context of this inquire.
Dedication

I would like to dedicate this dissertation to my niece, Kaycee R. Bethel.

You have proven how resilient children can be, and have been such an inspiration.
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I would first like to thank God for providing me with the knowledge, skills, and motivation to complete this journey. My faith has provided me strength throughout my academic experiences. However, God has given me many blessings and has held me up in the face of many adversities.

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Chapter 1: Introduction

This dissertation contains a rich thick description of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County. Specifically, the qualitative case study has utilized two strategies for data collection that include observations and semi-structured interviews. Semi-structured interviews were facilitated with children with disabilities who participated in play therapy services at a nationally accredited child advocacy center in southern, Ohio. However, to further enhance the data obtained from the children who participated in this study additional semi-structured interviews were completed with caregivers of these children. Moreover, two play therapists who offered services to the children who were selected for this study were also interviewed to add additional texture to this investigation. The data obtained from these various populations collectively provided the outcomes of the study and contributed valuable information towards acquiring a more detailed understanding of the experiences of children with disabilities who participated in play therapy services. Analysis of this case study has offered emerging themes that will contribute to the existing literature relevant to this population. This case study has also provided implications for future research and offer recommendations for clinical counselors and rehabilitation counselors who work with children with disabilities.

This initial chapter presents a background and overview of the current case study. A summary of this qualitative case study will be described throughout the present chapter. Specifically, this section will offer the background of the study, the statement of the problem, the purpose of the study, and the research question for this investigation. A
summary of the methodology for the present inquiry and discussions of limitations for the present study will also be included. This chapter concludes with a list of terms and definitions.

**Background of the Study**

Unfortunately, children with disabilities represent some of the nation’s most vulnerable citizens (Laudan & Loprest, 2012). Children who acquire a disability often encounter a great deal of challenges with disability adaptation, attitudinal, and environmental barriers. It remains common that children with disabilities experience many negative emotions as a result of their disability (Henderson & Thompson, 2011; Lorenz, 2010). Anxiety, fear, depression, and shame are cited as some common emotions that children with disabilities confront (Henderson & Thompson, 2011). Similarly, children with specific disabilities commonly develop maladaptive coping skills, poor communication skills, poor conflict resolution skills, and lower levels of self-esteem prior to child maltreatment (Shannon, 2006).

More disturbing is the fact that children with disabilities are not only vulnerable to these psychosocial difficulties, but are frequently violated as a result of child abuse and neglect. The professional literature across the past 24 years has reinforced the hypothesis that children with disabilities confront an increased risk of child maltreatment (Gore & Janssen, 2007; Sullivan & Knutson, 2000; Westcott, 1993). As early as 1993, the professional literature began to document the increased prevalence of child abuse and neglect for children with disabilities (Westcott, 1993). Gore and Janssen (2007) stated that a child’s disability was a significant factor for child
maltreatment in that a child’s disability was either a contributing factor or a precipitating factor in an overwhelming number of child maltreatment cases.

Despite these painful realities, the response towards addressing the psychological and environmental risk for children with disabilities remain problematic. Although it is common that children with disabilities are served by a multitude of professionals, it appears that significant gaps continue to exist in meeting the needs of this vulnerable population (Laudan & Loprest, 2012). There are a variety of professionals who serve children with disabilities. The professional disciplines who commonly serve children with disabilities include physicians, hospital personnel, social workers, psychiatrists, physical therapists, occupational therapists, speech therapists, nutritionals, personal care assistants, transportation professionals, clinical counselors, and rehabilitation counselors (Batshaw, Pellegrino, & Roizen, 2007). Laudan and Loprest (2012) reported that our nation invests over sixty billion dollars annually to assist children with disabilities. However, children with disabilities continue to confront major challenges despite these financial investments.

Arguably, it appears that our helping professionals continue to face major challenges towards best serving and advocating for children with disabilities. The professional responses toward serving this population have continued to yield poor outcomes. Henderson and Thompson (2011) reported that educators commonly cite a lack of preparation for working with children with disabilities. Similarly, Hibbard and Desch, (2007) cautioned that medical professionals often encounter difficulties in recognition of child abuse and neglect for children with disabilities. As a result, children
with disabilities often have poor health, lower educational attainment, poverty, and
dependency on public support, juvenile delinquency, and are unable to live independently
(Laudan & Loprest, 2012)

Likewise, the professional literature has cited a lack of recognition from child
protective services (CPS) workers who serve children with disabilities. Therefore, it has
been recommended that CPS workers receive additional training on identification of
children with disabilities and evaluating children with disabilities regarding the potential
for abuse and neglect (Hibbard & Desch, 2007). In addition, numerous children with
disabilities are placed within the foster care system and/or residential facilities each year
(Gore & Jansenn, 2007). As, children with disabilities are disproportionately represented
within child welfare agencies (Shannon, 2006). The literature has documented that
adolescents with disabilities are significantly overrepresented within the child welfare
system (Ringeisen, Casanueva, Urato, & Cross, 2008). Likewise, it is estimated that up to
thirty-one percent of the 200,000 youth placed in residential care are diagnosed with at
least one disability (Trout, Casey, Chmelka, DeSalvo, Reid, & Epstein, 2009).

Tragically, these numbers represent the fracture system when serving children
with disabilities. These systematic failures further exacerbate the emotional, physical,
social and psychological obstacles that children with disabilities confront. It is not
surprising that individuals with disabilities or chronic illnesses encounter various
obstacles toward adjusting to a different way of living (Henderson & Thompson, 2011).
Professionals have recognized the emotional challenges for children with disabilities for a
number of years (Carmichael, 2006; Williams & Lair, 1991). However, counseling
profession has continued to encounter challenges in adequately addressing the emotional needs of children with disabilities (Henderson & Thompson, 2011). Persons with disabilities or chronic illness must synthesize their lived experience through a new view in which they have lost a physical or psychological function (Michailakis, 2003; Smart, 2007). Therefore, it is likely that persons with disabilities will participate in counseling services to address many of these identified challenges (Carmichael, 2006; Henderson & Thompson, 2011).

Clinical counselors like other professionals are continually exploring opportunities for serving children with disabilities. Yet, there remain significant limitations in the literature to assist counselors towards empowering children with disabilities in the therapeutic environment (Carmichael, 2006; Henderson & Thompson, 2011). It is important for professionals who work with this population to maintain a level of competence and understanding of the various challenges that people with disabilities experience. Homeyer and Morrison (2008) argued that there remains an overwhelming and critical need for professionals with specialized competencies to serve children with disabilities. However, these competencies can only be acquired when professionals gain an adequate understanding of the broad range of disabilities that exist as well as an accurate understanding of the meaning of the term “disability.” This provides a framework for the present study.

Statement of the Problem

It is evident that children with disabilities encounter a great deal of challenges with disability adjustment and attitudinal and environments barriers. These often include
the negative perceptions of others as the result of a child’s disability and obstacles towards educational equality and attainment (Henderson & Thompson, 2011). Moreover, children with disabilities are not only vulnerable to these psychosocial difficulties but are frequently violated as a result of child abuse and neglect. It is estimated that at least thirty-one percent of all children with disabilities become victimized as the result of child abuse and neglect (Sullivan & Knutson, 2000). Unfortunately, these statistics represent a tragic reality that has created a broad consensus among professionals that children with disabilities confront an increased risk of child abuse and neglect (Sullivan & Knutson, 2000; Shannon, 2006). Consequently, counseling models that provide effective treatment are paramount for children with disabilities.

The problem addressed in this study is to increase the understanding of the experiences of children with disabilities who participate in play therapy services. The examination offers a rich thick description of experience of children with disabilities who participate in play therapy services at The Child Protection Center of Ross County. The current investigation has provided a qualitative case study that will assist professionals in gaining a more detailed understanding of the play therapy experiences of children with disabilities. Specifically the generation of a rich thick description of the play therapy experiences of children with disabilities who have participated in play therapy services at a facility with trained play therapy professionals, will offer alternative perspectives for professionals who work with this population.
A limited number of traditional counseling models have been proposed for working with children with disabilities (Henderson & Thompson, 2011). However, these approaches have failed to provide consistency for children with varying limitations in cognitive and communication abilities (Carmichael, 2006; Henderson & Thompson, 2011; Lorenz, 2008). The outcomes for children with disabilities and traditional counseling paradigms have largely been dependent upon a child’s verbal and cognitive competences (Lorenz, 2008; Landreth, 2002). Moreover, most approaches have failed to explore the therapeutic experiences of children with disabilities but rather utilized quantitative measures to support the efficacy of the model. Consequently, this qualitative case study examined the play therapy experiences of children with disabilities through a child advocacy with play therapist who specialize in working with traumatized children. Unlike quantitative investigations this study offers a more detail account of the phenomenon of children with disabilities who participate in play based interventions.

In particular, this study has utilized observations and semi-structured interviews with five children with disabilities who participated in play therapy services at The Child Protection Center of Ross County, their caregivers, and play therapists who facilitated these services. Evidence obtained through the present inquiry has offered valuable information that can assist professionals towards acquiring more in-depth understanding when working with this population.

**Purpose and Significance**

The goal of the current investigation is to acquire a more detailed understanding of the experiences of children with disabilities who participated in play therapy services.
specifically at The Child Protection Center of Ross County. This inquiry is important as it offers play therapy as an alternative counseling approach for children with disabilities. The significance of the present investigation is illustrated in emerging themes that support the therapeutic benefits of play. Therefore, professionals who serve children with disabilities may gain an increased understanding of the play therapy experience of children with disabilities who participate in play therapy services.

To obtain a rich thick description of this phenomenon qualitative methods were employed. Specifically, data were generated from observation methods and semi-structured interviewing. A rationale for qualitative inquiry is built upon the primary goal for this case study as professionals recognize the value of qualitative inquiry as it enhances an individual’s interpretation of a lived experience of a particular phenomenon (Glazer & Stein, 2010). As such, this study identified qualitative strategies as the most effective means towards acquire a more detailed account of the play therapy experiences of children with disabilities.

The practice of play therapy, like other counseling theories, is not immune from the on-going debate of producing replicable scientific data to provide credibility. As such the literature that supports play therapy as an effective and beneficial counseling paradigm is robust (Gil, 1994; Landreth, 2002; LeBlanc & Ritchie, 2001; Ray, Bratton, Rhine, & Jones, 2005). Moreover, the research that explores the use of play therapy for children with disabilities (Demanchick, Cochran & Cochran, 2003; Johnson, McLeod, & Fall, 1997; Kenny & Winick, 2000; Swan & Ray, 2014) has also been beneficial. A more comprehensive review of the play therapy literature will be provided in Chapter Two.
Yet, there continues to be limitations within the research that explore the lived experience of children with disabilities who participate in play therapy services. Therefore, this qualitative case study has contributed to the existing literature by offering a more detailed view of the play therapy experiences of children with disabilities who are served by a child advocacy center.

**Research Question**

The qualitative case study examined the lived experiences of children with disabilities who participated in play therapy services with a child advocacy center in southern, Ohio. Qualitative methods were used to answer one research question.

- Specifically, what is the experience of children with disabilities who participate in play therapy services at The Child Protection Center of Ross County?

The study was conducted in December, 2016 through a selection of participants and completion of interviews. A total of ten participants were selected for the present investigation. Specifically, the study examined the experience of five children with disabilities who participated in play therapy services at the facility through semi-structured interviews. Additional contributions to the study were obtained through semi-structured interviews with three of the caregivers of the child participants, and semi-structured interviews of two play therapist who provide services for children at this facility. By addressing the research question a rich thick description is offered to further empower professionals who work with this population.
**Research’s Philosophy**

The underlying philosophy of this research is that children with disabilities benefit from the experience of play therapy. Thus the focus is on the play therapy experience of children. According to Creswell (2007), the focus of qualitative research is to understand the meaning that events have for the individuals being studied. Consequently, this approach is offered to gain a greater level of understanding to what meaning children with disabilities ascribe to the play therapy experiences and how these experiences may influence his/her worldviews. The strength of qualitative research comes from the words of the participants and his/her actions. As a result, the following methods are proposed to capture the experiences through the language of participants. These include observation of play participants, interview data, and field notes (Patton, 2002).

**Psychosocial Adaptation to Disability**

The theoretical framework that also guides this research is the Psychosocial Adjustment to Disability. Individuals with disabilities must continually confront the challenges associated with the experience of their disability and the societal beliefs and perceptions about disability. As persons with disabilities attempt to assimilate themselves into a culture of environmental and attitudinal barriers, it is not surprising that they will experience a wealth of psychological reactions. Many have argued that adaptation to disability is a complex and continuous process (Livneh & Antonak, 1997; Kendall & Buys, 1998; Olkin, 1999; Smart, 2001). The rehabilitation literature remains saturated with countless theories that attempt to explain the phenomenon of psychosocial

In conjunction with these previously cited psychological challenges, there has been a wealth of research associated with the psychological adaptation to disability (Smart, 2009). Disability adjustment is a process that incorporates an array of emotions that can span over many years. The psychosocial stages of disability adjustment offer insight into common reactions that individuals may experience. These stages are not a linear process as not everyone will transition through every stage. Similarly, each of the domains of psychosocial adjustment has no specific timeframe. Therefore, this process is very individualized for persons with disability (Smart, 2009).

The adaptation to disability is a complex and challenging experience for persons with disabilities. According to Livneh and Antonak (1997), an individual’s adjustment to a disability is “an evolving, dynamic, general process through which the individual gradually approaches an optimal state of person environment congruence” (p. 8). There has been an abundance of research devoted to adaptation to disability process. Attempts to define, articulate, and apply various theories of the adaptation to the disability process have been well documented in the literature for more than half a century (Livneh, & Parker, 2005). Despite the exhaustive study of the adaptation process, this concept does not come without controversy. The debate is likely represented by the volumes of literature devoted to this area of study (Smart 2001).

Smart (2001) proposed six specific stages of disability adjustment. These include, 1) shock, 2) denial/defensiveness, 3) depression, 4) regression, 5) anger and questioning,
and 6) integration and acceptance (p. 244). The first stage introduced by Smart is shock, which is characterized by a sense of devastation and chaotic thinking. This stage is often the hallmark of the abrupt change that occurs with the onset of a disability. The next stage identified in the adjustment process is denial and defensiveness. An individual’s resistance to except the permanency of a disability is the common indicator of the stage. The third stage in this adaptation process is depression. Feelings of desperation, sadness, and hopelessness are characteristic during this transition. Regression is identified as the forestage in the disability adaptation process. This is represented when an individual reverts to previous behaviors. Anger and questioning are identified in the fifth stage of this philosophy. Individuals with disabilities exhibit internalized and externalized anger during this time and begin to question a new life with the onset of a disability. The final stage of this theory is integration and acceptance. During this period individuals with disabilities integrate new goals, values, and believes with their disability (Smart, 2001).

The psychosocial adaptation to disability offers important insight for professionals who work with individuals with disabilities. However, these stages of adaptation have most commonly been applied to adults with disabilities. Although Power and Dell Orto (2007) reported that children with disabilities experiences similar emotions as adults with disabilities, limited application of the psychosocial adaptation has been published related to children. Therefore, studies are limited that capture the true experiences of children with disabilities (Henderson & Thompson, 2011). Consequently this research study has offered an important opportunity for professionals to gain an
increased understanding of the experience for children who participated in play therapy services.

**Qualitative Methodology**

As previously addressed the research design for the present study used a qualitative approach to address the research question. This research philosophy is the most appropriate to answer the research question as the present study examined the experiences of children who participated in play therapy services. In contrast, quantitative research would be ineffective to address the research question identified in the current investigation. Creswell (2007) stated that the goal of qualitative inquiry is to investigate and gain an understanding of the meaning and complexity of individuals or groups ascribed to an experience. Qualitative research “begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a human problem” (Creswell, 2007, p. 37). Glazer & Stein (2010) asserted that qualitative research is the only research model that explores the experiences of an individual. Consequently, this expands the professional’s view of participants experience and offers a more broadened worldview (Snow, Wolff, Hudspeth, & Etheridge, 2009).

Although play therapy professionals can use all forms of scientific inquiry to advance the field, qualitative methodologies provide unique insight into the play therapy experience. According to Patton (2002), qualitative findings are produced from three sources. First, qualitative data can be achieved through in-depth, open interviews. In addition, direct observations can yield important qualitative results. Written documents
are another source of qualitative discovery. Qualitative research involves a group of inquiry designs that include case studies, narratives, ethnography, grounded theory, hermeneutics, phenomenology, and heuristics (Creswell, 2009; Glazer & Stein, 2010; Moustakas, 1994).

Within the present inquiry qualitative methods yielded a collection of data and identification of a number of themes (Patton, 2002) regarding the experiences of children with disabilities who participated in play therapy services at The Child Protection Center. As a result the study expanded the meaning of the play therapy experiences for children with disabilities through a descriptive case study presentation. Narratives of the participant studied are delineated in a descriptive manner that allows professionals to gain a more advanced understanding of the child’s world. Likewise, a completed review of the participant’s responses to interview questions strengthens the case study. Creswell (2007) stated that information within case studies should be thorough and obtained through multiple resources. The sources of information can include “observations, interviews, documents, and audiovisual materials” (p. 74).

Qualitative case study measures have been introduced as a means to determine the efficacy of play therapy interventions. The case study model has been the frequent method of research according to the play therapy literature (Ray, at al., 2005). Case studies encompass a thorough description of the child’s case history and his or her progression throughout the play therapy process. The goal of these descriptions is to obtain new understandings about how play therapy impacts a child and/or his/her family. Although this approach has been popularly implemented, the lack of numerical data to
support outcomes has led to many critics discounting the importance of this form of study (Carroll, 2000).

The investigator utilized a purposeful sampling strategy for selection of participants for the research. Purposeful sampling is defined through the identification of research participants who experienced the phenomenon under investigation (Creswell, 2007). All of the children who participated within the present study were identified as children with disabilities who had participated in play therapy services at the identified facility. Additionally, three caregivers of these children were also selected for participation in the present study and these individuals were selected based upon their child’s participation in the study. Two play therapists who facilitate play therapy services for children with disabilities were also selected to participate in the current inquiry.

Recruitment of participants occurred through contact with play therapists at The Child Protection Center of Ross County. Two play therapists employed by the center discuss participation in the present study with three children with disabilities and their caregivers who were participating in play therapy services. Two additional children were identified for participation in the current study after their adopted mother ask her child's therapist about the current research study after seeing a recruitment flyer on the agency's bulletin board. The researcher met with all of the children, caregivers, and play therapist selected in for the study prior to their initial participation. The child custodians and play therapist were provided an overview of the research proposal and offered an opportunity to ask questions before authorizing consent for participation.
All of the participants who participated in the research are from south central and southeastern Ohio. The child advocacy center identified in this study provides services to ten rural counties in south-central and southeastern, Ohio. As a result, the participants of current study are from this region and represent the same geographic region of Ohio. Consequently, demographic and cultural considerations identified the sample as homogeneous of the Appalachian culture.

Limitations

All forms of scientific research come with inherent limitations (Patton, 2002). The present study has identified three specific limitations for the current investigation. First, the sample used for analysis of the study is homogeneous and restricted to the play therapy experiences of children with disabilities within a specific geographic region of south central Ohio. Additionally, the sample also includes a narrow representation of disabilities. The second limitation noted for the case study is the sensitive nature of the research topic. All of the children who were represented with in the sample were survivors of child maltreatment.

First, geographic restrictions prevented a broader sample for the present study. Although the site selected for the present study provides services to a large area of southern and southeastern Ohio, the sample encompasses children within an approximate 40 mile radius of the facility. The research could have likely been strengthened from a more geographically diverse sample. However travel limitations presented challenges for participation of children in outlying regions to take advantage of play therapy interventions at the child advocacy center.
While the homogeneous nature of children in the study might represent a limitation, it is important to remember that the goal of qualitative inquiry is not to generalize to a larger population (Patton, 2002). Onwuegbuzie (2003) argued that qualitative discovery represents the voices expressed by the individuals and their experiences. Thus, the outcomes can never represent an entire population. Additionally, the participants encompassed within the present study represent cultural values that are unique to the Appalachian region of Ohio. Given that the children in the study are survivors of trauma the cultural values of Appalachia offer many strengths.

The Appalachian culture encompasses a number of qualities that promote a sense of resilience. The term Appalachian has been used to identify a significant population of individuals in the Eastern and Midwestern regions of the United States (Hayden, 2004). According to the Appalachian Regional Commission (ARC) (2009) the Appalachian territory includes portions of New York, Pennsylvania, Ohio, Kentucky, Tennessee, Maryland, Virginia, North Carolina, Georgia, Alabama, Mississippi, South Carolina, and all of West Virginia. As early as 1994, specific values and characteristics of the Appalachian culture were being defined within the literature. Jones (1994) identified ten cultural values commonly observed within the Appalachian culture. Specifically, a strong sense of religion, independence, self-reliance, neighborliness, family, personalism, humility, love of place, and a sense of beauty and love of place are characteristically found within the Appalachian culture. For counseling professionals, each of these cultural values can play an influential part in addressing therapeutic goals.
The following cautions have been offered when working with individuals with in the Appalachian culture. The Appalachian family has also been described as the core of the culture (Jones, 1994). Societal relationships are primarily family based (Russ, 2010). Throughout history, Appalachian families were not only enmeshed, but also relied upon one another for support and survival in times of crises (Bauer & Growick, 2003). It is also common for Appalachians to resist professional assistance as they typically turn to their family first when needing assistance (Russ, 2010). The Appalachian family is one of a patriarchal structure with males being responsible for making most of the major decisions. Likewise, traditional gender roles have been reinforced within the Appalachian family. Due to these strong family connections, it is common for individuals to be accompanied to counseling sessions by various family members (Russ, 2010).

Each of the children who were selected to participate in the study were identified as children with disabilities. However, this sample is representative of a minimal number of specific disabilities. In particular, all of the children who were selected were identified as children with speech and language difficulties. Additional, psychological disabilities were identified for the sample. These included, post-traumatic stress disorder, intellectual developmental disorder, autism spectrum disorder, and attention deficit hyperactivity disorder. Considering that disabilities encompass a broad categorizations of physical and psychological conditions, this study has offered an examination of limited number of disabilities. However, as previously discussed the goal of the current inquiry is not generalizability but rather to acquire a detailed understanding of the experiences of children with disabilities who participated in the present study.
The second limitation with the current investigation is the precipitating events that children with disabilities experienced prior to their initiation of play therapy services. Each of the children who participated in the present study disclosed histories of child abuse and neglect. Considering the site selected for this study serves children affected by trauma this is not surprising. However, the sensitive nature of these experiences could present limitations with the present study. Specifically, how the nature of these traumatic experiences impact the researcher (Dickson-Swift, James, Kippen, & Liampttong, 2007).

Considering the fact that credible qualitative analysis requires one to be immersed in the data (Patton, 2002), it is logical to assume that a researcher would not be immune to the delicate nature and sensitive topics that are investigated in qualitative discovery. The present study is no exception. However, guidelines have been proposed to assist qualitative researchers in navigating these sensitive topics. Specifically, Dickson-Swift, at al., (2007), cautioned researchers to examine the potential impact that certain research topics could have on their overall health. As discussed more comprehensively in chapter three, the researcher of the present study has several years of experience in working with the population under investigation. An additional recommendation for investigating challenging phenomenon in qualitative researcher is the establishment of informal support networks (Dickson-Swift, at al., 2007). Fortunately, the research of the current study has developed and maintained professional networks who are familiar with the nature of working with children who are impacted by trauma. These resources have been fundamental for not only the completion of the current study but continued self-care when working with this population.
Disability Defined

Defining the true meaning of disability is at times a confusing and a problematic task. The term disability has broad applications as it represents a number of physical, medical, cognitive, and psychological disorders with significant amounts of diversity across each of these domains (Susman, 1994). Consequently, the definition of disability can vary across many different agencies and institutions (Laudan & Loprest, 2012). However, it has been postulated that the full meaning of the disability experience is largely dependent upon the philosophical view of the individual (Michailakis, 2003). Persons who acquire a disability are not defined by the single event of a disability but rather by the fluid process that is commonly associated adaptation to disability (Pfeiffer, 2005).

The word disability itself often underscores the fact that an individual lacks specific physical or psychological abilities. The research has utilized two contrasting models in an attempt to explain the philosophic framework to understand the meaning of disability. The medical model of disability views an individual’s condition as a deficit. This philosophy operates from the belief that an individual’s disability is the result of a physical and/or mental condition (Olkin & Pledger, 2003). Conversely, the social model operates from the belief that the meaning of disability is an interaction between the individual and his or her environment (Thomas, 1999). However, much of the literature cautions professionals that neither model is absolute as individuals with disabilities are likely to apply applications from each of these models of disability (Shakespeare, 2006).
Although there is no universal definition, Susman (1994), reported that disability implies a loss or abnormality of physical, psychological, or anatomical structure. Disability has also been defined as any impairment, activity limitations, or participation restrictions that result from the health condition or from personal, societal, or environmental factors in the individual’s life (Falvo, 2005). Similarly, Berns (2010) defined the term disability as a reduction or absence of functioning in a particular body part or organ. According to The World Health Organization (2015), disability is defined as a restriction or lack of ability in a manner that is considered to be normal for a human being. The Americans with Disabilities Act of (1990) defined disability as a mental or physical impairment that substantially limits one or more of major life activities.

Sadly, many definitions of the word disability consistently highlight the deficits of an individual implying that the individual is less than “normal”. Although these definitions provide a general framework for identifying persons with disabilities, professionals must note that an individual’s experience is also fundamental in defining the term. Michailakis (2003) reported that an accurate meaning of disability is based upon the interaction of the person with a disability and society. Consequently, persons with disabilities must adapt to a different way of living in which he or she falls outside of what is considered to be typical. This often precipitates some significant challenges for individuals with disabilities.

The vast number of disorders and conditions encompassed in the word disability also continues to make the establishment of an accurate definition difficult. The United States Census Bureau identified six categories of disabilities. These include:
1. hearing disability,
2. visual disability,
3. cognitive disability,
4. ambulatory disability,
5. self-care disability,
6. independent living disability

(Erickson, Lee, & von Schrader, 2010, p. 3).

The Individuals with Disabilities Education Act (IDEA, 2004) has also delineated specific categories of disabilities for children within the educational system. Thirteen specific disabilities are identified under the IDEA legislations. These include learning disabilities, speech or language impairments, mental retardation, emotional disturbance, hearing impairments, visual impairments, autism, orthopedic impairments, traumatic brain injury, multiple disabilities, and other health impairments.

While there is a broad spectrum of physical and psychological conditions that are encompassed in the word disability, this investigation examined the play therapy experiences of five children who represent five distinct types of disabilities. In particular, all of the children who are represented in the present study were identified with a speech and language disability. According to The Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), speech and language disabilities are characterized by marked limitations in vocabulary, an individual’s difficulty with recalling words and/or articulation of sentences that are developmentally appropriate (American Psychiatric Association, 2013).
In addition to the unanimous representation of speech and language disabilities within the sample of this study, four psychological disabilities were also identified among participants. Specifically, one child was diagnosed with posttraumatic stress disorder. Posttraumatic Stress Disorder (PTSD) is defined as an anxiety disorder that is precipitated by a significant traumatic event. The disorder is characterized by symptoms of re-experiencing the traumatic event, avoidance, and hypervigilance that creates significant distress in the individual's life (American Psychiatric Association, 2013). Two children who participated in the study were diagnosed with Intellectual Developmental Disorder. Intellectual Developmental Disorder (IDD) is defined as a neurodevelopmental disorder for children. Three primary criteria are associated with intellectual developmental disorder. These include, deficits in intellectual functioning, deficits in adaptive functioning, and an onset during childhood (American Psychiatric Association, 2013). One child was reported to be diagnosed with Autism Spectrum Disorder. Autism Spectrum Disorders (ASD) are defined as deficits in the social use of verbal and nonverbal communication (American Psychiatric Association, 2013). One child was also identified with a diagnosis of Attention Deficit Hyper-Activity Disorder (ADHD). Attention Deficit Hyper-activity Disorder is a condition that is the fine by an individual's impairment in and in attention, impulse control, and hyperactivity (American Psychiatric Association, 2013).

**Prevalence**

Due to the varying definitions and interpretations of the word disability, the exact prevalence of persons with disabilities is difficult to ascertain. However, it is estimated
that there are 57.6 million persons in the United States currently living with a disability (Brault, 2012). The United Nations Convention on the Rights of Persons with Disabilities (2014) cited that 10% of the world’s populations live with a disability. According to the World Report on Disability, it is estimated that globally one billion individuals are living with a disability. The Centers for Disease Control (2009) reported 54 million people within the United States are impacted by a disability. This translates to at least one in five individuals in the United States lives with a physical, psychiatric, and/or cognitive disability.

It is important to note as our society has witnessed more advances in medical technology, we have also experienced older adults acquiring a disability in later stages of the lifecycle (Smart 2007). As advances in medical technology occur, the number of persons with a disability is likely to increase, and it has been suggested that most people at some point in their life will experience a disability (Henderson & Thompson, 2011). Smart and Smart (2007) reported that there are a number of factors that have influenced the increased in prevalence of persons with disabilities. These include a higher standard of living, advances in medical technology, availability of health insurance, and more medical and psychiatric services. According to the United States Department of Labor (2009), the prevalence of individuals with disabilities continues to increase and in fact people with disabilities now represent the largest minority group in our nation. Generational estimates have stated that more Americans will experience disability during older adulthood than any other stage of the life cycle (National Center for Health
Statistics, 2006). Most alarming, is the estimate that each American has a 20% chance of acquiring a disability at a point in his or her lifetime (U.S. Department of Labor, 2009).

While gaining an accurate estimate of adults with disabilities is difficult, it is equally as challenging to identify the true prevalence for children with disabilities (Sullivan, 2009). Globally, it is believed that at least 200 million children are identified as having some type of a disability. At the turn of the century, 4.4 million American children were reported to have a disability (Centers for Disease Control, 2009). More recent data has suggested that 17% of all children from birth to seventeen are identified as having a disability (Shannon, 2006). Eighty percent of these children are identified as living in developing countries (World Health Organization, 2015). However, like the adult population, the number of children with disabilities has continued to increase (Mac, 2002). In consideration of the fact that the term disability is used for various types of physical, psychological, and/or cognitive impairments these demographics suggestions are likely to be underestimated.

The increase prevalence of children with disabilities has also been documented in the educational system. Seventeen years ago, it was reported that 40 to 45 million school-aged children are classified as having a disability (Glenn, 1998) and current statistics have reported that fourteen percent of all children receive special education services (Henderson & Thompson, 2011). The United States Department of Education (2007) reported that educational institutions, including elementary, secondary school, and universities and colleges, will likely witness a significant increase of students with disabilities. Henderson and Thompson (2011) reported that 13.6% of children in 2007
were identified as having a disability. Similarly, Webb (2006) reported that one in six children up to the age of seventeen have a developmental disability.

**Stigma of Persons with Disability**

Throughout history individuals with disabilities have confronted significant oppression, bias, and stereotypes. The pervasive attitudes towards individuals with disabilities can be traced back to the practices of infanticide in Ancient Greek and Rome. In the early civilization period the Greeks believed that an individual’s disability was a blemish of the soul. These ideas also carried into the middle ages as the strong beliefs in Christianity promoted views that an individual’s disability was a consequence of a personal sin. While the Renaissance period welcomed some changing attitudes toward individuals with disabilities, many people were confined to asylums and prisons. In the early times of America, individuals with mental illness or disability related behaviors were burned or hanged (Rubin & Roessler, 2008).

Thankfully, our societies have evolved to more humane treatment of people with disabilities. More appropriate treatment of persons with disabilities was marked by the Industrial Revolution, but this did not prevent the discrimination of individuals with disabilities in the workplace. (Marini, 2012). However, it would be a gross injustice to ignore that fact that stigma and discrimination continue to exist for persons with disabilities (Antonak & Livneh, 2000; Au & Man, 2006). These attitudinal barriers have further exacerbated the emotional experiences of persons with disabilities (Marini, 2012; Rubin & Roessler, 2008). Tragically, much of the historical treatment of individuals with disabilities has been perpetuated by societal fears, intolerance, prejudice, and a lack of
knowledge regarding disability (Marini, 2012). These historical representations of individuals with disabilities have greatly influenced persons with disabilities in establishing a group identity that Smart (2008) equates to the Civil Rights Movement.

Fortunately, during the last forty years the United States has made progress towards advocating for individuals with disabilities. Legislative actions have been instrumental in advocating for persons with disabilities. In particular, The Rehabilitation Act of 1973 and The Americans with Disabilities Act of 1990 have provided significant protection for individuals with disabilities (Marini, 2012; Rubin & Roessler, 2001). These legal advances have established precedents for individuals with disabilities. Prior to these recent legislative mandates, persons with disabilities were not afforded the same rights as individuals without disabilities (Marini, 2012). Although these attempts to ensure equal treatment for individuals with disabilities were instrumental, the unfortunate reality is that persons with disabilities continue to confront attitudinal barriers (Rubin & Roessler, 2001; Smart, 2008).

Persons with disabilities continue to encounter a number of societal and attitudinal obstacles as the result of their limitations (Parker, Syzmanski, & Patterson, 2005). Louvet (2007) reported that persons with disabilities remain devalued and discredited by individuals without disabilities. It has also been recognized that persons without disabilities find it challenging to develop relationships with individuals with disabilities. Persons with disabilities are often viewed with a sense of sadness and pity (Green, 2007). As discussed in the historical review of persons with disabilities, these
present attitudinal barriers further complicated the adaptation process for persons with disabilities (Louvet, 2007; Parker, Syzmanski, & Patterson, 2005).

It is more appalling to note that this form of negativity and tolerance is not just reserved for adults with disabilities. Throughout the last thirty years, it has been understood that there are a range of negative feelings towards children with disabilities (Barg, Armstrong, Hetz, & Letimer, 2010; Westervelt & Turnbull, 1980). These misconceptions have served to isolate children with disabilities and further complicate their social interactions (Westervelt & Turnbull, 1980). Children with disabilities are also frequent targets of both physical and psychological bullying in the educational system (Henderson & Thompson, 2011). Children who experience these attitudinal obstacles have greater difficulty with disability adjustment. (Barg, Armstrong, Hetz, & Letimer, 2010). Tragically, the misconceptions of disability that perpetuate these behaviors are preventable.

While education is one of the basic rights of all children, the educational lives of children with disabilities if often met with rejection, confusion, disjuncture, and uncertainty. According to Henderson and Thompson (2011) nearly 14% of children 6-21 years of age receive special education services as a result of their disability. While there are specific laws that are designed to protect children with disabilities in the educational environment, these legislative acts do not address the stigma associated with a child’s disability. For example, when child’s disability is exposed for purposes of receiving specialized support, there is the potential for others in the educational setting to attach negative labels to the child (Sherry, 2004). It has been suggested that one of the major
obstacles for children with disabilities in the educational setting is a teacher’s perception and beliefs regarding a child’s disability and its effect on their behavior (Cawley, Hayden, Cade, & Baker-Kroczynski, 2002; Henderson & Thomson, 2011).

Although these studies provide staggering statistics regarding the prevalence of abuse and neglect among children with disabilities, most professionals opine that the rate of abuse of children with disabilities is grossly underestimated. The literature underscores the importance for professionals to recognize that some medical conditions may include symptoms that distorts traditional signs of abuse and/or neglect. Therefore, medical professionals may not identify the potential of child maltreatment for children with disabilities as easily when compared to children without disabilities (Hibbard & Desch, 2007). Furthermore, it has been determined within the last decade that state agencies do not always have consistent definitions of child abuse and use varying definitions of children with disabilities (Bonner, Crow, & Hensley, 2007). The professional literature has also cited a lack of recognition from child protective services (CPS) workers of children with disabilities. Therefore, it has been recommended that CPS workers receive training on identification of children with disabilities and evaluating children with disabilities regarding the potential for abuse and neglect (Hibbard & Desch, 2007).

**Childhood Trauma and Disability**

In recent years there has been an increasing focus on examination of the impact of trauma events in the lives of children. According to the National Child Traumatic Stress Network (NCTSN, 2012), childhood traumatic events include, physical and sexual abuse,
neglect, emotional abuse, death or separation from loved ones, exposure to intimate partner violence, community violence, bullying, and exposure to disasters. Although these are shocking to most, research has found that traumatic experiences unfortunately are common. It has been reported that most people will experience at least one traumatic event in their lifetime (Kilpatrick, Resnik, Milanak, Miller, Keyes, & Friedman, 2013).

While traumatic events often leave individuals with a temporary loss of stability, most adults are able to gain a sense of resilience with limited effects of their long-term functioning (Kilpatrick, at al., 2013). However, children are particularly vulnerable to the effects of trauma. Research has documented the comparison of adult reactions to trauma versus a child’s reaction to traumatic events. Evidence has suggested that children have significant more effects on the social and emotional functioning following traumatic experiences compared to adults with similar experiences (van der Kolk, Spinazzola, Blaustein, Hopper, Hopper, & Korn, 2007). A child’s reaction to traumatic events is an individualized process. However, there remain predictable factors that are influential to a child’s reaction. These include, the child’s development, the support available to the child, and the frequency of the event (Falasca & Caulfield, 1999).

It has long been understood that traumatic events impair a child’s ability to cope and can leave a child with a continual state of arousal and feelings of helplessness (Terr, 1991). Yet over the last two decades research has identified specific neurological changes that occur to a child’s brain following traumatic events (Perry, 2000). These effects of traumatic experience in combination with a child’s disability increase the complexity of trauma reactions for children with disabilities (Perry, 2000).
While all children might be susceptible to mental health issues, children with disabilities confront a number of complex psychological and emotional challenges as well as an increased vulnerability of abuse. Specifically, children with disabilities often experience a variety of stress reactions and frustrations that are associated with the difficulties in trying to manage their disability (Lyons, Leon, Rocker Phelps, & Dunleavey, 2012). It has also been suggested that children with disabilities exhibit mood fluctuations that can include anger, depression, and grief related responses (Glover-Graf, 2012). Children with disabilities commonly experience feelings of anxiety, shame, and other negative feelings surrounding his or her disability (Henderson & Thompson, 2011). Consequently, mental health professionals have explored various therapeutic methods in attempting to address these barriers. Professional counseling must not only hold a foundation towards understanding a child’s specific disability but also appreciate the multicultural aspects of children they serve (Henderson & Thompson, 2011). These shared experiences of oppression, physical and psychological maltreatment, and emotional reactions have solidified children with disabilities as a unique cultural entity (Smart & Smart 2005).

The Disability Culture

Although some people might consider culture to only include persons of different racial, ethic, geographic, gender, and sexual orientations, individuals with disabilities also comprise a unique cultural group. There has been a substantial amount of research that has identified persons with disabilities as a cultural entity (Brown, 2002; Hahn, 2005; Pfeiffer, 2005; Smart & Smart, 2005). Smart and Smart (2005), reported that disability is
a culture within itself as individuals with disabilities have a unique perspective with one another, are aware of the standards for interaction, and/or use a specific language to express meaning as well as sharing other characteristics of a cultural group. Similarly, Brown (2002) stated that individuals with disabilities have shared a common history of oppression and have advocated for rights of equality. The issues of social isolation, social adaptation, and functional impairments have traditionally forced individuals with disabilities out of the mainstream of our society. It has been these social and functional issues that have propelled individuals with disabilities into a distinct minority group (Szymanski & Parker, 1996). As a result of this criterion, the United Nations Convention on the Rights of Persons with Disabilities report that individuals with disabilities represent the world’s largest minority group (United Nations Convention on the Rights of Persons with Disabilities, 2014).

Considering this cultural identification, counselors who serve individuals with disabilities have an ethical and moral duty to maintain competence in an ethnographic understanding of persons with disabilities. Although there are differing definitions of multicultural counseling (Baruth & Manning, 2007), Sue and Torino (2005) defined multicultural counseling as a process of helping through the implementation of techniques and identifiable goals that are consistent with the cultural experience and values of our consumers. Culturally competence skills are essential for professionals who work in the counseling profession (Henderson & Thompson, 2011). The counseling literature has offered specific guidelines for professionals in addressing the pursuit of cultural competence. Henderson and Thompson (2011) reported that culturally competent
counselors must maintain a level of self-awareness regarding their personal values, preconceived ideas, as well as limitations and beliefs about specific cultural groups. Similarly, Sue and Sue (2008) highlighted the importance of knowledge acquisition for culturally competent counselors. Particularly, counseling professionals must be proficient with understanding the culture of those individuals whom they serve. Moreover, culturally skilled counselors must obtain comprehensive skills to ensure that they communicate effectively with persons of differing cultures (Henderson & Thompson, 2011).

**Family Adjustment to Disability**

While the disability adjustment process can be difficult for children with disabilities, family members also become challenged with the onset of a child’s disability. Unfortunately, no one is immune from the impact of a child’s disability, as the disability experience often resonates throughout a child’s family (Glover-Graf, 2012). Many stressors are precipitated as the result of a child’s disability (Shannon, 2006). Changes in family routine typically affect the entire family unit creating enormous adjustment issues and increased tension within the family system. Similarly, family isolation, irrational parental expectations for their child, as well as, the parental belief that the child exhibits difficult behavior all places the child in a vulnerable environment (Gore & Janssen, 2007).

Given the complexities of these challenges counseling professionals must explore strategies to assist children and families who are impacted by disabilities. Therefore, a number of recommendations have been provided to assist mental health professionals in
working with children and families affected by disabilities. Henderson and Thompson (2011) illuminated the importance of self-evaluation for professionals. These authors suggested that one of the greatest challenges associated with counseling children with disabilities is largely related to a clinician’s preconceived ideas regarding a child’s specific diagnosis. This categorization of children with disabilities has often led to professionals overlooking a child’s individual strengths. Counselors who view children with disabilities simply as a label or as a victim can greatly minimize a child’s strengths and capabilities (Henderson & Thompson, 2011). Therefore, adherence to specific guidelines or recommendations becomes essential for professional counselors.

The Role of Counselors

In today’s world, professional counselors can no longer ignore the reality that they are likely to serve children with disabilities (Henderson & Thompson, 2011; Tarver-Behring & Spagna, 2004). Thus, clinical counselors hold a paramount role towards empowering children with disabilities and their families. Many have reported that counseling and psychotherapy for children with disabilities can provide significant benefits toward personal and social development (Carmichael, 2006; Henderson & Thompson, 2011; Lorenz, 2008). Moreover, therapeutic services also serve as an avenue for families of children with disabilities with effectively navigating the disability adjustment process (Henderson & Thompson, 2011). Despite the importance of counseling services for children with disabilities, it has also been reported that clinical counselors commonly report being apprehensive when providing services to this population (Henderson & Thompson, 2011).
As a result, clinical counselors like other professionals are continually exploring opportunities for serving children with disabilities. Yet, there remain significant limitations in the literature to assist counselors towards empowering children with disabilities in the therapeutic environment (Carmichael, 2006; Henderson & Thompson, 2011). It is important for professionals who work with this population to maintain a level of competence and understanding of the various challenges that people with disabilities experience. As Homeyer and Morrison (2008) argued that there remains an overwhelming and critical need for professionals with specialized competencies to serve children with disabilities. However, these competencies can only be acquired when professionals gain an adequate understanding of the broad range of disabilities that exist as well as an accurate understanding of the meaning of the term “disability.”

**Recommendations for Counselors**

Among the various recommendations for counseling professionals who work with children with disabilities is the continual examination of one’s values, attitudes, and beliefs. Henderson and Thompson (2011) illuminated the importance of self-evaluation for professionals. These authors suggested that one of the greatest challenges associated with counseling children with disabilities is largely related to a clinician’s preconceived ideas regarding a child’s specific diagnosis. This categorization of children with disabilities has often led to professionals overlooking a child’s individual strengths. Regrettably, these further create therapeutic roadblocks for children with disabilities in their pursuit towards resilience.
The ability to establish a therapeutic rapport is an essential skill for counseling professionals. However, when serving children with disabilities, the importance of a strong therapeutic relationship cannot be overly emphasized. Children with disabilities frequently encounter feelings of anxiety, shame, as well as other negative feelings surrounding his or her disability (Henderson & Thompson, 2011). The disability experience itself exacerbates these affective responses as it robs children of the basic ability to trust others. Therefore, clinicians must work diligently to foster a nurturing and supportive environment for children with disabilities who are impacted by the abusive experience.

Collaboration is also an essential element for counselors who work with children with disabilities. A child’s disability may require specialized services from a diversity of health care professionals. Henderson and Thompson (2011) reported that it was paramount for counselors who work with children with disabilities to work closely with all agencies who serve the children as well as the children’s parents and family members. Hibbard and Dresch (2007) echoed this recommendation by stating that medical professionals need to collaborate with other treatment providers who work with children with disabilities.

Counselors who serve children with disabilities may also find themselves in an advocacy role. Professional counselors are in a unique position to not only serve as a therapeutic agent of change but also support for the best interest of the child via advocacy efforts. These responsibilities can include working to ensure that appropriate referrals being initiated, as well as recommendations are pursued (Gore & Janssen, 2007).
Similarly, it is estimated that nearly 14% of children 6 – 21 years of age receive special educational services (Henderson & Thompson, 2011). Therefore, educational advocacy is often another role for counseling professionals to explore in advocating for children with disabilities.

A limited number of counseling theories have been offered in the research to assist counselors who work with children with disabilities. Cognitive Behavioral Counseling has been reported as a beneficial model for exploring a child’s irrational ideations, negative self-perceptions, as well as behavior modification (Thurneck, Warner, & Cobb, 2007). Henderson and Thompson (2011) suggested group counseling as a means for children with disabilities to increase his or her relationship skills while simultaneously being offered a supportive and nurturing environment.

Although these recommendations provide a framework for clinical counselors who serve children with disabilities, they fail to meet the needs of all children with disabilities. Considering that many children with disabilities may have communication impairments or cognitive disabilities, counselors should also explore non-traditional counseling paradigms. While traditional counseling theories have remained dependent upon the verbal exchanges between a child and clinician, creative therapies offer a unique approach that is not as dependent on a child’s communication skills (Landreth, 2002). These can include play therapy, art therapy, bibliotherapy, and sand play (Bethel; 2005; Thurneck, at al., 2007). This proposed study explores the use of play therapy as an effective paradigm when serving children with disabilities.
Rationale for Play Therapy

Although the aforementioned strategies offer some benefits for counseling children with disabilities, each of the theories remain largely dependent upon a child’s psychological, emotional, social and cognitive capacities. It is essential that clinicians address the developmental characteristics of children when implementing counseling strategies. Therefore, this study proposes play therapy as an alternative treatment modality for clinicians who serve children with disabilities. The literature has documented the efficacy of play therapy for children with a diverse range of behavioral and emotional difficulties (LeBlanc & Ritchie, 2001; Muro, Ray, Schottelkorb, Smith & Blanco, 2006). A study by Ray, at al., (2005) further provided meta-analytical support for play therapy as an effective medium for children with mental health challenges.

Despite the history of child therapists implementing play activities with children since the 1920’s (Freud, 1946), the specialization of play therapy and play therapists has grown significantly over the last ninety years (Homeyer & Morrison, 2008; Kauson, et al. 1997). Play therapists have been defined as “mental health professionals trained specifically to use children’s play as the basis of therapeutic interaction” (Homeyer & Morrison, 2008 p. 213). The growing demand for play therapy and advanced training is represented by the expansion of graduate-level play therapy curriculums and practicum experiences. In particular, only 33 universities offered courses in play therapy in 1989 (Landreth, 2002). By 2004, 104 universities were providing play therapy courses and 146 universities offered play therapy courses in 2008 (Homeyer & Morrison, 2008).
Today more than 167 universities provide courses in play therapy education and training (Association for Play Therapy, 2015).

The Association for Play Therapy was founded in 1982 as an organization that promotes play therapy practice. The mission of this organization is to promote the value of play, play therapy, and credentialed play therapists by advancing the psychosocial development and mental health of all people and sponsoring and supporting those programs, services, and related activities that promote the:

(a) Public understanding and appreciation of play and play therapy

(b) Effective practice of play therapy through research, education and training, and support

(c) Recognition, incorporation, and preservation of diversity in play and play therapy

(d) Development and maintenance of a strong professional organization that satisfies this mission (Association for Play Therapy, 2015).

Although play therapy remains a highly specialized area of competence, the Association for Play Therapy has experienced significant growth in its membership. In 2012, the organizational membership was 5,759 professionals. Additionally, the Association for Play Therapy awards credentials to mental health practitioners who achieve advanced education and training in play therapy. Specific course work must be completed to petition the Association for Play Therapy for credentialing. In particular, clinicians must complete courses in ethics, child development, theories of personality,
principles of psychotherapy, and child and adolescent psychopathology for eligibility in the credentialing process (Association for Play Therapy, 2010).

The Association for Play Therapy offers two registrations for mental health clinicians. Five areas are required to obtain the credentials of a registered play therapist (RPT). These are licensure in the state of practice, educational degrees, clinical experience, play therapy training and supervised play therapy experience. Six areas are required for individuals to obtain the credential as a registered play therapist supervisor (RPT-S). In addition to meeting the five required areas for the registered play therapist, persons seeking the registered play therapist supervisor designation must also document training in supervision (Association for Play Therapy, 2010).

Play has always been a significant and common occurrence in the lives of children. Axline (1947) first proposed that play is a natural and spontaneous medium by which children communicate. However, the motive behind the play activity of children far exceeds the commonality of behavior. Play is a means by which children bridge gaps between their experiences and abstract reasoning (Piaget, 1962). Landreth (1991) emphasized the importance of play, “Play is the singular central activity of childhood, occurring at all times and in all places” (p. 41). For these reasons, play has become a universal language of children that has no barriers to ethnicity or language (Drewes, 2005). Consequently, play therapy has become an effective therapeutic intervention for children of various cultures (Gil & Drewes, 2005; Henderson & Thompson, 2011).

Further support for the use of play therapy for children with disabilities is represented in the curative powers of play. While these elements are beneficial for all
children, these characteristics reinforce opportunities for communication, development of adaptive coping skills, and development of support systems for children with disabilities. Schaeffer (1993) identified fourteen factors that enhance the play therapy experience for children. They are:

1. Overcoming resistance: Play draws children into a working alliance with the counselor.
2. Communication: Play provides a natural medium of self-expression encouraging understanding.
3. Competence: Play satisfies the need to explore and master, thereby building self-esteem.
4. Creative thinking: Problem-solving skills are encouraged so that innovative solutions to dilemmas can occur.
5. Catharsis: Children can release emotions that they have had difficulty confronting.
6. Abreaction: In play, children can process and adjust to difficulties by reliving them with appropriate emotional expression.
7. Role play: Children can practice new behaviors and develop empathy.
8. Fantasy: Children can use their imagination to make sense of painful reality.
9. Metaphoric teaching: Children gain insight by facing their conflicts and fears through the metaphors generated in play.
10. Attachment formation: Children develop a bond with the counselor.
11. Relationship enhancement: Play enhances the positive therapeutic relationship allowing children to move toward self-actualization and grow closer to others.


13. Mastering developmental fears: Repeated play activities help reduce anxiety and fear.


Definitions of Terms

The following terms are offered for clarification:

Appalachian Culture: The term Appalachian has been used to identify a significant population of individuals in the Eastern and Midwestern regions of the United States (Hayden, 2004).

Attention Deficit Hyper-Activity Disorder: Attention Deficit Hyper-activity Disorder is a condition that is the fine by an individual's impairment in and in attention, impulse control, and hyperactivity (American Psychiatric Association, 2013, p. 59).

Autism Spectrum Disorders: Autism Spectrum Disorders (ASD) are defined as deficits in the social use of verbal and nonverbal communication (American Psychiatric Association, 2013, p. 50).

Children with disabilities: The most widely accepted definition of children with disabilities is that “children under the age of eighteen who have or are at increased risk for a chronic physical, development, behavioral, intellectual, or emotional condition and who also require health and related services of a type or amount beyond that required by
children generally (Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2007).”

Disability: A mental or physical impairment that substantially limits one or more of major life activities (Americans with Disability Act, 1990)

Disability Adaptation: “An evolving, dynamic, general process through which the individual gradually approaches an optimal state of person environment congruence (Livneh & Antonak, 1997).”

Intellectual Developmental Disorder: Intellectual Developmental Disorder (IDD) is defined as a neurodevelopmental disorder for children. Three primary criteria are associated with intellectual developmental disorder. These include, deficits in intellectual functioning, deficits in adaptive functioning, and an onset during childhood (American Psychiatric Association, 2013, p. 31).

Neglect: “Failure of parents or other caregivers, for reasons not solely due to poverty, to provide the child with needed, age-appropriate care, including food, clothing, shelter, protection from harm, supervision appropriate to the child's development, hygiene, education, and medical care (Child Welfare Information Gateway, 2011, p. 3).”

Physical Abuse: “Physical acts by parents or caregivers that cause or could have caused physical injury to the child (Child Welfare Information Gateway, 2011, 3).”

Play Therapy: “A developmentally sensitive therapeutic modality in which a trained play therapist uses the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (The Association of Play Therapy, 2003).”
Play Therapist: “Mental health professionals trained specifically to use children’s play as the basis of therapeutic interaction (Homeyer & Morrison, 2008, p. 213).”

Posttraumatic Stress Disorder: Posttraumatic Stress Disorder (PTSD) is defined as “an anxiety disorder that is precipitated by a significant traumatic event. The disorder is characterized by symptoms of re-experiencing the traumatic event, avoidance, and hypervigilance that creates significant distress in the individual’s life (American Psychiatric Association, 2013, p. 265).”

Registered Play Therapist Supervisor: Registered Play Therapist Supervisor (RPT-S): “A play therapist who has applied to the Association for Play Therapy and met the criteria in all six areas (license/certification, educational degrees, clinical experience, play therapy training, supervised play therapy experience, and supervisory training) for certification.”

Sexual Abuse: “Sexual activity, by a parent or other caregiver, with a child, including but not limited to any kind of sexual contact through persuasion, physical force, or other coercive means; exploitation through sexual activity that is allowed, encouraged, or coerced; and child prostitution or pornography (Child Welfare Information Gateway, 2011, p. 3).”

Summary

In conclusion, this introductory chapter has provided an overview of the present qualitative case study. This introductory chapter has highlighted the need for acquiring a more in-depth understanding of the play therapy experience for children with disabilities. It has become evident that children with disabilities are impacted by personal, social, and
environmental barriers. However, counselors are in an excellent position to assist children with disabilities through direct counseling services and work with the child’s family and support system. The present study examined the phenomenon of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County. Through data analysis the current investigation will offer important insights that will further contribute to the scholarly literature and subsequently serve as a tool to further assist professionals who work with children with disabilities.

In the following chapter a review of the research will provide a more detailed review of the disability adaptation process and built a rationale for play therapy for children with disabilities. Chapter two will follow with a review of relevant literature of the present study. A more detailed discussion of the research design will be described in Chapter Three. Introductions for the participants of the study will be provided in Chapter Four and Chapter Five has described emerging themes from the data of this inquiry. A concluding chapter will summarizes the findings of this investigation.
Chapter 2: Review of the Literature

Change is an inevitable part of childhood. Although many children exhibit adequate resilience towards adapting to the various changes throughout their childhood, children with disabilities confront substantial changes in all domains of their life. It has well been established that a chronic illness, traumatic injury, and/or disability triggers a series of psychological reactions (Dembo, Lvinton, & Wright, 1956; Kendall & Buys, 1998; Linkowski, 1971; Liven & Atonak, 1997; Olkin, 1999; Smart, 2008). Unfortunately, these changes often represent significant adversity for children with disabilities and his/her family (Henderson & Thompson, 2011). The onset of a disability, chronic illness, or traumatic injury forces an individual to adapt to a different way of life. This transitional process has commonly been referred to as the disability adaptation process. The disability adaptation process is an individualized process that can present complex challenges for persons with disabilities (Livneh & Antonak, 1997; Smart, 2008).

As a result of the complex challenges that exist for people with disabilities, it is not uncommon for children with disabilities to participate in counseling services (Henderson & Thompson, 2011). Professional counselors have an ethical and moral duty to assist and advocate for persons with disabilities. However, meeting the multifaceted needs of persons with disabilities is challenging for mental health practitioners (Demanchick, Cochran & Cochran, 2003; Henderson & Thompson, 2011). Accordingly, there remains an emergent need for professional counselors to explore effective counseling strategies for serving individuals with disabilities (Carmichael, 2006; Demanchick, at al., 2003).
To acquire a more broad understanding of the play therapy experiences of children with disabilities this study identified one research question for exploration. What is the experience of children with disabilities who participate in play therapy services at The Child Protection Center of Ross County? To aide in address this phenomenon a review of the literature will provide a foundation to answer this researcher question. This chapter will highlight the existing literature regarding the disability adaptation process and various models of the psychosocial disability adjustment. It is paramount that counseling professionals acquire a competent understanding of the disability adaptation process to best serve persons with disabilities (Smart, 2008). However, the literature indicates that traditional counseling models are not always effective tools when serving children with disabilities (Henderson & Thompson, 2011). Therefore, this chapter will also present a review of the literature that highlights play therapy as an alternative counseling intervention and specifically review the efficacy of play therapy theories. Additionally, specific research will be discussed that supports the effective implementation of play therapy with children with disabilities.

Childhood disability encompasses a broad spectrum of birth defects, chronic illnesses, injuries, developmental disabilities, intellectual disorders, and mental and emotional disorders. For children, a disability can occur at birth, early in their childhood, or following a traumatic injury or accident. Although there are countless types of disability for children, the most commonly identified disabilities in childhood include hearing impairments, visual disabilities, cerebral palsy, autism, and other mental and emotional disorders (Boulet, Boyle, & Schieve, 2009). Regardless of the specific
classification, children with disabilities confront significant physical, environmental, educational, and attitudinal challenges. Tragically, these challenges continue throughout childhood (Henderson & Thompson, 2011).

Trachtenberg, Batshaw and Batshaw (2007) provided a developmental perspective regarding the effects of disability on children. In particular the authors noted that children prior to school age are often unaware that they are different from their peers. However, a child’s entry into the educational environment can be challenging for children with disabilities. A school age child with a disability may be tensed or bullied by his or her peers and a child’s impairments can create barriers to interpersonal communication skills. Likewise, academic task may prove more challenging for children with disabilities and require specialized accommodations. These precipitating factors can reinforce behavioral difficulties, and barriers in attainment of a positive self-image for children with disabilities (Trachtenberg, Batshaw & Batshaw, 2007).

Adolescence also marks a significant time of adjustment for children with disabilities. The developmental hallmark of adolescence is marked by physical and hormonal changes for children. For children with disabilities these normal growth experience can create new obstacles as they assimilate these changes with their disability (Kim & Turnbull, 2004). Adolescences is also represented by a child’s increased association and comparisons with his or her peers. For children with disabilities this developmental transition can validate the fact that they cannot relate to their peers in the same manner (Orsmond, Krauss, & Seltzer, 2004). This developmental period is also a critical time for future planning. This period of transition often leads an adolescent to
question future planning for independence, career options, and housing. For adolescence with disabilities this can exacerbate feelings of anxiety and uncertainty (Trachtenberg, et al., 2007).

Although children with disabilities may initiate counseling for a variety of reasons, the following section offers an overview of the various models of the psychosocial adaptation to disability. The review of the research that highlights these models of adaptation is paramount to the current investigation. While the majority of the literature that addresses adaptation has focused largely on adults, the models provide a theoretical framework for the present inquiry. Considering the purpose of the present study, it is vital to address potential areas of adaptation that children may exhibit within their play therapy experiences.

Models of the Psychosocial Adaptation to Disability

Some of the earliest views of disability adaptation are rooted in the philosophies that were introduced by Dembo, Levinton and Wright (1956). This model was built upon the principles that individuals with disabilities have two competing choices. Either persons with disabilities can succumb to his/her disability or they can focus on what functional abilities remain. Positive coping within this model was correlated to an individual’s ability to negotiate the physical and societal barriers that exist for persons with disabilities. By contrast, poor adjustment was representative of individuals with disabilities’ resistance to move forward and focus on his/her disability (Dembo, Lvinton, & Wright, 1956; Marini, 2012).
Wright (1983) expanded upon this model and asserted that individuals with disability have changing values based upon their experiences. There were four specific changes of values that were believed to be fundamental to an individual’s adjustment to chronic illness or disability. First, the enlargement of the scope of values includes a period in which persons with disabilities find values in other events, abilities, and goals. The Subordination of Physique change in values is designated by a person’s ability to have limited importance on both physical appearance and physical abilities. Containment of disability effects includes the point at which persons with disabilities no longer allow their disability to define their identities. Transformation from comparative to asset values is marked by a change in values in which an individual with a disability recognizes his or her intrinsic values (Marini, 2012; Wright 1983).

Expanding on the work of Dembo, Levinton, and Wright (1956), Linkowshi began to explore strategies to identify a quantitative measure for individual’s adjusting to disability. Of particular note was a focus that individuals with disabilities commonly experienced a grief response based upon the loss of physical or psychological functioning (Linkowski, 1971). Linkowski (1971) offered a standardized measure of the disability adaptation process in the Acceptance to Disability Scale. This psychometric instrument used a Likert-Scale to identify the varying degrees of symptoms that are common for persons with disabilities during the adaptation process. This assessment measure has been revised to further assist professionals in acquiring a more detailed view of consumers with disabilities (Grooms & Linkowski, 2004).
**Stage-Phase models of adaptation.** The most influential models of disability adaptation and adjustment are defined under the umbrella of Stage Models (Falvo, 1999). Most stage models have emerged from the same principles of Kubler-Ross (1969) Stages of Grief Model (Parker, Schaller, & Hansman, 2003). The general philosophy of this model is that persons with disability experience a variety of psychological and emotional reactions during the sequences of disability adaptation (Kendall & Buys, 1998). The earliest theorists emphasized the linearity of the Stage-Phase models. The models suggested that persons with disabilities commonly transition through predictable stages of psychological reactions to disability (Livneh & Parker, 2005).

Although the models of disability adaptation have not been specifically applied to children with disabilities, the theoretical application of the models provided a heightened awareness of what children with disabilities may experience. There has been a significant research that supports a stage-based philosophy to disability adjustment. Livneh & Antonak (1991) offered five stages of disability adaptation. These include (a) Initial Shock, (b) Defense Mobilization, (c) Initial Reaction (d) Retaliation, (e) Final Adjustment or Reintegration. More recently, Smart (2009) proposed six distinct stages of disability adjustment. These include (a) shock, (b) denial/defensiveness, (c) depression, (d) regression, (e) anger/questioning and, (f) integration/acceptance (p.244). Although the specific stages of adaptation may vary, all of the stage-phase models of disability adjustment recognize the enormous emotions challenges that persons with disabilities encounter. In fact, the literature has outlined various psychological reactions that accompany the identified stages (Livneh & Antonak, 1991; Smart, 2008).
The initial stage of this philosophy is characterized by a sense of devastation and disorganized thinking. This shock stage is often characterized by numbness feelings surrounding the onset of a disability. The denial or defensiveness stage of adjustment is marked by an individual’s failure to recognize the permanency of the disability. As is common with most grief related experiences, individuals with disabilities may also experience feelings of loss and depression during this stage. Individuals who revert to previous behaviors are classified in the regression stage of disability adjustment which can include maladaptive coping skills. During the fifth stage of adjustment individuals with disabilities confront issues of anger and begin to reorient himself/herself through questioning his or her new world. The final stage of this process is identified by the person’s integration of his or her disability into reality (Livneh & Antonak, 1991; Smart, 2008).

Livneh (1991) provided a comprehensive review of more than forty specific stage-based models. From this review Livneh (1991) found that many stage-phase theorists share many basic assumptions regarding the manner in which individuals react and adjust to a disability. One such assumption is that the adjustment process is ongoing. Professionals also agree that the immediate reaction following a disability creates an imbalance that will restore itself in time. Likewise, theorists share the view that most people with disabilities transition through a sequence of stages by gaining a psychological resolution to the trauma of his/her experience. It is also understood that not all individuals with disabilities will experience each identified stage. Another basic assumption is that individual may not transition through these stages sequentially and
may possibly skip a specific stage in the adjustment spectrum. Stage-phase theorists have also acknowledged that specific cognitions, emotions, and behaviors are characteristic for individual stages. Lastly, it is the philosophy that individuals with disability can achieve successful transition with appropriate adaptive coping resources (Livneh, 1991, Marini, 2012).

Although these Stage-Phase models share some commonalities, each particularly has introduced a different classification for the stages of adjustment. Overall, the models have introduced many different numbers of stages through the adaptation process. Marini (2012) reported that these models can vary as some models proposed three identified stages whereas others offered up to ten different stages. However, most professionals cite four to six stages in the adaptation process. Livneh and Antonak (1991) developed a model that identified five stages following the onset of a disability. The specific stages are outlined as (a) Initial impact, (b) Defense mobilization; (c) Initial reaction, (d) Retaliation (e) Final adjustment or reintegration.

Livneh and Antonak (1997) cited the range of emotional reactions that are characteristic for each stage of the process. These include shock, which is characterized by a sense of numbness and thought disorganization and although relatively short can disrupt a person’s level of functioning. This experience is often followed by anxiety which is marked by feelings of panic. This stage can create somatic symptoms of hyperventilating, increased heart rate, perspiration, and gastrointestinal distress. Denial is the third stage identified in this process of adjustment to disability. These reactions are viewed as a self-defensive mechanism that is a psychological protective factor that
insulates individuals from more intense or vulnerable emotions. Individuals with disabilities might also experience depression which is identified as another stage in the adjustment process. The hallmarks of this stage include feelings of hopelessness, feelings of despair, distress, and isolation. Anger and hostility also represent another stage in the transitional process. The anger and hostility for persons with disabilities can be internally or externally directed. Lastly, the stage of adjustment is identified by an individual’s restored self-concept and renewed view of self as he or she continues to explore his/her role in the world with a disability (Livneh & Antonak, 2005).

More recently, Livneh (2001) offered a more comprehensive view of the psychosocial adaptation to disability. The newer model of disability adaptation focused on the interaction of triggering events and process variables. It was hypothesized that it is the interaction of these two domains that produces the outcomes of disability adaptation. Considering the varying degree of reactions to disability, this model argued that Livneh (2001) believed that the interaction of many variables is responsible for the overall adaptation process.

The Stage-Phase models of disability adaptation have provided important contributions to the rehabilitation counseling field. Many experts consider this philosophy to be the standard approach in conceptualizing disability adjustment as it has provided a historical blueprint for counselors to assist persons with disabilities (Marini, 2012). Kendal & Buys (1998) also acknowledged that that stage models are beneficial because they serve to normalize the experiences of persons with disabilities.
However, these models have also drawn a great deal of criticism (Kendall & Buys, 1998; Olkin, 1999; Smart, 2001). There has been concern that these models can be dangerous as they have the potential for counselors to have preconceived ideas about individuals with disabilities’ adaptation (Kendal & Buys, 1998). Bogart (2014) expressed as these models are only applicable for persons with acquired disabilities. None of the stage-phase models has been utilized in addressing the adaptation process for individuals with congenital disabilities. Moreover, the stage-phase models have been developed through certain assumptions and lack merit in explaining the varying differences that occur in the adaptation process (Bogart, 2014; Kendal & Buys, 1998).

**The recurrent model of adaptation to disability.** The criticisms and limitations of the Stage-Phase models propelled the exploration and development of the Recurrent Model to Disability Adaptation (Marini, 2012; Kendall & Buys, 1998). This theory was largely constructed from Beck’s cognitive theory as it emphasizes the importance of positive and negative cognitions. Individuals with disabilities who adhere to negative cognitions become more susceptible to depression, low self-esteem, and self-pity (Marini, 2012). The recurrent model assumes that adaptation to disability is a continuous process in which persons with disability will re-evaluate and modify their identity as an individual with a disability (Kendal & Buys, 1998). The development of a new identity is upon an individual’s ability to (a) search and find meaning in their disability and their life after acquiring a disability; (b) gain a sense of mastery over the person’s environment, their disability, and their future; and (c) protect and enhance themselves through a newly obtained identity (Kendall & Buys, 1998, p. 17.).
Consistent with this model, Yoshida (1993) described the adjustment process as being continually pulled between two extremes and metaphorically equated this to a pendulum. Individuals with disabilities transition between the polar extremes of a pre-disability self and a post-disability identity. As individuals with disabilities shift between these two extremes uncertainty and confusion is often experienced. Over time the shift becomes less dramatic and the person with a disability develops a new identity is developing. Eventually the pendulum stops and this represents adaptation (Yoshida, 1993).

**Transactional model of coping.** The transactional model explores coping resources for individuals with disabilities and his or her ability to access these resources. Developed by Lazarus and Folkman (1984) this model explores when adaptive coping strategies can be utilized. Marini (2012) reported that the transactional model is the most frequently documented and empirically justified model for disability adaptation. Lazarus and Folkman (1984) defined coping as “a constant cheap constantly changing cognitive and behavioral alternatives to managing specific external and internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). The key elements of the transactional model include two forms of appraisal. Primary appraisal is defined by an individual's ability to determine if the situation is stressful. For the person with a disability primary appraisal allows the individual to determine if the situation requires the use of his or her coping resources. Secondary appraisal is characterized when a person utilizes his coping skills (Lazarus & Folkman, 1984).
These models do not represent an exhaustive or comprehensive review of all theories of disability adaptation. However, each of these models has offered rehabilitation professionals and counselors important insight in working with individuals with disabilities. As a result, this review is important for the present study. Smart (2008) echoed the idea that no one single model of disability adaptation is applicable for every person with a disability. However, professionals who maintain an awareness of the various principles of each model of disability adjustment position themselves to best serve consumers with disabilities. As such, this review of the identified models of psycho-social adaptation to disability is intended to provide professionals an opportunity to capitalize on opportunities for clinical utility. For professionals who serve children with disabilities, these models further provide a basis for acquire a more detailed understanding of the experience of persons with disabilities. Through the course of the current investigation, these models have aided in shaping a theoretical lens to answer the research question.

**Psychosocial Adaptation of Children with Disabilities**

The psychosocial models of adaptation to disability provide valuable insight for professionals who serve individuals with disabilities. However, there appears to be significant limitations in the application or relevance of these theories when working with children with disabilities (Marini, 2012). There are some beliefs that children who are born with disabilities do not have great difficulty with adaptation. It has been proposed that children who have no experience prior to their disability would have limited difficulty, although there is little scientific merit to support this belief (Olkin, 1999).
Considering the paucity of literature regarding the adaptation of children with disabilities, these findings remain controversial and inconsistent (Marini, 2012).

Other professionals have offered explanations of a child’s adjustment through a development context (Falvo, 1999; Glover-Graf, 2012). Falvo (2005) opined that a child’s age and developmental understanding of the disability were significant to his/her adjustment process. For example, children who do not possess the cognitive maturity to manage the rejection from their peers will have a more challenging experience with the adaptation process. A child’s disability might also interfere with the typical progression of child development. Children who become isolated or lack opportunities to socialize with friends as the result of their disability are more likely to experience deficits in their social and emotional progression (Falvo, 2005).

Children with disabilities also have reactions similar to adults with disabilities and can experience a range of psychological responses throughout the disability process. Dell Orto and Power (2007) revealed a host of emotional experiences that are possible for children and adolescences with disabilities. Anger, grief, and denial were all cited as potential emotional hardships for children with disabilities. Children with disabilities also experience greater struggles with self-esteem, more frustrations and anxiety (Henderson & Thompson, 2011). Similar to the process of for adults, Power & Dell Orto (2007) hypothesized that this can often serve as a self-protective process for children. In an attempt to avoid the powerful emotional reactions children may deny the full consequences of his/her disability but this also stagnates his/her progress of adjustment. Although there are no specific models of adaptation to disability specific to children, it is
clear that children with disabilities encounter many challenges and a host of emotional reactions. Super (1990) introduced career theory that examines an individual’s experiences, personal attributes, with specific developmental characteristics as they explore career aspirations and obtainment. While some researchers have argued that several factors of Super’s “career-life rainbow” model can be utilized to assist children with disabilities (Henshenson & Szymanski, 1992), other professionals have opined that many children with disabilities encounter significant challenges to transition through the predictable stages of career development (Roessler, Brolin, & Johnson, 1992).

Since the present investigation examined the experience of children with disabilities through play therapy services at The Child Protection Center of Ross County, the literature specific to the psycho-social adaptation of children with disabilities is fundamental. While the children selected for this study were referred to play therapy services for a variety of experiences, the models of disability adaptation represent a foundation of common experiences that the sample may have encountered. As such this investigation explored play therapy treatment for children with disabilities at the child advocacy center through multiple interviews. In addition, to the interviews of children two play therapist who are employed by this facility highlighted their experiences of providing services for children with disabilities. Additionally, the present investigation also includes data obtained from caregivers of children with disabilities who participated in play therapy services at this facility. Therefore, a review of the literature regarding family adaptation to disability is also relevant.
Family Adaptation to Disability

Although theories of psychosocial adaptation have highlighted the potential experiences of persons with disabilities, the onset of a disability can also have a devastating impact on persons closest to the individual with a disability. Power and Dell Orto (2007) recognized that a chronic illness or disability does not just occur in a vacuum but has the potential to impact an entire family system. They also postulated that the adjustment process is a continuous transition for both the child as well as the entire family unit. For children with disabilities this means that their entire support system becomes vulnerable to the disability adaptation process. Trute and Hiebert-Murphy (2002) stated that a child’s disability precipitates a range of emotional responses for parents. These fall on a spectrum from crisis reactions to adequate adaptation.

All families strive to maintain a sense of balance in the daily lives, but for families of children with disabilities achieving homeostasis is a challenging task. With the onset of a disability family roles become disrupted (Yeates, Henwoog, Gracey, 2007). Family members of children with disabilities have the overwhelming task of not only addressing the needs of a child with a disability but simultaneous coping with their personal adaptation to a child’s disabilities. Considering the fact the large majority of children with disabilities are being cared for within their own home (Perrin, 2002), it is not surprising that caregivers are faced with many competing demands when caring for a child with a disability. The caregiver’s ability to successfully navigate these multifaceted duties of a child’s disability is key to the overall outcome for the entire family.
Marinelli and Del Orto (1999) asserted that the family’s response to a child with the
disability will either strengthen or hinder the child’s psychosocial functioning.

A child’s disability sends ripples of emotions throughout the entire family system.
Similar to individuals with disabilities, the immediate reactions of parents and caregivers
of children with disabilities are commonly reported to be shock, denial, numbness, and/or
disbelief (Dell Orto & Power, 2007). A sense of guilt or feeling as though they did
something to cause the disability is another common experience for parents of children
with disabilities (Norton, & Drew, 1994). Feelings of helplessness, despair, and
depression have also been proposed as typical reactions for parents of children with
disabilities (Tornasello, Manning, & Dulmus, 2010). Consequently, the adaptation
process is a highly charged emotional experience for all persons connected to the child
with a disability.

There are predictable factors that have a direct effect on parental and caregiver’s
reactions to a child’s disability. Parents of children with disabilities experience physical
and psychiatric conditions as the result of caring for a child with a disability (Eddy &
Engel, 2008). Specifically, it has been noted that the more severe and challenging a
child’s disability is to manage, the more likely caregivers are to experience more stress
associated reactions. These can include feelings of being overwhelmed and a greater
degree of frustration (Lyons, Leon, Roecker, Phelps, & Dunleavy, 2010). However, the
literature has also found that providing resources and support decrease the stress for
parents of children with disabilities (Green, 2007). Gallagher, Phillips, Oliver and Carrol
(2008) also found that the greater the caregiver’s burden, the more increases in of anxiety and depression for parents and caregivers.

Power and Dell Orto (2004) also delineated seven characteristics that will impact a family’s reaction to a child’s disability. The risk factors associated with the family are significant. These include exigent factors, family support, and family in conflict and single-parent families. Conversely, protective factors are beneficial toward the overall outcomes of disabilities adjustment. Specifically, effective communication, strong familiar support, and problem solving abilities are helpful in the adaptation process. The belief systems of a family are also important. These can include religious beliefs and cultural beliefs that shape the view of a child’s disability for the family. Individual coping resources are also influential in the adaptation process. Previous family experiences can be fundamental characteristics in the adjustment process. The ability for family members to communicate in a healthy manner yields more positive outcomes. The person who is identified as having a disability plays an important role in outcomes of adaptation (Power & Dell Orto, 2004).

Parents of children with disability are particularly vulnerable for depression. Although an accurate rate of depression for parents of children with disabilities is difficult to measure (Olsson & Hwang, 2001; Resch, Elliott, & Benz 2012), there are various studies that indicate depression for caregivers of children with disabilities is significant. Resch, Elliott, and Benz (2012) developed a study that found nineteen percent of parents of children with disabilities achieved the criteria for depression. Additional research has suggested that 35% - 53% of parents who have a child with a
disability report difficulty with depressive symptoms (Olsson & Hwang, 2001). There are a variety of contributing factors that influences the likelihood of depression for parents of children with disabilities. In particular, parents with negative attitudes regarding their child’s disability, fears regarding the child’s disability, and poorer physical health have significant influences in depressive symptoms for parents of children with disabilities (Resch, Elliott, & Benz, 2012).

The varying emotional reactions are understandable for parents of children with disabilities. However, parental and family reactions can also create substantial risks for children with disabilities. Hibbard and Desch (2007) indicated that higher emotional, physical, economic and social demands that are put on families as the result of a child’s disability significantly increase the potential of maltreatment for children with disabilities. The range of psychological reactions of family members with children who have disabilities can create an atmosphere of instability and chaos. Henderson and Thompson (2011) suggested that families who fail to address this instability have significantly greater difficulty with the adaptation process. Consequently, the family may sabotages a child’s ability to successfully navigate the adaptation process. Families of children who are depressed can also negate child parent bonding opportunities and further intensify the depressive symptoms of children with disabilities (Hibbard & Desch, 2007).

Despite all the physical and psychological difficulties that parents of children with disabilities may experience, many families of children with disabilities are successful in adaptation to disabilities. In fact, family members can be strong allies in the adaptation process for children. It is clear that no other persons can influence the health and well-
being of a child with a disability more than a parent or caregiver (Elliott & Mullins, 2004). Caregivers who are included are able to identify needed services, balance routines, and make significant decisions regarding care. As a result, these skills have a direct correlation to improve functioning of the child with a disability and the entire family system (Brookman-Frazee 2004).

The literature above has provided significant insight regarding family reactions to a child’s disability. The present study included data obtained via interviews with caregivers of children with disabilities. However, the review of the research has also established increased vulnerability for children with disabilities and the occurrence of child maltreatment. All of the children represented in the current study are survivors of adverse child abuse and neglectful experiences. In attempt to explore the impact that these experience had in the lives of children with disabilities who are represented within the current study, it is important to review the existing research associated with this population.

**Child Abuse and Children with Disabilities**

Nationally, child abuse and neglect are recognized as a pervasive social problem of epidemic proportions (Balderian, 1994; Gore & Janssen, 2007). While this is a universal concern, there is no universal definition of child abuse and neglect. However, the Child Welfare League of America (CWLA) Standards for Services for Abused or Neglected Children and Their Families provide generally accepted definitions of child abuse, neglect and maltreatment. These include physical abuse, sexual abuse, and emotional maltreatment.
- Physical Abuse: Physical acts by parents or caregivers that cause or could have caused physical injury to the child.

- Neglect: Failure of parents or other caregivers, for reasons not solely due to poverty, to provide the child with needed, age-appropriate care, including food, clothing, shelter, protection from harm, supervision appropriate to the child's development, hygiene, education, and medical care.

- Sexual Abuse: Sexual activity, by a parent or other caregiver, with a child, including but not limited to any kind of sexual contact through persuasion, physical force, or other coercive means; exploitation through sexual activity that is allowed, encouraged, or coerced; and child prostitution or pornography.

- Emotional Maltreatment: Parental or other caregiver acts or omissions, such as rejecting, terrorizing, berating, ignoring, or isolating a child, that cause or are likely to cause the child serious impairment of his or her physical, social, mental, or emotional capacities (Child Welfare Information Gateway, 2011, p. 3).

The professional literature across the last two decades has reinforced the hypothesis that children with disabilities confront an increased risk of child maltreatment (Gore & Janssen, 2007; Sullivan & Knutson, 2000; Westcott, 1993). Since 1993, the professional literature began to document the increased prevalence of child abuse and neglect for children with disabilities (Westcott, 1993). Gore and Janssen (2007) asserted that a child's disability was a significant factor for child maltreatment in that a child's disability was either a contributing factor or a precipitating factor in an overwhelming number of child maltreatment cases.

One of the most widely cited studies indicated that children with disabilities were 3.4 times more likely to be abused than children without disabilities. This translates into 31% of children with disabilities had been abused compared with a prevalence rate of 9% among children without disabilities (Sullivan & Knutson, 2000). Although there is some variation, the rate of abuse for children with disabilities ranges from 22% to as high as 70% (The National Research Council, 2001). While individuals with disabilities
experience oppression and domination in various domains of their daily lives (Shannon, 2006), these statistics certainly illuminate the vulnerability of children with disabilities with regard to child maltreatment.

Various studies have also explored the increased risk of maltreatment for children with specific types of disabilities. According to Sullivan and Knutson (2000) children with behavioral disorders have the greatest risk of physical abuse while children with speech and language disorders are at greater risk for neglect. Similarly, children with hearing disabilities have twice the risk for neglect and emotional abuse, whereas children with speech and language disabilities have a five times higher risk for neglect and physical abuse and a three times higher risk for sexual abuse (Kendall-Tackett, Lyon, Taliaferro, & Little, 2005). As a result, numerous children with disabilities are placed within the foster care system and/or residential facilities (Gore & Jansenn, 2007). Children with disabilities are disproportionally represented within child welfare agencies (Shannon, 2006). Similarly, it is estimated that up to 31% of the 200,000 youth placed in residential care are diagnosed with at least one disability (Trout, Casey, Chmelka, DeSalvo, Reid, & Epstein, 2009).

The literature also suggests that children with behavioral disorders and developmental disorders are the most vulnerable for all types of child maltreatment. Sullivan and Knutson (1998) reported that children with behavioral disorders and children with mental retardation had a greater risk across multiple forms of abuse including neglect, physical abuse, as well as sexual abuse when compared to children with other types of disabilities (Gore & Janssen, 2007). Moreover, Shannon (2006)
reported that child protective service agencies have greater difficulty in meeting the needs of children with developmental disabilities who are survivors of abuse. Although child protective services professionals are knowledgeable about the general nature of child abuse and neglect, children with developmental disabilities have a complexity of behavioral, cognitive, social, and physical health care needs. These challenges often leave social service professionals ill-equipped to provide appropriate care to children with developmental disabilities who have a history of child maltreatment.

Although these studies provide staggering statistics regarding the prevalence of abuse and neglect among children with disabilities, most professionals opine that the rate of abuse of children with disabilities is grossly underestimated. The literature underscores the importance for professionals to recognize that some medical conditions may include symptoms that distorts traditional signs of abuse and/or neglect. Therefore, medical professionals may not identify the potential of child maltreatment for children with disabilities as easily when compared to children without disabilities (Hibbard & Desch, 2007). Furthermore, it has been determined within the last decade that state agencies do not always have consistent definitions of child abuse and use varying definitions of children with disabilities (Bonner, Crow, & Hensley, 2007). The professional literature has also cited a lack of recognition from child protective services (CPS) workers of children with disabilities. Therefore, it has been recommended that CPS workers receive training on identification of children with disabilities and evaluating children with disabilities regarding the potential for abuse and neglect (Hibbard & Desch, 2007).
While child abuse presents devastating effects for all children, there is a broad consensus among professionals that children with disabilities confront an increased risk of child abuse and neglect (Mandell, et al., 2005; Shannon, 2006; Sullivan & Knutson, 2000). Previous literature has highlighted the increased prevalence of child abuse and neglect for children with disabilities as well as causal factors associated with child maltreatment and children with disabilities (Gore & Janssen, 2007; Henderson & Thompson, 2011; Sullivan & Knutson, 2000). However, only a limited number of studies offer specific recommendations for working with children with disabilities who are survivors of child abuse and neglect. The professional literature across the last twenty four years decades has reinforced the hypothesis that children with disabilities confront an increased risk of child maltreatment Gore & Janssen, 2007; Sullivan & Knutson, 2000; Westcott, 1993).

There is a multitude of research that outlines the numerous effects of child abuse in the lives of children (Barfield, Donson, Gaskill, & Perry, 2012). Orange and Brodwin (2005) asserted that abuse can have lifelong implications that thwart psychological, social, educational, vocational, and interpersonal development. These consequences of abuse are similar for children with disabilities. Children with disabilities affected by maltreatment frequently face challenges of negative behavioral, emotional, and social experiences (Shannon, 2006). Bethel (2005) asserted that children who are survivors of abuse commonly feel betrayed, overwhelmed, and helpless which may further complicate the child’s healing process. Consistent with earlier research, Henderson and Thompson
(2011) reported that child survivors of abuse often have feelings of isolation, a great
sense of fear, as well as an inability to trust.

However, the abuse of children with disabilities has been identified as a critical
public health issue (Hibbard & Desch, 2007). Whereas all maltreated children experience
psychological challenges, research states that children with disabilities confront more
frustrations, misunderstanding, and have greater difficulties related to internal assets of
self-confidence (Thurneck et. al., 2007). As a result, children with disabilities who are
survivors of abuse can present a greater and more complex combination of clinical
symptoms. Therapeutic services are often warranted for children with disabilities who are
abused. These services can include both clinical and rehabilitation counseling.

For some children with disabilities who are abused issues of anxiety,
depression, and social isolation often present a need for therapeutic services (Shannon,
2006). Children with developmental disabilities experience maladaptive coping skills,
poor communication skills, poor conflict resolution skills, and lower levels of self-
esteeem prior to child maltreatment (Shannon, 2006). For these children, the abuse
experience only serves to exaggerate these difficulties. Shaw and Goode (2005)
reported that children with disabilities that were maltreated experienced higher risks
for a host of developmental difficulties including attachment, social and emotional
problems, cognitive delays, and neurobiological changes. These social difficulties
only compound the issues that children already face due to their disabilities.

Furthermore, a great deal of research supports the hypothesis that children
living in “at risk” homes confront a higher risk of neuropsychiatric challenges (Squires
Similarly, Barfield, Donson, Gaskill, & Perry (2012) asserted that children growing up in chaotic or traumatizing environments often have a diversity of consequences including cognitive delays, as well as other functional problems. It is estimated that child abuse causes at least 14% of all developmental disabilities (Balderian, 1994; as cited in Mitchell, Turbiville, & Turnbull, 1999). Consequently, this research supports the belief that child maltreatment can precipitate a host of disabilities for children.

Children with disabilities who are abused have difficulties with educational attainment (Gore & Janssen, 2007). It has been stated that children with disabilities miss more school days, have lower levels of participation and withdraw from classroom interaction. This may be attributed to frustration, low self-esteem and lack of social skills. While it is understandable that children with disabilities would receive lower standardized test scores, Sullivan and Knutson (2000) reported a statistically significant interaction between maltreatment and disability. In particular, the lowest academic achievement scores were reported among children with disabilities.

Oleary, Coohey, and Easton (2010) declared that the impact of child abuse is not limited to childhood. For example, one studied indicated that adults who have been or are currently receiving employment disability were significantly related to histories of childhood maltreatment (Sansone, Dakrour, Pole, & Buttler, 2005). Other vocational implications cited included higher functional limitations in the work environment. Orange and Brodwin (2005) further found that individuals with disabilities who experienced sexual abuse were more likely to have lower socioeconomic statuses that
could not be accounted for by educational failure nor explained by reduced participation in the workforce. Disruptions of function and functional impairments have also been cited for adults who have experience childhood abuse and/or neglect (Orange & Brodwin, 2005; Sansone et al., 2005). Similarly, Henderson and Thompson (2011) stated a child’s maladaptive coping strategies of isolation, fear and mistrust often become stagnant and lifelong features of a child’s environment. Ammerman and Balderian (1993) reported that approximately 25% of children who experienced abuse and 50% of children who experienced neglect were classified as having permanent disabilities. Consequently, individuals with disabilities who have histories of child maltreatment, often work with professionals, both from a clinical and rehabilitation setting, in order to address their psychological, social, educational, vocational and interpersonal challenges.

The review of the literature addressing children with disabilities and child maltreatment represents a common pattern within this present study. The Child Protection Center of Ross County is dedicated to assisting child victims of abuse. Therefore, the sample selected for the current study have histories of childhood abusive experience. This information provides additional layers for a more detailed understanding of the experience of children with disabilities who participate in play therapy services at The Child Protection Center of Ross County. Since this services as the research question for the present investigation, it is further needed to gain an appreciation of the value of play and models of play therapy.
The Value of Play

Although most people might view play as simply an enjoyable activity, the importance of play in the lives of children has become apparent throughout history. The behavior of play dates back to ancient times (Schaefer, 2003) and has been described as a natural means of communication for children (Landreth, 2002; Axline 1947). However, the importance of play far exceeds a simple behavior. While play may create joy and laughter, play also has intrinsic value. Play can serve as an important tool in managing stressful situations and assist individuals in joining their concrete experiences with abstract thought (Landreth, 2002; Kottman, 2001; Schaefer, 2003). Play has a critical influence in promoting healthy child development (Roopnarine & Johnson, 1994).

While the value of play has been well documented as a critical asset for child development (Roopnarine & Johnson, 1994), not all children have been afforded the same privilege of play. Children with disabilities are represented by a diverse range of physical and psychological competencies. Consequently, many children with disabilities encounter challenges in traditional play and may not achieve the same beneficial outcomes compared to children without disabilities (Buchanan & Giovacco Johnson, 2009). Unfortunately, the limitations of play for children with disabilities may create a progression of a child’s disability or the onset of additional forms of psychopathology. Gray (2009) argued that play provides children the opportunity to develop intrinsic competencies, promote decision making skills, regulate emotions, build social relationships, and experience joy. Consequently, the absence of play in the lives of children is likely to contribute to a rise in psychopathology (Gray, 2009).
The Association for Play Therapy (2015) defined play therapy as a developmentally sensitive therapeutic modality in which a trained play therapist uses the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development. Landreth (1991) defined play therapy as “the dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express self through the child’s natural medium, play” (p.14).

The development of play therapy has grown significantly throughout the years, as the specialization of play therapists, play therapy techniques, and play therapy theories have been popularly implemented over the last fifty years (Kaduson, Cangelosi, & Schaefer, 1997). Anna Frued (1946) was one of the first child therapists in the United States to document her use of play therapy through her work with toys and games to strengthen her therapeutic rapport with children. Melanie Klein (1932) was another pioneer and used play therapy as a means of interpretations. Clark Moustakas (1959) and Virginia Axline (1947) all focused on the child’s natural growth process.

Today research suggest that play therapy has become a primary and usually the most appropriate, intervention for children (Gil, 1994; Landreth, 2002; Ray, Bratton, Rhine & Jones, 2005). Although a number of theoretical models of play therapy have been developed over the years, each of the schools of play therapy draws from the curative powers of play (Reddy, Files-Hall, & Shcaefer, 2005). This section will
highlight various theoretical models of play therapy and offer an overview of the research of play therapy for children with disabilities.

It is important to note that the use of play therapy for children with disabilities is not a new concept (Carmichael, 1993). Unlike traditional therapeutic models, play therapy does not require children to cognitively re-visit their past traumatic events. Landreth (2002) concluded that most counseling approaches have disregarded the fact that young children may not have the advance developmental ability or knowledge to express themselves adequately through verbal communication. Landreth (2002) asserted that some children may lack the developmental skills needed to verbally express themselves in traditional counseling paradigms. Similarly, children are also confronted with cognitive disabilities that leave them unable to focus on the intensity of what he or she feels. While traditional counseling theories have remained dependent upon the verbal exchanges between a child and clinician, play therapy offers a unique approach that is not as dependent on a child’s communication skills (Landreth, 2002).

A limited number of previous studies have asserted that play therapy is an appropriate an effective therapeutic modality when counseling children with disabilities (Carmichael, 2006). For over twenty years the beneficial outcomes of play therapy for individuals with disabilities have been reported (Williams and Lair, 1991). Carmichael (2006) reported that play therapy provides alternatives for children with disabilities when addressing issues of self-confidence. Moreover, the implementation of play therapy can highlight individual strengths of children with disabilities. Similarly to other counseling paradigms, play therapy includes a variety of theoretical perspectives. The following
section provides a review of various theories of play therapy to further examine the experience of children with disabilities who participated in play therapy services through The Child Protection Center of Ross County.

**Child-Centered and Non-Directive Play Therapy**

It was Virginia Axline’s (1947) work that established non-directive play therapy as a significant contribution to the play therapy community. Axline adapted the principles of Carl Rogers’ (1980) client-centered therapy and used them in her work with children. Specifically, Axline’s work emphasized the philosophies of unconditional positive regard and being present with the child as foundational for this theory (Axline, 1947). Axline (1947) suggested that the therapeutic relationship must be engaging and inviting, provide unconditional acceptance by the therapist, and be nonjudgmental in order for the child to feel safe to express emotions, feelings, and behaviors. She asserted that the therapist must be attentive and aware of the child’s behaviors and provide reflective of behaviors back to the child helping to develop self-awareness. Axline thought that therapy is steady and should progress at its own pace, not a pace set by the therapist and the only limitations ensure the safety of the child and therapist. Therapists who utilize the child-centered play therapy approach believe in the child’s ability to find solutions to his or her own problems and understands that the child is responsible for the changes he or she makes or does not make. The therapist acts as the shadow, allowing the child to lead therapy through discussions and actions (Axline, 1947). Non-directive play therapy and is rooted in the philosophical belief that children have the capacity to heal themselves when offered the optimal therapeutic milieu (Kottman 2001).
Axline (1969) later identified eight basic tenants of child-centered play therapy. The eight guiding principles have been identified as the paramount features of child-centered play therapy. Axline offered the following:

1. The therapist must develop a warm, friendly relationship with the child in which good rapport is established as soon as possible.

2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74).
Landreth (1991) expanded on Axline’s work and identified the term child-centered play therapy by using similar standards of child-centered play therapy. Similar to the work of Rogers and Axline, child-centered play therapy focuses on the relationship between the clinician and the child (Landreth, 1991). In conjunction with Axline’s original tenets of child-centered play therapy, the child-centered play therapist actively reflects the child's thoughts and feelings believing that when a child's feelings are expressed, identified and accepted, the child can accept them, and it is free to deal with these feelings (Landreth, 2002). One essential element of nondirective play therapy is to allow the child to accept the responsibility for the therapeutic session. Consequently, the child gains independence as well as a sense of control. The development of a warm and accepting relationship is important as this frequently empowers children to express a variety of emotions. Therefore, the objectives of nondirective play therapy are self-awareness and self-direction (Landreth, 2002). Landreth (2002) asserted that play therapy is a process by which children can progress through the therapeutic process to achieve resolution of negative experiences.

Landreth (2002) outlined the five stages of child-centered play therapy. Initially, children often use play to communicate and minimize negative feelings. Throughout the second stage, children use play to express difficult feelings. The third stage of nondirective play therapy is recognized by a child's attempt to project his/her negative feelings toward significant persons or via regressive play behaviors. The display of reluctant feelings can also continue into the fourth stage. By contrast, the fifth stage of
nondirective play therapy is typically represented by more positive feelings as well as a sense of control over a child's negative experience (Landreth, 2002).

A key component of child-centered play therapy is allowing the child to maintain control of the therapeutic session by giving freedom and choice while the counselor simply remains present. The therapist still remains active in the play session through the role of an observer, encourager, and reflector of feelings (Axline, 1947; Landreh, 1991). The development of a warm and accepting relationship is important as this frequently empowers children to express a variety of emotions. This in turn reinforces independence and empowers the children gaining mastery over particular issues (Landreth, 2002).

**Filial Play Therapy**

Another common theory and application within the play therapy community is filial play therapy. Filial play therapy is a therapeutic paradigm that uses principles of non-directive play therapy to promote improvements in the parent-child relationship (Guerney, 1964). The origins of filial play therapy were developed by Bernard and Louis Guerney (1964) and encouraged mental health professionals to educate parents on the basic principles of child-centered play therapy and non-directive play therapy. Guerney (1964) suggested that parents can be more effective in using play therapy than clinicians as they are most often the primary support person in a child's life. Consequently, this modality simultaneously strengthens parenting skills (Landreth, 1991) through educating parents and caregivers on the principles of non-directive play therapy (Van Fleet, 1994). By teaching caregivers the skills of interacting with their children through play, they
become agents of therapeutic change (Guerney, 1964). Empowering a child’s parent and/or caregiver remains an essential feature of filial play therapy (Sweeney & Skurja, 2001).

Although the primary goal of filial play therapy relates to improvements in parent-child relationships, additional benefits are common with the successful implementation of filial play therapy. Specifically, filial play therapy has been found to decrease a child's symptoms while simultaneously increasing a child's self-image and coping ability (Guerney, 2001). Van Fleet (1994) highlighted more generalized goals for children and families who participate in filial play therapy. For children, these goals include a greater ability to recognize and express feelings more fully, provide the children the opportunity to be heard, establish an atmosphere for children to develop problem-solving skills, increase self-esteem, increase their sense of trust and confidence in their parents, decrease maladaptive behaviors, develop pro-social skills, and establish an open cohesive family climate. Secondary goals identified for parents include a more in-depth understanding of child development and increased understanding of their own child. It further helps parents in recognizing the importance of play, decreasing their level of frustration, assisting in developing a variety of skills, increasing confidence level, promoting child-parent communication, increasing feelings of warmth and trust, and providing a non-threatening environment in which parents can relate better to their children (Van Fleet, 1994).

Filial play therapy practices have been well documented in the research over the last 40 years and have yielded empirically sound support for the practice (Guerney, 2001;
Jang, 2005; LeBlanc & Ritchie, 2001; Ray, at al., 2005). The benefits of filial play therapy have been implemented with a variety of populations (Sweeney & Skurja, 2001) and these studies have found that filial play therapy produces positive outcomes. Ray, Bratton, Rhine, and Jones (2005) completed a meta-analysis of play therapy outcomes through research articles from 1940-2000 and found parental involvement has been shown to be one of the most significant predictors of play therapy outcomes. These results, as well as the on-going research, have established filial play therapy as a highly effective intervention.

Children with disabilities can benefit from filial play therapy practices. Carmichael (2006) discussed the benefits of incorporating parents and caregivers into play therapy sessions when working with children with disabilities. Although the primary goal of filial play therapy relates to improvements in parent-child relationships, additional benefits are common with the successful implementation of filial play therapy. Specifically, filial play therapy has been found to decrease a child's symptoms while simultaneously increasing a child's self-image and coping ability. Consequently, this modality empowers parents and improves the overall parenting skills (Guerney 2000; Landreth, 1991).

**Focused and Directive Play Therapy**

Focused and directive play therapy practices can serve as an important model when addressing a child’s short-term therapeutic goals. Directive and focused play therapies differs from non-directive play therapy in that specific play therapy techniques are used to educate children about alternative behaviors and coping strategies.
These models offer play therapy techniques that are typically best implemented to address specific therapeutic goals. Carmichael (2006) recommended the use of focused play therapy for children as a time-limited intervention. The literature has suggested the implementation of directive play therapy techniques to assist children with a variety of issues (Carmichael, 2006).

Directive and focused play therapy techniques have been used for assisting children with disabilities nearly forty years (McWilliams, 1974). For children with disabilities, focused and directive play therapies can be implemented to educate children about alternative behaviors and thus create more appropriate adaptation skills (Carmichael, 2006). It is important to note however, counselors may be required to modify the play therapy environment and materials to accommodate children with disabilities. Lorenz (2010) also cited specific considerations for play therapy modification when working with children with disabilities. Carmichael (2001) suggested that toy selection may need to be limited as children with motor or physical disabilities may have difficulty in exploring the play therapy environment. O’Conner and Braveman (2009) reported that some directive and focused play therapy techniques might require counselors to modify materials to better suite children with particular disabilities. For example, Carmichael (2006) offered specific modifications that included using gloves with Velcro or magnets attached to them to assist children with disabilities in grasping objects in the play room.

While each of these play therapy models offers significant benefits for children with disabilities, counseling professionals should consider all models of play therapy to
determine the most effective strategy in meeting a child’s therapeutic goal(s). Lorenz (2010) opined that the child is the most important consideration when choosing the most appropriate theory of play therapy. Gil (2006) echoed this philosophy in stating that clinicians must be responsive to a child’s individual needs as this becomes paramount in maintaining a strong therapeutic alliance. These beliefs align with the philosophy of prescriptive play therapy. There has been growing evidence across the last decade that supports the integration of various models of play therapy in addressing the therapeutic needs of a child (Gil, 2006).

**Prescriptive Play Therapy**

Prescriptive play therapy has been described as a child-led but practitioner-informed part of treatment that incorporates various approaches of play therapy to most effectively address a child’s specific symptoms or problems (Gil & Shaw, 2009). Likewise, Schafer (2001) reported that prescriptive play therapy “challenges the clinician to weave together a variety of play interventions into one comprehensive, tailor-made treatment program…” (p. 57). Considering the diverse counseling needs of children with disabilities, this model of play therapy can utilizes therapeutic strengths from differing theories of play therapy that best meet the clinical challenges of children. Schaeffer (2003) reported that prescriptive play therapy is an effective intervention for children, teens, and adults who experience a variety of issues. Therefore, it is essential that play therapists are knowledgeable in various aspects of play therapy. The effective implementation of prescriptive play therapy requires a delicate balance between evidenced-based research and information specific to the child (Henderson & Thompson,
Consequently, counselors who implement a prescriptive play therapy philosophy must be knowledgeable in not only the varying theories of play therapy but also the range of clinical symptoms that children with disabilities may experience.

Prescriptive play therapy can be beneficial for children in various stages of development experiencing differing emotional challenges. In consideration of the fact that a disability can limit developmental progress a prescriptive approach seems logical for children with disabilities. Moreover, the broad application of the term disabilities represents the fact that clinicians will likely work with children who present with a wide range of physical, psychological and cognitive disabilities. Schaefer (2001) opined that the more tools a play therapist has empowers them to become successful in implementing interventions that match a child’s specific need.

**Cognitive Behavioral Play Therapy**

A more recent model of play therapy also hold promise when working with children with disabilities. Cognitive Behavioral Play Therapy was developed from principles of cognitive therapy which is one of the most frequently used treatment approaches. Cognitive Behavioral Therapy is a short-term therapy based on the principle that cognitions determine how people feel and act and that defective cognitions can result in psychological and emotional disturbances. Cognitive Behavioral Therapy is a structured and directive approach that helps the client understand and learn about the assumptions associated with the thoughts and working on restructuring irrational thoughts and maladaptive behaviors that have impacted the client’s activities of daily living (Drewes., 2009; Schaefer, 2001).
O’Connor and Braverman (2009) stated that Cognitive Behavioral Play Therapy is developmentally sensitive and targets maladaptive behaviors. Some examples of interventions include the use of puppets to model cognitive strategies and change the maladaptive behaviors in addition to have the child learn how to make positive self-statements. According to Drewes (2009), blended play therapy with CBT has been successful in addressing issues connected to sexual abuse, trauma, domestic violence, social skill development, emotional/affect regulation, anxiety, depression, and aggression. As previously discussed children with disabilities are likely to experience an array of psychological responses to a disability. Therefore, Cognitive Play Therapy may be ideal model in addressing irrational ideation or cognitive distortions that a child has based upon attitudinal or psychological barriers.

**Play Therapy for Children with Disabilities**

There are several studies that have highlighted the effectiveness of play therapy when working with children who exhibit a diversity of social, emotional, and behavioral problems. Child-centered play therapy has been found to improve a child’s self-concepts (Baggerly, 2004; Post 1999), behavioral functioning (Kot, Landreth, Giorodona, 1998), and improved language development (Danger & Landreth, 2005; Fall, Navelski, & Welch 2002). It has also been proposed that child-centered play therapy is beneficial in improving the child-caregiver relationship (Ray, Henson, Schottelkorb, Garofano Brown, & Muro; 2008).

LeBlanc and Ritchie (2001) summarized the efficacy of child-centered play therapy through meta-analysis that included twenty-three journal articles, sixteen
dissertations and three additional unpublished studies of play therapy outcomes. The researchers examined a number of characteristics in defining the specific outcomes of play therapy. The following characteristics were cited in the meta-analysis:

1. The modality of play therapy (i.e. child-centered, non-directive, etc.)
2. The inclusion of parents in the play therapy process
3. The duration of play therapy
4. The gender composition of participants
5. The presenting factors of treatment
6. The use of other therapies as an adjunct to play therapy
7. The publication date of each study that was examined
8. The type of article (i.e. journal article vs. dissertation)
9. Scientific validity (if the study was published)
10. Average age of participants
11. Control groups versus comparison groups (measure of study quality)
12. Specific research design of each study
13. The use of individual or group intervention (p.152).

The researchers utilized hierarchical linear modeling and found a medium effect size of .66 standard deviations. The researchers concluded that children who participated in play therapy gained twenty-five percent improvement on treatment outcomes as compared to children in non-play therapy treatment modalities. In addition, LeBlanc and Ritchie (2001), reported that parental involvement in the play therapy process was one of the most significant predictors of play therapy outcomes. Likewise, the length of play
therapy sessions, and number of play therapy sessions were also important contributors to
the play therapy outcomes. Results of the meta-analysis found that play therapy
interventions are most effective when a child receives thirty to thirty-five minutes of play
therapy services. In fact, LeBlanc and Ritchie, found that there was a decrease in
efficacy for play therapy outcomes when session exceeded thirty-five minutes.

Similarly, Ray, et al., (2005) analyzed the outcomes of ninety-three play therapy
studies that were published between 1953 and 2000. The meta-analytic review coded the
following characteristics for examination:

1. Treatment modality/therapeutic model used.
2. Treatment provider: mental health professional versus trained
   paraprofessionals (primary parents) supervised by a professional.
3. Treatment setting.
4. Treatment duration.
5. Treatment format (group vs. individual).
7. Type, number, and source of outcome measures.
8. Gender, age, and ethnicity of child participants.
9. Published versus nonpublished document;.
10. Study design, and

11. Source of child participants receiving treatment (clinical vs. analog) (p.379).

The meta-analytical study found a large effect size (.80) for the use of play therapy.
Moreover, the researchers found a large effect size (.90) for those studies with
developmental adaptive outcome measures. These results supported play therapy as an effective treatment paradigm for children with behavioral, social, and emotional difficulties.

More recently, Lin and Bratton (2015) offered a meta-analytic review of child-centered play therapy approaches. In particular, the authors reviewed fifty-two outcomes studies that were published between 1995 and 2010. Specific characteristics for this study included:

1. Publication status,
2. Demographics of child participants,
3. Family demographics,
4. Setting of the study,
5. Population focus of the study,
6. Presenting issues,
7. Clinical level of participants,
8. Participant recruitment,
9. Research design,
10. Treatment model,
11. Treatment format,
12. Treatment group,
13. Sample size,
14. Duration and intensity of treatment,
15. Treatment provider demographics,
The review estimated a statistically significant moderate effect size (.47) for Child-Centered Play Therapy.

As the result of the strong scientific support of child-centered-play therapy, it is not surprising that it has been suggested as an advantageous therapeutic model when counseling children with disabilities. Lorenz (2008) argued that child-centered play therapy offers flexible conditions for practitioners and is well-suited for serving children with a diversity of disabilities. William and Lair (1991) stated that children with disabilities often perceive themselves as having a lack of control due to their possible lack of mobility, authoritarian treatment climate, and over protective parental attitudes. Moreover, children with disabilities frequently experience a sense of dependency and loss of control as a result of their disability (Jones, 2001). Through the use of child-centered play therapy children often gain a greater sense of control and mastery as they remain in control throughout the therapeutic process (Landreth, 2002; Williams & Lair, 1991). Furthermore, non-directive play therapy provides children with a warm and nurturing environment which according to Williams and Lair (1991) minimizes feelings of inadequacy commonly experienced by children with disabilities.

Although child-centered play therapy can be implemented with a broad spectrum of therapeutic challenges, there is increasing evidence to suggest the efficacy of this theory for children with various forms of childhood disabilities. A review of the existing literature has found research that supports the implementation of child-centered play therapy for individuals with disabilities. Specifically, Johnson, McLeod, and Fall (1997)
investigated the outcomes of child-centered play therapy for six children who were identified as having special education diagnoses. These included autism, attention deficit hyperactivity disorder, cerebral palsy, and/or developmental disorders. Each of the six participants were provided six sessions of child-centered play therapy as part of the study. Pre and posttest measures were used to investigate the impact of child-centered play therapy had with the participants. The researchers indicated that child-centered play therapy precipitated a greater expression of feelings, coping skills, and feelings of control for the children.

Similarly, Kenny and Winick (2000) explored the benefit of child-centered play therapy with a young girl who was diagnosed with high functioning autism. Using a single case design, the researchers studied the effect of child-centered play therapy as compared to directive interventions with the child. Findings supported the use of child-centered play therapy as the researchers found that the child responded more emphatically to child-centered play therapy. The study credited the child’s behavior alterations and emotional progression to child-centered play therapy. In contrast, the researchers noted that directive interventions served to stagnate or influence regression with the child.

Additional support for child-centered play therapy was offered by Demanchick, at al., (2003). Although not specific to children, these researchers explored the outcomes of child-centered play therapy for adults with developmental disabilities. Descriptive case studies were used to highlight the power of child-centered play therapy for two adults with developmental disabilities. The treatment regimen consisted of a child-
centered play therapy model that was implemented at a day treatment facility. Both participants were reported to have improved observable changes with frustration tolerance. Likewise, professional staff reported using standardized assessment measures that each participant also progressed with changes in self-direction and self-expression.

Josefi and Ryan (2004) studied the effects of child-centered play therapy on the therapeutic relationship, attachment behavior, and autonomy with a young boy who was diagnosed with autism spectrum disorder. The researchers found that child-centered play therapy was effective with this single case design. The identified goal of the research was to explore the effectiveness of child-centered play therapy in conjunction with traditional behavioral treatments for children who were identified on the autism spectrum. The researchers concluded that child-centered play therapy was effective in areas that traditional behavioral interventions failed to address. In particular, the child responded to treatment via child-centered play therapy with a greater sense of autonomy, attention and concentration, and improved relationships with his treatment providers.

More recently, Swan and Ray (2014), evaluated the efficacy of child-centered play therapy for children with intellectual disabilities. The researchers used a single Adaptive Behavioral Scale research design to examine the effectiveness of child-centered play therapy with two participants. This study was conducted within an elementary school environment in the southwestern United States. During the initial investigation observers used the behavioral scales to document the child’s behaviors during school hours and on three alternative days. As a result a baseline was established for each child. Each child then participated in thirty minute child-centered play therapy session for five
weeks. Observers continued to complete behavioral ratings for the children to investigate
the effects of child-centered play therapy. Following the five week play therapy
interventions each child was reported to have decreased mean levels of irritability. The
researchers reported that the findings are consistent with other experiential studies that
explore the effectiveness of child-centered play therapy for children with disabilities.

These contributions have established a solid foundation and have provided a
strong argument that play therapy produces positive outcomes for children with
disabilities. Although these contributions have yielded some important benefits for
clinicians who serve children with disabilities, there continues to be a need to explore the
play therapy experiences for children with disabilities. Therefore, in an attempt to gain a
greater appreciation of the play therapy experience for children with disabilities the
present study has generated rich thick descriptions of children with disabilities who
participated in play therapy services at The Child Protection Center of Ross County to
build upon these strong foundations.

In conclusion, children with disabilities confront an array of psycho-social
challenges. This chapter has provided a review of the literature of psychosocial
adaptation to disability as it applies to individuals with disabilities and their families, and
the impact of child maltreatment. A rationale for play therapy has been offered to assist
professional who serve children with disabilities. Moreover various models of play
therapy intervention were identified and each model has the potential to provide valuable
resources in assisting children with disabilities. Therefore, it is evident that counselors
and all social services professionals are likely to work with children with disabilities as
well as their families. Counselors are in an ideal position to empower children in the adaptation process of a disability. However, clinicians must utilize effective counseling practices and maintain an awareness of the unique cultural values exhibited by children with disabilities.

This chapter has highlighted relevant research that addressed various models of psychosocial adaptation to disability, play therapy, and specific play therapy research for working with children with disability. This review of the literature establishes a foundation for the present investigation. In the following chapter an overview of the methodology for this study has been described.
Chapter 3: Methodology

This chapter highlights a rationale for qualitative inquiry which will be offered in exploration of the play therapy experience for children with disabilities who participated in play therapy services at The Child Protection Center of Ross County. In particular, the chapter will be divided into the following sections to provide a blueprint of the current study: 1) methodology of the study, 2) the setting for data collection, site selection, 3) sampling strategy, 4) recruitment of participants, and 5) data collection, and data analysis. The present study used qualitative inquiry to answer one research question. What are the lived experiences of children with disabilities who participate in play therapy services at The Child Protection Center of Ross County? Additional ethical considerations are included at the conclusion of this chapter relevant to the current investigation. These include a discussion of the research as the instrument in gathering and obtaining data, the analysis, and interpretation of the evidence collected.

The emphasis of this study is to acquire as much information as possible about the play therapy experiences of children with disabilities and their family. Each child, caregiver, and clinician who participated in the present study served as a beneficial instrument in gaining a better understanding of the therapeutic experience for children with disabilities. According to Maykut and Morehouse (1994) human instruments provide a multifaceted approach that captures the important elements of lived experiences. This case study examined the experience of children with disabilities who participated in play therapy services at a child advocacy center. Therefore, qualitative inquiry was determined to be the most effective form of research for the proposed study.
The study implemented qualitative methodology to address one research question. Qualitative methodology provides beneficial inquiry for research questions that seek to explore a particular experience or phenomenon. Through the examination of rich thick descriptions, evidence can be obtained through qualitative data collection strategies (Patton, 2002). Similar to varying types of quantitative analysis, qualitative research encompass many types of discovery. Creswell (2007) stated that the goal of qualitative inquiry is to investigate and gain an understanding of the meaning and complexity of individuals or groups ascribed to an experience. Qualitative research “begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a human problem” (Creswell, 2007, p. 37).

According to Creswell (2007), the focus of qualitative research is to understand the meaning that events have for the individuals being studied. This qualitative case study examined the meaning of the play therapy experiences of children with disabilities at The Child Protection Center of Ross County. This qualitative case study is driven by four philosophical views a qualitative design. In particular, Creswell (2013), identified four philosophical views that provide a general framework for qualitative inquiry. Specifically, qualitative research is viewed as ontological, epistemological, axiological, and methodological (Creswell, 2013). The current investigated utilized these views in data collection and analysis.

The present study will use multiple perspectives to obtain a meaning of the play therapy experiences for children with disabilities at the identified agency. In addition to
data collection from semi-structured interviews with children with disabilities, this study will also obtain data through semi-structured interviews with caregivers of these children. Evidenced will also be utilized from interviews with two play therapists who work for The Child Protection Center of Ross County. Through the use of multiple forms of data collection a rich thick description of the experiences of children with disabilities who participate in play therapy services at the advocacy center can be illustrated. These methods are consistent with the ontological philosophy of qualitative research (Creswell, 2013).

Data collection for the present case study has included facilitation of semi-structured interviews with ten participants, transcription of these interviews, coding of the data, interpretation, and analysis. This process has allowed the researcher to become immersed with the participants of the study as well as the data obtained. These attempts to become immersed with the research have provided subjective evidence regarding the experiences of children with disabilities and their play therapy services at the advocacy center. Consequently, a more in-depth understanding can be obtained through these measures. These attempts parallel the epistemological philosophy of qualitative discovery (Creswell, 2013).

Throughout the case study the research has identified and discussed his personal values, assumptions, and potential bias relative to the study. These disclosures create transparency within the present study. Moreover, through the discussion of the researcher’s professional experience and personal interest in the research area reflexivity is created to further alleviate potential bias. More accurate and detailed outcomes of the
study have been generated as the result of the researcher’s transparency and reflexive approach to the research. These mirror the axiological philosophy of qualitative research (Creswell, 2013).

The emerging and salient themes generated from the present study have been shaped through the researcher’s experience of data collection, interpretation, and analysis. Qualitative methods of semi-structured interviews and observations provided the most accurate measures for identifying and documenting the lived experiences of children with disabilities who participate in play therapy services with The Child Protection Center of Ross County. The methodological philosophy (Creswell, 2013) provides a vehicle to articulate a true and accurate reflection of the experiences for children who participated in this study. These meanings could not have been achieved through quantitative research methods.

**Rationale for Methodology**

The support for qualitative research in the field of counseling has been well documented. Patton (2002) argued that significant contributions can be gained through qualitative study. In particular, professionals can acquire a deeper understanding through observations, interviewing, and studying the experiences of others. Hanna and Shank (1995) supported the use of qualitative research in counseling to gain better insight into difficulties in the counseling and psychotherapy relationship. Glazer and Stein (2010) asserted that qualitative research is a natural extension of the therapeutic process. Specific to the broader profession of counseling, Hunt (2011) acknowledged that The Council for Accreditation of Counseling and Related Education Programs (2009)
recognized the importance of qualitative research in its standards for master’s and doctoral training.

Qualitative study is not a new concept for play therapy professionals. The increase and support for qualitative inquiry has been well documented. Miller, Hengst, and Wang (2003) reported that research regarding play is a good measure for qualitative study. Ethnographic studies have been proposed as a means of gaining a more detailed account of the process of filial play therapy (Rennie & Landreth, 2000). Even the *International Journal of Play Therapy* has included qualitative studies in its publication since 1998 (Glazer, 1998).

The marriage of qualitative research and play therapy is further validated by guiding principles of each discipline. Both qualitative study and play therapy emphasize the power of the relationship between the researcher and the individual being studied. Moustakas (1994) provided seven criteria of qualitative research that highlights its difference from quantitative inquiry:

1. Recognizing the value of qualitative designs and methodologies, studies of human experience that are not approachable through quantitative approaches
2. Focusing on the wholeness of experience rather than solely on its objects or parts
3. Searching for meanings and essences of experiences rather than measurements and explanations
4. Obtaining descriptions of experiences through first-person accounts in informal and formal conversations and interviews
5. Regarding the data of experience as imperative in understanding human behavior and as evidence for scientific investigation

6. Formulating the questions and problems that reflect the interest, involvement, and personal commitment of the research

7. Viewing experience and behavior as an integrated and inseparable relationship of subject and object and of parts and whole (p. 21).

Ironically, these elements parallel the principals of client-centered counseling and are specifically applicable to non-directive play therapy. Child-Centered Play Therapy was developed based upon the work of Carl Rogers’ (1951) client-centered philosophy of counseling. Rogers operated from the belief that individuals have this ability to resolve his/her own problems. The center principles to Roger’s theory have been described as core conditions needed in a therapeutic relationship. Specifically, Roger’s argued that counselors need to feel what a client is experiencing and emphasized the concept of empathetic understanding. In addition, this paradigm underscored the principles of genuiness and honesty with clients. Lastly, client-centered approaches adhere to a deep respect and acceptance for individuals who participate in psychotherapy (Roger, 1951).

**Research Design**

The research design for the present study focuses on the experiences of children with disabilities who participate in play therapy services specifically at The Child Protection Center of Ross County. The current study is built upon an emergent design where the researcher has operated from educated opinions and initial hunches that have been guided by clinical experience. Although the literature review (Chapter Two) has
identified prior research regarding the use of play therapy for children with disabilities, this case study has offered additional contributions through a rich thick description of the children with disabilities who have been involved with play therapy services at the child advocacy center. It is believed that this study will enhance the existing literature and further serve to offer insights into the play therapy experiences of children with disabilities.

The following section provides an overview for the context of the present study. This includes a discussion of the site selection and rationale for the site of the current study. Additional discussions will provide accounts of the researcher’s process towards gaining entry into the site selected, sampling strategy, and how the participants were identified and selected to participate in the present study. Furthermore, the methods for data collection, interpretation, and analysis will also be described in the following section.

**Case study.** This current study was generated from a motivation to expand the meaning of the play therapy experiences for children with disabilities through a descriptive case study presentation regarding their experiences at The Child Protection Center of Ross County. There are a variety of case studies that can be utilized in qualitative inquiry. Specifically these include, include: single instrumental case study, collective or multiple case study, and intrinsic are all cited a forms of case study methodology (Creswell, 2007). The present study offers a single case study with multiple units of analysis. A single case study is used by researchers when a theme or concern has been identified and illustrated through a specific case. By contrast, a collective case
study is used when several case studies are used to describe and report an identified issues or concern (Creswell, 2007).

There are many inherent strength common with case study research. Although the selection of one site versus multiple sites could be seen as a limitation, the present design utilized existing recommendation to facilitate effect case study design. Yin (2009) highlighted five factors that are associated with effective case study research design. These include research questions, propositions of the study, unit analysis, logic that link data to propositions, and criteria for interpreting the data. The breadth and depth for which information can be obtained from a single case has also been cited as a strength of case study research (Yin, 2009).

There is a consensus among professionals that cases are bound through time and activity and are inclusive to a specific setting in which the experience occurs (Denzin & Lincoln; Yin, 2009). This bounded setting allows researchers to use multiple methods of data collection to offer a rich thick description of the case that is under investigation (Creswell, 2013). For the present study, the phenomenon that was investigated was the play therapy experience of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County.

**Context of the Study**

The researcher was purposeful and intentional in identifying and selecting the research site for the current study. The research was conducted in south central Ohio through a nationally accredited child advocacy center. The selection of this facility and geographic location was determined based upon the specialized nature of play therapy.
Because this study seeks to gain more understanding regarding the meaning of play therapy for children with disabilities, selecting a facility that incorporates play therapy into their services is paramount. Play therapy has been recognized within the counseling and psychology fields as a therapeutic treatment paradigm since 1982. Clinicians who achieve the certification as a Registered Play Therapists (RPT) or Registered Play Therapist Supervisors (RPT-S) must have completed specialized training and maintain these competencies through continuing educational opportunities. (Ray, Bratton, Rhine, & Jones, 2005). The facility selected for this study utilizes three professionals who are Registered Play Therapists (RPT) or Registered Play Therapist Supervisors (RPT-S).

**Site selection.** Site selection was also influenced by the services that are offered by the child advocacy center. The chosen site for this study provides comprehensives services to children and families. These include forensic services, medical assessments of children, child and family advocacy, body safety prevention services, supervised visitation, parent education and counseling. The child advocacy center offers counseling services to children who are referred to their facility due to some spectrum of traumatic experience(s). These can include physical abuse, sexual abuse, and exposure to domestic violence, grief, loss, etc. Child Advocacy Centers (CACs) operate from a service delivery model that is commonly recognized as a nationwide standard of care for children and families who are impacted by trauma. Specifically, Child Advocacy Centers are identified as the most effective model in serving children and their families following traumatic experiences (Conner-Burrow, Temple, Seigel, Church, Kramer, & Worley, 2012).
It has been well-documented that children with disabilities confront a higher risk for maltreatment and a greater likelihood of being exposed to violence as compared to children without disabilities (Gore & Jansen, 2007). Consequently, it is not uncommon for child advocacy centers to serve children with disabilities. As a result, it seems logical that the child advocacy center clinicians will assist a higher prevalence of children with disabilities as compared to traditional community mental health centers or private clinicians. In addition, the site selection was also influenced by the specialization of mental health clinicians who offer play therapy services. Play therapy has also been cited as a more appropriate form of counseling for children with disabilities as the paradigm is not dependent upon a child’s verbal or cognitive skill acquisition (Henderson & Thomson, 2011; Landreth 2002).

**Gaining entry.** The researcher adhered to a three step process to gain entry to the sample. First the researcher completed the required review criteria with the Institutional Review Board (IRB) with Ohio University. After approval was received from the IRB, contact was made with the research site. The final step in this process was contact with potential participants for the current study. Fortunately, the researcher experienced limited obstacles in gaining entry for the research study. As a former member of the Board of Directors, former volunteer, and current employee with the agency selected for the research study the researcher experienced limited obstacles towards gaining entry.

Initially, the researcher developed a research proposal that was submitted to the Institution Review Board (IRB) at Ohio University and the proposal was ultimately approved by the governing board. Following this approval, contact was made with the
Executive Director of The Child Protection Center of Ross County at which time the research proposal was introduced to the administrator. Through the assistance of the Executive Director and two play therapists who are employed through the center, three children and two caregivers were identified for participation in the study. Contact with two additional children and their caregiver was precipitated by the children’s adoptive mother’s response to the research recruitment flyer that was posted in the waiting area of The Child Protection Center of Ross County.

**Sampling Strategy**

The strategy that was used in the current study is purposeful. According to Creswell (2007) purposeful sampling means “that the inquirer selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (p. 125). The selection process for the present study was initiated through discussions with the three Registered Play Therapists who work with the child advocacy center.

The following criteria were offered to select participates for the study:

a) The selected child will have an identified disability.

b) The selected child will be between the ages of five and ten years of age.

c) The selected child will have participated in at least six play therapy sessions.

d) The selected parent and/or caregiver will have a child who meets criteria a,b,and c as listed above.

e) The selected play therapist will have facilitated play therapy services to a child who has met the first three criteria.
The required sampling size for qualitative research is typically smaller. Patton (2002) opined that the sampling size of qualitative research is determined based upon the purpose of the study, time and resources of the researcher, and access to participants. The goal of this study is not generalization, but rather acquisition of a deeper understanding of the play therapy experiences for children with disabilities. Therefore, the proposed sampling size is suggested to range from five to eight participants. It is believed that the proposed sample size will provide an opportunity to report descriptive, informative, accounts of the play therapy experiences of children with disabilities and his or her family.

Recruitment of Participants

The recruitment of participants for the present study was initiated through a review of the research proposal with the Executive Director of The Child Protection Center of Ross County and three play therapists employed by the agency. Participation of all participants was voluntary. Through telephone contact with three of the children's caregivers and additional personal conversations with all participants a total of ten individuals agreed to contribute to the present study. These included five children with disabilities who participated in play therapy services at The Child Protection Center of Ross County, three of the caregivers of the child participants, and two play therapists who facilitated play therapy services for these children. Each of the caregivers of the five children executed voluntary consent for their children's participation as well as their own. Likewise, both play therapists selected for participation in the current study provided voluntary consent.
Interviewing

The present study explored emergent themes through semi-structured interviews. Among all forms of qualitative study, interviewing is one of the most commonly employed methods (Rubin & Rubin, 2005). According to Seidman (1998) semi-structured interviews are designed to guide conversations but also allow participants the ability to provide information that is important to them but are not necessarily reflected in the interview questions. Patton (2002) stated that a semi-structured interview allows the researcher to probe and ask follow-up questions that elucidate and illuminate the subject that is being studied. The present study was designed to use one semi-structured interviews of children with disabilities who participate in play therapy sessions at the Child Protection Center of Ross County, one interview with the child’s parents or caregiver and one interview with the play therapist assigned to the child. The interviews were initiated after validation that the child had completed at least six play therapy sessions. All participants for the current study were initially asked the same questions relative to their sample. However, the researcher had freedom to ask follow-up questions and deviate from the established order of the pre-designated questions.

Digital recordings, with the permission of participants and his/her custodian, were used to assist the researcher in data collection and analysis. Recordings were maintained and stored in a secure location and in compliance with the International Review Board’s approval. A standardized set of predetermined questions was used with the interviews. However, the researcher had the flexibility of asking follow-up questions and was not be held to a linear sequence of standardize questions. Therefore, data analysis was a
continuing endeavor throughout the research process. The following tables list specific questions that guided the semi-structured interviews.

Table 1

*Research Interview Questions for Children with Disabilities*

<table>
<thead>
<tr>
<th>Q1. Do you like coming to the play room? Tell me about it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2. Tell me about being in the play room?</td>
</tr>
<tr>
<td>Q3. Why did you start coming to play therapy?</td>
</tr>
<tr>
<td>Q4. What has changed since you started coming to play therapy?</td>
</tr>
<tr>
<td>Q5. What are your favorite things about coming to play therapy?</td>
</tr>
</tbody>
</table>

Table 2

*Research Interview Questions for Caregivers of Children with Disabilities*

<table>
<thead>
<tr>
<th>Q1. Is there anything different since your child started play therapy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2. Does your child share what went on in the play room?</td>
</tr>
<tr>
<td>Q3. What did you hope your child would get out of play therapy?</td>
</tr>
<tr>
<td>Q4. Does your child look forward to coming to play therapy?</td>
</tr>
<tr>
<td>Q5. Were you familiar with play therapy prior to your child starting play therapy? If so</td>
</tr>
<tr>
<td>tell me about your knowledge.</td>
</tr>
<tr>
<td>Q6. Have your views of play therapy changed?</td>
</tr>
</tbody>
</table>
Table 3

*Research Interview Questions for Play Therapist*

Q1. Do you think play therapy is different for children with disabilities? If so, how.

Q2. Do you make any adaptations for children with disabilities in the playroom?

Q3. Is your theoretical orientation different for children with disabilities? If so, how.

Q4. Do you see differences in the playroom between children with disabilities and children without disabilities? If so, how.

Q5. How long have you been licensed as a mental health professional?

Q6. How long have you been certified as a Registered Play Therapist-Supervisor?

Q7. In your practice, what do you see as the therapeutic objectives for children with disabilities?

**Observation**

Observations are viewed as an important and vital element of qualitative research (Marshall & Rossman, 2011). It is further been asserted that observations can significantly contribute to other forms of qualitative strategies. Specifically, it has been argued that other forms of qualitative strategies are unable to capture the rich thick essence of sights, sounds and other great sensory aspects of the research environment (Patton, 2002). Consequently, observations allow researchers to contribute additional data that enhances the description of a specified phenomenon (Yin, 2009).

The current study used field notes through the interactions with 10 participants who participated in the present investigation. Research has supported the use of field
notes to document specific accounts of what was witnessed by the researcher (Marshall & Rossman, 2011). In the present study the researcher’s field notes were essential in recording and reporting factual descriptions of what was observed. Specifically, fourteen pages of field notes were recorded throughout the researcher’s interactions with the research participants. In conjunction with the audio recordings of the semi structured interviews, the field notes were examined and analyzed for identification of specific patterns and emerging themes.

Data Analysis

The specific data collection methods employed for the current study were observation and interviews. According to Creswell (2007), data analysis is a process consisting of six important steps. First, data analysis involves the gathering and organization of the data. The next process involves a review of the data through the reading of transcriptions and making notations regarding the comments of the person being interviewed. This step is followed by offering descriptions of how each individual experiences the phenomena. Identification of emerging themes through the statements and quotations the participants is included in the next step of this process. This also involves the clustering of particular statements to reflect grouping of meanings. The preceding step of this framework involves interpretation. This includes the identification of contextual influences on how the phenomenon was experienced by the individual. The final step in the process is the researcher’s written essence of the phenomenon (Creswell, 2007).
The framework proposed by Creswell (2007), provided guidance in data analysis of the present study. First, data was collected from the digital recordings of the semi-structured interviews, observations, and field notes from the interaction with the ten participants who participated in the current study. This organization of the material was followed by the researcher immersing himself within the data through transcription and review of the transcription for each participant. In addition to identifying how each of the ten participants experienced the phenomenon, a line by line code strategy was implemented. This procedure allows the researcher to identify categories of emerging themes through the examination of the coding that was completed in the prior step. After the identification of emerging clusters, the researcher explored patterns of salient themes for interpretation. The researcher concluded the data analysis process by writing a final summary of emerging themes that illustrate the essence of the phenomenon.

The line-by-line coding analysis is further highlighted in the following chart. In particular, Figure 1 provides an overview of the eight themes identified in the present study and specific codes for each of the identified themes. The emerging themes identified within the current investigation are 1) problem solving, 2) abreaction, 3) self-expression, 4) posttraumatic play, 5) attachment, 6) rapport building, 7) gaining competence, and 8) power and control.
Figure 1. List of themes and coding
**Trustworthiness and Credibility**

Qualitative research has been criticized due to the limitations of generalizability, reliability, and validity issues (Marshall & Rossman, 2006; Phillips, 2010). Yet, the goal of qualitative research is not to generalize to a larger population. Rather the purpose of qualitative inquiry is for the research discoveries to enhance the understanding of similar participants and populations. Unlike the concepts of reliability and validity offered through quantitative research, qualitative researchers established credibility through trustworthiness. According to Patton (2002), credibility can be achieved through the establishment of rigorous methods, the researcher’s credibility and the possession of a core belief in the value of qualitative study.

The credibility of the researcher was established through the researcher’s professional knowledge and experience of facilitating play therapy services for children with disabilities. However, detailed methods were designed for data collection and analysis thus further creating credibility. Moreover, the researcher brings a philosophy in the belief and importance of qualitative discovery. Specifically, through examining the experiences of children with disabilities who participate in play therapy services at The Child Protection Center, significant contributions can be made to the existing body of research in this area.

Patton (2002) also proposed the achievement of credibility through triangulation which uses multiple sources of information to increase the credibility of a study. Through the use of data collection by observations, interviews with children with disabilities, their caregivers, and two play therapists, the researcher has strengthened the
credibility of the present study. However, the use of different samples not only established a higher degree of credibility but likely provided varying perspectives of the phenomenon of the play therapy experiences for children with disabilities.

**Ethical Considerations**

Ethical considerations are natural and ingrained component that are anticipated when facilitating research (Creswell, 2009). Various professional licensing bodies provide ethical codes that serve as a blueprint for clinicians when conducting research. The present study references ethical guidelines among three specific organizations. As a licensed clinical counselor supervisor (LPCC-S) and member of the American Counseling Association, this researcher must adhere to the ethical guidelines set forth by the American Counseling Association (ACA). Likewise, as a registered play therapist supervisor (RPT-S) ethical conduct is also described by the practice guidelines of the Association for Play Therapy (APT). Lastly, the Institutional Review Board (IRB) at Ohio University has provided ethical oversight for the present study.

First the American counseling Association (ACA, 2014) lists specific guidelines for counselors to conduct research and publication. These guidelines address multiple areas for consideration including research responsibility, the rights of research participants, maintaining appropriate boundaries, the reporting of results, and publication and presentation of the results (ACA, 2014). Similarly, the Association for Play Therapy has cited similar guides in their assertion of ethical practice for clinicians in conducting research (APT, 2017). The guidelines established by the ACA and APT provide not only standards of practice but also serve as a resource for situations that may present ethical
ambiguity. As such the researcher is knowledgeable of the code of ethical standards established by both organizations and thus these guidelines were relevant in guiding ethical practice of the current study.

In conjunction with the ethical considerations from the professional bodies listed above, this research study was approved by the Institutional Review Board (IRB) at Ohio University. As required by the Institutional Review Board (IRB) this researcher study was evaluated through a rigorous review and was approved as meeting the standards for ethical research. As a result adherence to the ethical standards set forth by the Institutional Review (IRB) at Ohio University is vital to the ethical considerations in the current study.

**Researcher as Instrument**

Unlike quantitative forms of research, the researcher serves as the instrument for data collection, interpretation, and analysis in qualitative research (Patton, 2002). Two key concepts that are associated with this theory are reflexivity and positionality (Marshall & Rossman, 2011). The reflexive approach enables researchers to position themselves and experiences within the phenomenon of the study (Marshall & Rossman, 2011). As such the researcher should address any previous experience that may influence the interpretation and/or analysis of an investigation (Charmaz, 2006). These experiences often include individualized demographics, identities, and experiences (Creswell, 2009). Similarly, positionality is identified as the manner in which a researcher describes his/her experiences and interest of the topic being investigated and the phenomenon without influence (Marshall & Rossman, 2011).
As the research design has stated, the present study has used methods of observations and interviews to obtain a rich thick description of the experiences of children with disabilities who have participated in play therapy services at The Child Protection Center of Ross County. However, the method for which this data was obtained, organized, and analyzed was through the instrument of this researcher. Therefore, in maintaining reflexivity and positionality the following discussions will be offered to underscore the researcher’s interest in the topic that was investigated as well as address any experiences that could have influenced the outcomes of the present study.

The researcher is a single Caucasian male who was born and raised in south central Ohio. Throughout the last 45 years the researcher has lived and worked within the Appalachian region where he was born. As the younger of two children the researcher was raised by his mother and father in a traditional Protestant household. A strong emphasis was placed on family values as is characteristic of the Appalachian culture. As such extended family (grandparents, aunts and uncles, etc.) were also influential in the researcher’s life. Many of the researcher’s childhood peers were of similar cultural backgrounds. The researcher attended and completed elementary and high school in a school district in southeastern Ross County.

After completing high school the researcher attended Ohio University where he earned an Associate of Applied Science degree in Human Services Technology and a Bachelor’s degree in Psychology. Following these academic achievements the researcher obtained employment in a child welfare agency where he worked for five years. As a caseworker and administrator the researcher advocated for and served children who were
victimized by abusive and neglectful experiences. The researcher also was employed as a paraprofessional for a local community mental health center provided crisis and emergency services to consumers of the center.

In November of 1997, the researcher was involved in a serious automobile accident. After sustaining multiple injuries, the researcher was diagnosed with a brachial plexus injury February of 1998 as the result of the automobile accident. Acquiring a permanent disability was in contrast to the active lifestyle that the researcher had previous enjoyed. The brachial plexus injury required extensive medical and therapeutic services which have included over fourteen surgical procedures. While much of the focus remained on his medical and therapeutic services, the researcher maintained employment with the local community mental health center working in emergency services and crisis intervention.

After some stabilization with his disability, the researcher started graduate school in 2000 and earned a master’s of education degree in Clinical Counseling and Rehabilitation Counseling. Additionally, the researcher also initiated a new role with the local community mental health center as a child and adolescent therapist and clinician. Through this endeavor the researcher worked primarily with children and adolescents who had experienced traumatic events. The researcher has earned licensure as a Licensed Chemical Dependency Counselor (LCDC III), and a Licensed Clinical Counselor with Supervisor endorsement (LPCC-S).

Following the completion of his graduate degree the researcher accepted a new role at the community mental health center and was appointed as the Director of
Counseling Services. The researcher also began to pursue his certification as a Registered Play Therapy Supervisor. As required as part of this specialized certification the researcher participated in numerous educational opportunities and completed supervision with a Registered Play Therapist Supervisor. The researcher obtained certification of a Registered Play Therapist in 2006 and has continued to provide therapeutic services to children who are affected by trauma.

Most recently, the researcher has expanded his professional duties and works as an independent trainer and consultant where he lectures extensively on topics of clinical mental health, working with child survivors of trauma, and working with children with disabilities. As a trainer with the Ohio Child Welfare Training Program, the researcher offers educational trainings for child welfare professionals and licensed foster and adoptive parents. The researcher also provides counseling services for children who are victims of child maltreatment as well as other traumatic experiences.

It has been the culmination of these experiences that have influenced the researcher’s interest in this area of study. Although the researcher’s previous experiences may influence his view and philosophy of the present study, disclosure of these experiences provides a balance of reflexivity and positionality. Moreover, as an individual who identifies as a person with a disability, who has extensive experience in working with children with disabilities, and is a Licensed Professional Clinical Counselor Supervisor and Registered Play Therapist, the researcher brings a diversity of experiences to the present study that are beneficial in creating a rich thick description of
the experiences of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County.

Summary

This chapter has provided a thorough review of the methodology that was utilized for the present study. The discussions throughout this chapter has further outlined the research design and the setting for which the data was collected. This included referencing the sampling strategies, the recruitment of participants, methods for collecting the data, and the analysis and interpretation of the data. A concluding segment of this chapter addresses ethical considerations that were identified in the current study that included a comprehensive narrative of the researcher as the instrument. Chapter Four will share the history of The Child Protection Center of Ross County and offer introductory information of the ten participants who were included in the present study.
Chapter 4: The Children Shall Lead Them, Play Therapy Participants

The purpose of this qualitative case study is to explore and elucidate the lived experiences of children with disabilities who participate in play therapy services at The Child Protection Center of Ross County. Similarly, the overall objective of this qualitative inquiry is to address the research question and offer additional scientific evidence that contributes to the existing literature. In particular, the existing literature has offered general recommendations for clinicians who serve children with disabilities (Carmichael; Henderson & Thompson, 2011). Play therapy has been asserted as a beneficial paradigm for working with children with disabilities (Carmichael, 2006). However, there appears to be limitations within the existing research that explores the lived experiences of children with disabilities who participate in play therapy services.

This chapter will offer a comprehensive description of the lived experiences of children with disabilities who participate in play therapy services at a child advocacy center in south central Ohio. The current study highlights the experiences of children with disabilities who are served by The Child Protection Center of Ross County and will be captured through this case study investigation. Consequently, a historical narrative will establish a foundation for gaining insight into the nature of the site for the present study. Additionally, thorough descriptions of ten participants further provide an extensive picture of the experiences of children with disabilities who have been offered play therapy services at this facility. The ten participants include five children with disabilities who have experienced play therapy services, three primary caregivers of the
children, and two Registered Play Therapist Supervisors who have facilitated play therapy services of the five children.

The Child Protection Center of Ross County is a nationally accredited child advocacy center that offers a diverse range of services for children and families who are impacted by trauma. However, this case study focuses on the therapeutic services of play therapy for children with disabilities. Children who are referred to The Child Protection Center of Ross County are alleged survivors of severe physical and/or sexual trauma. As part of the comprehensive services offered through this facility, many children are referred for counseling and play therapy services. Although the center serves children from varying populations, it is common that children with disabilities are referred to this facility for therapeutic services. While child abuse and neglect have no socioeconomic, demographic, religious, or cultural boundaries, it is well documented that children with disabilities have an increased vulnerability of victimization. Specifically, the professional literature across the last two decades has reinforced the hypothesis that children with disabilities confront an increased risk of child maltreatment (Sullivan & Knutson, 2000, Gore & Janssen, 2007, & Westcott, 1993).

Although, there are a myriad of consequences associated with child maltreatment for all children, children with disabilities encounter significant challenges due to the cumulative effect of vulnerability factors. The duplicity of child maltreatment, societal, and environmental barriers for children with disabilities exacerbates the effects of traumatic experiences for children with disabilities (Gore & Jansen, 2007). As a result, clinicians who serve children with disabilities who are survivors of maltreatment must
acquire competencies to empower this population (Henderson & Thompson, 2011). Play therapy is a powerful tool for to assist children with disabilities (Carmichael, 2006, Henderson & Thompson, 2011). Therefore, the present investigation examines the experiences of children with disabilities who have participated in play therapy services at The Child Protection Center of Ross County. While play therapy has been promoted as a popular intervention for children who experience a variety of mental and emotional challenges (Bratton, Ray, Rhine, & Jones, 2005; Phillips & Landreth, 1995), limited researcher has been proposed to examine the play therapy experience for children with disabilities. Furthermore, the psychosocial model of disability adaptation provides a philosophical framework for the current study.

The present study utilized data obtained via interviews from children with disabilities who participated in play therapy services at The Child Protection Center of Ross County, their caregivers and two Registered Play Therapist Supervisors who facilitated play therapy intervention. Considering the psychosocial adaptation model this study acknowledged that children with disabilities experiences a variety of challenges related to their disabilities experience.

This chapter illuminates the history of The Child Protection Center of Ross County and provides a thick rich description of the play therapy services offered through the facility to children with disabilities. Specifically, this chapter will provide a historical overview and organizational of The Child Protection Center of Ross County, highlight the experiences of Registered Play Therapists who are employed by the facility, and provide services to children with disabilities. While this information establishes a
foundation towards describing the lived experiences of children with disabilities who participate in play therapy via The Child Protection Center of Ross County, the following chapters will provide a detailed and thorough analysis of interviews of five children with disabilities who participate in play therapy services through the center. Additionally, interviews with two Registered Play Therapist Supervisors and three custodians of children will further contribute to the in-depth analysis of the lived experiences of children with disabilities who participate in play therapy services at the facility.

A Place to Heal: The Child Protection Center of Ross County

The Child Protection Center of Ross County has been in operation since 1995. Prior to its inception, there were significant limitations to serving children and families affected by child physical and sexual maltreatment within the south central Ohio region. The Child Protection Center was formed to assure that Ross County children and children in surrounding counties who had been physically and/or sexually abused received appropriate attention in a timely and family-friendly manner without regard for ability to pay. Prior to the opening of The Child Protection Center, families were forced to travel approximately one hundred twenty miles round trip and wait approximately six to eight weeks in order to receive the same comprehensive assessment that a child advocacy center could offer locally. Community efforts explored the possibility of decreasing the possibility of secondary trauma for children and families through repeated interviews. Prior to a multi-disciplinary approach, child survivors of abuse would often be subjected to numerous interviews by various professionals (law enforcement, child welfare
professionals, physicians, victim advocates, prosecutors, mental health providers, etc.) in different locations and differing times.

Strong collaboration efforts started in the early 1990’s to strengthen the region’s response of addressing child victimization. A consortium of agencies (Ross County Children’s Services, Adena Regional Medical Center, Scioto-Paint Valley Mental Health Center, Family Healthcare, Inc., Ross County Sheriff’s Department, Chillicothe Police Department, Ross County Prosecutor’s Office and local pediatricians) sought grant opportunities to establish a child advocacy center in south central Ohio. The combined efforts precipitated funding with federal grant dollars through the Rural Health Outreach Grant. This financial endeavor provided monetary resources for the development and operation of The Child Protection Center of Ross County through 1998.

Through additional funding opportunities with the Ohio Attorney General’s office, The Child Protection Center has expanded services and presently works with ten counties in south central and southeastern, Ohio. The Center utilizes a multi-disciplinary, multi-agency approach to care and has been recognized by the National Children’s Alliance as one of fourteen Children’s Advocacy Centers in the state. The Child Protection Center became incorporated in October 1997 and is recognized as a 501(c)(3) nonprofit agency. The organizational mission statement is “The mission of the Child Protection Center of Ross County, a children’s advocacy center, is to reduce the incidence and trauma of child abuse through a coordinated multi-agency approach and to promote healthy children, families and communities through the professional provision of
education, prevention and protective services (Joan, personal communication, December 2, 2016).”

Fiscal and Administrative oversight of The Child Protection Center of Ross County is the responsibility of the Governing Board and an Advisory Board. Each Board is comprised of community members and multi-disciplinarian team members. The Governing Board provides fiscal oversight, executive director recruitment, selection, and supervision as well as direction in the adherence to center policies. The Governing Board meets every other month and oversees the administrative direction of the agency. The Advisory Board reviews protocol, case governance and overall function of agency services. The Advisory Board monitors practices and protocols that promote cultural diversity and the cultural and professional competencies of the staff.

The Child Protection Center of Ross County’s outreach encompasses many rural areas throughout southern and southeastern Ohio. The child advocacy center is located and serves many families within the Appalachian region of southern and southeastern, Ohio. As one of fourteen child advocacy centers in Ohio, The Child Protection Center of Ross County provides services to nine counties in Ohio which include Ross, Pike, Pickaway, Fayette, Jackson, Vinton, Scioto, Gallia, and Meigs counties. Children and families are referred to the center through child welfare professionals, medical professionals, law enforcement agencies, and/or prosecutors. Through an array of funding and grant opportunities, services are provided to families and children with a history of trauma at no financial costs.
As a nationally accredited child advocacy center, The Child Protection Center of Ross County offers an array of services for children and families. In particular, child interviews, medical assessments, child advocacy, mental health and therapeutic services, supervised visitation and exchange programs, a body safety program, parenting resources educational classes, and numerous community prevention and educational services are provided by the agency. In addition, to the services that are offered directly through the agency, The Child Protection Center of Ross County is a “unique entity within the communities it serves as it facilitates strong collaboration among various agencies who serve child victims and their families (Joan. personal communication. December 2, 2015).”

While each of these services provide valuable resources to children and families, this case study offers a rich thick description of the mental health and therapeutic services and more specifically the specialized practice of play therapy. The Child Protection Center employs two child therapists and the Executive Director also provides a limited amount of counseling and mental health services. Each of the clinicians are independently licensed mental health practitioners within the state of Ohio and have also earned specialized training and certification as Registered Play Therapist Supervisors through the Association of Play Therapy. Two of the three Registered Play Therapist employed by The Child Protection Center of Ross County participated in this current case study. Each of these professionals provided valuable information that contributed to answering the research question.
The Voices of Children with Disabilities through Play Therapy

For the present study, a total of five children with disabilities have offered significant information towards gaining insight into their lived experience as children with disabilities who participate in play therapy services at The Child Protection Center of Ross County. The following sections will introduce each of these participants and provide an overview of their affiliation with The Child Protection Center of Ross County. Likewise, developmental information will be offered for each of the five children who participated in this study. To protect the anonymity and confidentiality of these children pseudonyms have been assigned to each child. These pseudonyms reflect the resilience of these children and have been assigned based upon their individual stories.

**Hope.** The first participant is Hope who is a five-year-old Caucasian female and resides with her paternal grandmother in Circleville, Ohio. The pseudonym Hope was assigned to this participant to reflect the hope that children can acquire a sense of mastery following adverse childhood experiences. During the interview Hope presented with an illuminating smile. She was dressed in more formal attire wearing in a light blue dress with lace trim ending at her knees. A matching blue bow pinned in her hair complimented the child’s appearance. Hope is fair complexed, with long blond hair that extends midway down her back. Standing at approximately four foot in height Hope presented herself with a large smile and was eager to talk with this researcher (Hope. personal communication. December 5, 2016).

Hope was referred to The Child Protection Center of Ross County at the age of four due to allegations of sexual abuse during the time she lived with her biological
mother. Both the child’s primary care physician and the county child welfare agency referred the child to the center for a medical assessment and interview. Hope’s grandmother (custodian) also reported that both of Hope’s parents had a history of substance use disorders which precipitated incarceration of both parents. Upon incarceration of the child’s biological mother, the child was placed with her maternal grandmother. Additional information from the family’s social assessment noted that Hope has made verbal statements regarding people touching her vaginal area and the child’s grandmother reported that the child had been acting out sexually.

Hope’s medical assessment identified the child as having a speech and language disabilities and regression across a number of developmental milestones. Following the medical assessment and the child’s interview, the multidisciplinary team recommended that the child be referred for counseling services and considering the child’s age specifically play therapy. Hope had participated in approximately twelve play therapy sessions through The Child Protection Center when her Registered Play Therapy Supervisor suggested that Hope participate in the current study and referred the child and her custodian to contact this researcher. The child’s custodian was the first participant to express interest in the present study and the first to schedule an interview for the child.

Hope’s interview was scheduled at The Child Protection Center of Ross County. Considering the child’s familiarity with this facility with her participation in services this seemed like an environment that would be comfortable with the child. Hope presented herself for the interview accompanied by her grandmother (custodian) and greeted this researcher with a big smile. At the time of the interview it was reported that this child is
in kindergarten at Circleville Elementary School and has educational accommodations due to her mental health diagnosis of posttraumatic stress disorder. Her level of comfort was demonstrated by her eagerness to join this researcher and her skipping to the conference room of the agency. Hope’s openness to the interview was also illustrated as she spontaneously described to this researcher the room that she comes to play therapy. Without prompting Hope stated that she comes to see:

Ms. Joan because I got hurted when I was little girl and my mommy and bad men hurt me in privates (Hope. Personal communication. December 5, 2016).

The child continued by providing a detailed description of “worry rocks” that is a play therapy technique that was offered to the child for addressing worries:

I get these rocks to help me with my worries ’cause sometimes I even worry when I go to sleep.” Hope then reached in her pocket and pulled out a small blue gem and said “Do you have worries (Hope. Personal communication. December 5, 2016)?

Hope exhibited a high degree of excitement when she reported what she did in the play room. The child nodded repeatedly when asked if she enjoyed coming to the play room and said; “Yes, yes and yes.” Without hesitation, the child verbalized various activities that she has completed in the play room. These included playing in the sand, drawing and coloring, playing puppet show, using worry rocks, painting pictures of dream monsters, and games. However, Hope was quick to report that her favorite thing about coming to the play room was playing with puppets (Hope. Personal communication. December 5, 2016).
According to Hope’s grandmother, the child was assigned a diagnosis of Post-traumatic Stress Disorder when she initiated play therapy services at The Child Protection Center of Ross County. In particular, the child was described as experiencing night terrors and has repeatedly verbalized fears associated with her abuse. Moreover, the child’s grandmother reported “extreme anxiety” when Hope started play therapy services. Hope’s grandmother stated that the child had an extremely difficult time being around strangers, would not sleep in her own room, and constantly discussed her mother coming to take her away. The child’s custodian also reported that Hope’s progress has been filled with “ups and downs” due to legal issues and the child being forced to participate in supervised visitation with her biological mother. These experiences only served to intensify the child’s anxiety according to her grandmother.

Despite these challenges, Hope’s grandmother reported that the child has improved significantly since participating in play therapy services. Hope’s grandmother, Angel, offered a measure of the child’s improvements by stating:

Did you see how comfortable she was talking with you? That would have never been the case a year ago. The child is more at ease around strangers and in crowds of people. She is also only having one or two night terrors a week when before she would have three a night (Angel. personal communication. December 5, 2016).

**Gunnar.** The second participant in the current study is Gunner who is a ten year old Caucasian male who resides with his adoptive parents in Kingston, Ohio. The pseudonym Gunnar was given to this participant due to his active and impulsive nature.
Despite a number of childhood adversities, Gunnar continues to push forward and presents himself as fearless. Gunnar is a rather tall ten year old and standing at approximately five feet in height. The child attends Huntington Elementary School where he is placed in a special needs classroom. He presented for the interview with short blond hair and wore blue framed glasses. Gunnar exhibited a willingness to participate in an interview through making direct eye contact with this researcher and nodding his head when asked if he would talk with this researcher.

According to Gunnar’s adoptive mother Faith, The Child Protection Center first became involved with Gunnar and his siblings in 2013 after the county’s child welfare agency received allegations of severe physical abuse, neglect, and suspected sexual abuse of Gunnar and his two siblings. The child’s case worker from child protective services referred Gunnar and his siblings to The Child Protection Center of Ross County for a medical assessment and interview. At the time of the initial referral, Gunnar and his siblings were placed in foster care and there were limited developmental histories for the children. However, the child’s foster mother reported that the children had reported they did not have food to eat at their old home and Gunnar had said that his dad hurt him and pointed to his penis. It was also reported that the child welfare caseworker had indicated a significant history with the child’s parents and reported chronic neglect of the children and suspicion of drug activity in the home.

Gunnar’s medical assessment noted Intellectual Developmental Disorder and multiple areas of developmental regression according to his adoptive mother. The physician also noted delayed speech and communication challenges. Findings from the
multidisciplinary team supported a high suspicion of abuse and neglect and several treatment recommendations were made. These included, speech therapy, occupational therapy, educational advocacy, and counseling to include play therapy services. Gunnar and his younger brother were adopted in 2014 by his foster parents and have remained active with counseling and play therapy services at The Child Protection Center of Ross County. Gunnar’s adopted mother inquired about the research study after seeing a recruitment letter in the waiting area of the agency. Gunnar had participated in approximately twenty-three play therapy sessions when his adopted mother asked about his participation in the study. Through contact with the child’s Registered Play Therapist-Supervisor Gunnar was referred to this researcher for participation in the study. Gunnar’s interview was scheduled at The Child Protection Center. The child’s adoptive mother and his Registered Play Therapist’s Supervisor reported that Gunnar is very comfortable at the agency as he has been active in services for well of 18 months.

Gunnar presented himself for the interview accompanied by his adoptive mother and brother. The child was compliant but somewhat reserved as indicated by his head being lowered at times. However, when asked about showing this research where he comes to play therapy, the child immediately grabbed the researcher’s hand and led him down the hall. Gunnar wore long black jogging pants with a red Ohio State shirt to the interview. Although Gunnar’s exhibited obvious regression in speech, he was compliant and verbal through the interview process. When asked if the child likes coming to play therapy, he stated, “Yea, I can play.” The child stated that he comes to play therapy to
“help me with all the bad stuff, but I live with new mom dad now (Gunnar. Personal communication. December 7, 2016).”

When asked about being in the play room, Gunnar started reporting many of the activities that he has engaged in during play therapy. These included, “Playing with soldiers in the sand, building stuff, drawing, making gremlins, drawing pictures, coloring, playing cops, and stuff.” Although Gunnar verbalized many activities that he has completed in play therapy, he indicated that he favorite thing to do in play therapy was “build stuff in sand (Gunnar. Personal communication. December 7, 2016).”

With nearly two years of participation in play therapy, Gunnar had no difficulty in talking about things that have changed since he initiated services at The Child Protection Center of Ross County. The child first referred to his adoption and stated “Well I got a new mom dad.” He continued to report that he is no longer experiencing bad dreams and said “I sleep and no pee in bed (Gunnar. personal communication. December 7, 2016).”

According to Gunnar’s adoptive mother, the child was diagnosed with Intellectual Developmental Disorder and anxiety at the time of his intake with play therapy services through The Child Protection Center of Ross County. Based upon the information provided by Gunnar’s adoptive mother, the child’s educational assessments validated Intellectual Developmental Disorder. Moreover, the child verbalized fears of fires as the biological family had experienced a house fire. Gunnar also was reported to be fearful of his biological parents especially during the times of supervised visitation. Although these experiences have presented significant obstacles for Gunnar, his adoptive mother reported that this child has made compelling progress since his initiation of play
therapy services. The child’s adoptive mother states, “There has been a remarkable decrease with his anxiety.” Gunnar continues to participate in speech therapy and has also made strides in this area according to his custodian. While the finalization of Gunnar’s adoption helped build a sense of security, his adoptive mother was also quick to credit play therapy services for the child’s improvements (Faith. personal communication. December 7, 2016).

**Rocky.** Rocky is the third participant in the study. Rocky is the biological brother of Gunnar and was referred to this research study by his adopted mother. The pseudonym Rocky was assigned to this participant, as he is a fighter. Similar to his brother, Gunner, Rocky has confronted significant challenges related to childhood trauma. However, by many accounts Rocky has exceeded developmental and therapeutic expectations with his participation in services. This participant is an eight-year-old Caucasian male who is thin and short in stature. He attends second grade at Zane Trace Elementary School where he is placed in a special needs classroom. At the time of the interview Rocky appeared to stand at approximately four feet six inches in height and had short buzz cut blond hair. He wore dark framed glasses that complimented his bright smile. The child wore grey sweat pants and a grey sweatshirt at the time of his interview. He was accompanied by his brother and adoptive mother.

Similarly, to the historical information of his brother, Rocky was placed in foster care in 2013. The child and his siblings were referred to The Child Protection Center of Ross County due to chronic neglect, physical abuse allegations, and suspected sexual abuse. Rocky was referred for a medical assessment and interview with the advocacy
center. Results from the medical assessment assigned Rocky a diagnosis of Intellectual Developmental Disorder, regression in speech and language skills, and global developmental delays. Medical findings also validated high suspicion of both physical abuse and neglect. However, findings associated with sexual abuse were inconclusive as the interviewers reported the child’s limited communication skills presented significant obstacles in disclosure of abuse for Rocky.

The child’s adoptive mother reported that the child was the youngest of three children who were being raised by their parents. According to child welfare reports the parents were suspected of having substance use disorders. Multiple reports of neglect (unclean home, children not being supervised, medical neglect, etc.) had been made to the local child welfare agency. Additionally, officials at the child’s elementary school had reported that Rocky had made statements alleging oral sex with his biological father. Based up on the investigations by child welfare investigators, Rocky and his brothers were placed in foster care.

The multidisciplinary team through The Child Protection Center referred the child to a multitude of medical and mental health services. Specifically, the team recommended that the child be referred for speech therapy, occupational therapy, educational advocacy, educational psychological testing, and counseling with a specific recommendation for play therapy services. Rocky and his older brother were adopted by their foster parents in 2014 and have remained consistent with The Child Protection Center. Rocky had participated in approximately twenty-two play therapy sessions prior to his participation in this research study. As documented with Rocky’s brother, Gunnar,
it was his adoptive mother who responded to a recruitment letter in the lobby of The
Child Protection Center requesting participants for this study.

Rocky presented himself for the interview walking closely behind his biological
brother. The child was initially timid in his initial interaction with this researcher as he
stayed in close proximity to his adoptive mother. However, Rocky was very curious after
his brother’s interview and asked this researcher several questions about what Gunnar
had done with the researcher. His eagerness continued over the course of a forty-three
minute interview. Although Rocky exhibited deficits in speech he was talkative and
active throughout the interview process.

Rocky was quick to respond when asked if he enjoyed coming to play therapy.
The child jump up and down and loudly exclaimed, “Yes.” Like his brother, Rocky stated
that he comes to play therapy “because my old mom dad were bad.” The child expanded
and stated, “They used to not give food, they also hit us. (Rocky. Personal
communication. December 7, 2016).” After being prompted about the play room, the
child moved around the room as if he was guiding a tour. He discussed many activities
that he has completed in the play room. Specifically, sand tray, puppets, doll house,
crayons and drawing, Legos, batman, games, cars, and balloons were listed as material
that Rocky has used. However, Legos were identified as the favorite activity for Rocky.
The child reported that since he started coming to play therapy he is sleeping in his own
bed with a nightlight and not experiencing dreams about monsters. Rocky also stated that
he does not have to see his mean mom and dad.
Rocky’s adoptive mother reported that the Registered Play Therapist assigned to Rocky listed a diagnosis of Intellectual Developmental Disorder as well as an anxiety disorder according to the child’s adoptive mother. It was reported that educational assessments validated cognitive limitations with the child and supported the diagnosis of Intellectual Developmental Disorder. In addition, the child’s adoptive mother reported that Rocky was experiencing enuresis when he became frightened, was very clinging, and easily startled prior to his participation in play therapy services. Likewise, the child had made statements about abuse to both his adoptive family and school officials. The child’s behaviors were exacerbated by supervised visitation with the child’s biological parents prior to the finalization of adoption.

Although there have been many challenges that Rocky has encountered in his young life, his adoptive mother feels as though this child has made tremendous progress since his placement in foster care. The child continues to participate in a multitude of services including play therapy through The Child Protection Center of Ross County. Rocky’s adoptive mother reported noticeable improvement in the child’s self-confidence and feelings of security. According to the family, Rocky has improved in his social interactions and there have been decreases in his level of anxiety. The child’s adoptive mother stated that, “he loves to come to play therapy” and believes it has greatly aided in improvements with Rocky (Faith. personal communication. December 7, 2016).

**Ethan.** Ethan is a six-year-old Caucasian male who is the fourth participant in this research study. Both Ethan and his brother (Ezekiel) were identified as possible participants for this research study by their Registered Play Therapist-Supervisor who is
assigned to their care. The pseudonym Ethan was assigned to this participant due to the child’s experience as a survivor of child maltreatment. Ethan comes from the Hebrew language and means “strong.” After talking with the child’s play therapist, the child’s adoptive mother contacted this researcher via telephone to inquire about her children’s participation in this study. Ethan and his brother were interviewed at The Child Protection Center of Ross County.

Ethan presented himself for the interview accompanied by his brother and adoptive mother. The child was approximately four feet five inches tall and had short buzzed cut black hair. Ethan wore blue jeans and a Spiderman tee-shirt with a black sweatshirt. He is a first grade student at Miami Trace Elementary school. The child had brown eyes and a bright smile with two front teeth missing from his mouth. Ethan’s comfort level was demonstrated by his immediately approach this researcher and saying, “I’m Ethan” (Ethan. personal communication. December 9, 2016).

According to Ethan’s adoptive mother, Ethan has been involved with The Child Protection Center of Ross County since early 2016. The child and his brother were referred for counseling and play therapy services by their child welfare worker from Hamilton, County Job and Family Services. Ethan was initially seen at another child advocacy center in Cincinnati, Ohio before being placed in foster care in closer proximity to The Child Protection Center of Ross County. The child welfare officials had noted reports of drug activity in the children’s home prior to their removal and placement in foster care. Tragically, the child’s mother was also found unconscious after a 911 call was made from the family’s residence and the child’s father was arrested on charges of
domestic violence. Consequently, Ethan and his sibling were placed in foster care in late 2015. After the child’s placement in foster care it was reported that Ethan made verbal statements about his father and mean people hurting his butt. This information precipitated a referral for Ethan was made to the Mayerson Center which is a child advocacy center located in Cincinnati, Ohio. Allegations of sexual and physical abuse were received by Hamilton County Children’s Services. Results from the child’s interview and medical assessment found a high suspicion of physical and sexual abuse. Furthermore, the child’s medical assessment reported physical findings consistent with anal penetration for Ethan.

As reported by Ethan’s adoptive mother, findings from the child’s medical assessment from the child advocacy center in Cincinnati, Ohio supported a diagnosis of high functioning autism spectrum disorder and regression in speech and language. Similarly, the child’s initial diagnosis with The Child Protection Center of Ross County validated these disabilities with Ethan. However, Ethan’s adoptive parent also reported that the child’s Registered Play Therapist Supervisor has indicated many of the child’s symptoms are likely the effects of the child’s traumatic experiences. Ethan’s adoptive mother estimates that the child has participated in approximately sixteen play therapy sessions since his involvement early 2015.

The child presented himself for the interview accompanied by his brother and adoptive mother. Ethan exhibited a strong level of comfort at The Child Protection Center by immediately going to the play area in the lobby and telling this researcher that “they have lots of toys here. (Ethan. Personal communication. December 9, 2016).”
There was no apparent reluctance or distress with Ethan separating from his adoptive mother for the interview. Ethan nodded his head when asked if he enjoys coming to the play room.

The child was open and stated, “I come here to feel better when I sad. But I get to play too.” Ethan expanded his statement by talking about pictures of monsters that he drew in play therapy. He stated “she lets me make the monsters in my bad dreams silly.” The child reported drawing funny hands and red noses on pictures that he drew of his bad dreams. Ethan said that he does not experience as many bad dreams as he did prior coming to play therapy (Ethan. personal communication. December 9, 2016).

According the Ethan’s family, the child has made significant strides since his participation in play therapy services. Ethan is less “clingy” and more social according to his adoptive mother. It was also reported that there has been a significant decrease in the child’s verbalization about his prior maltreatment. Although Ethan continues to be triggered by specific events (i.e. hearing sirens, loud sounds, and storms) he is better equipped to communicate his fears and response better to efforts to assist him in managing his anxieties. Ethan’s adoptive mother states that there is no question in her mind regarding the benefits of play therapy for Ethan

**Ezekiel.** The last child participant for the present study is Ezekiel. The name Ezekiel was assigned to this participant as a representation of the strength this child has had towards his survival of childhood traumatic experiences. The origins of Ezekiel are Hebrew and offers the translation of “God strengthens.” Ezekiel is the biological brother of Ethan who was also placed in foster care and subsequently adopted in late 2014.
Ezekiel is a five year old Caucasian male with short dark hair and light freckles on his face. Like his brother, Ezekiel was also interviewed at The Child Protection Center of Ross County.

Ezekiel was approximately four feet in height when he presented himself for the interview. Ezekiel was accompanied by his adoptive mother and biological brother when he came to the interview at The Child Protection Center of Ross County. Ezekiel wore blue jeans and a grey long sleeve sweatshirt with red converse tennis shoes. He quickly ran up to this researcher after his brother initiated a conversation as if to compete with his brother. Although there was a slight speech impairment noted, Ezekiel quickly followed his brother’s lead by introducing himself.

Similar to the historic information that was provided for Ezekiel’s brother, his adoptive mother, Grace, highlighted the tragic circumstances that led to the child’s placement in foster care. Officials with Hamilton County Job and Family Services placed the child and his sibling in foster care following a domestic violence situation that left the child’s mother hospitalized. The child’s father was charged in this incident with domestic violence. Additionally, child welfare officials also reported having concerns with drug activity in the home and physical abuse of both children. Sexual abuse suspicions were also listed as a concern for this child. Specifically, Ezekiel was reported to have engaged in sexual acting out behavior in the foster home and when asked about his behavior the child responded “dad does it to me” and pointed to his penis. Initially, Ezekiel was referred to the Mayerson Clinic in Cincinnati, Ohio in 2014 due to
allegations of physical and sexual abuse. The child was referred for an interview and medical assessment.

Ezekiel’s adoptive mother reported that the findings from the child’s assessments at the Mayerson Clinic provided diagnoses of speech and language disabilities, attention-deficit hyper-activity disorder, a possible sensory disorder, and post-traumatic stress disorder. As a result the child was referred to speech therapy, occupational therapy, a psychiatric evaluation, and recommended to participate in play therapy services. Given the geographical distance between the foster home and The Mayerson Clinic, a referral for follow-up for play therapy services was made to The Child Protection Center of Ross County. Ezekiel’s adoptive mother estimates that the child has participated in approximately sixteen play therapy sessions since his initial visit in early 2015.

Ezekiel exhibited no difficulty in separating from his adoptive mother for his interview. In fact, the child demonstrated a strong level of comfort as he pointed to one of the play rooms and stated, “That’s where I come to play.” The child was open and active during his thirty-nine minute interview. Ezekiel stated, that he enjoyed coming to play therapy and that he gets to play and that it helps him. As with his earliest introduction, some regression in speech was noted. However, the child was open and active through the interview process. In regards to the reasons that Ezekiel comes to play therapy, the child reported, “To help ‘cause my old mom and dad were mean.” The child continued and stated, “Sometimes I ‘fraid that they will take me away and hurt me more” (Ezekiel. personal communication. December 9, 2016).”
Similar to his brother Ezekiel discussed various activities that he participated in during his experience in play therapy. The child described making a worry can which he uses to keep pictures that he draws when he is worried. He also discussed drawing a circle of people who can keep him safe and he proudly recited five individuals as he counted them out with fingers on his right hand. It was apparent that Ezekiel was very content in talking about his play therapy experiences. He reported that his favorite activity was playing with the blocks and cars.

While it is evident that Ezekiel has encountered many challenges at his young age, his adoptive mother expressed a high degree of optimism for his future. Furthermore, Ezekiel’s adoptive mother credits the play therapy services that he has received as being and integral part of the child’s progress. According to his adoptive mother Ezekiel has better ways to express himself and stated that before the child participated in play therapy he would “just got into hysterics.” Comparatively, his adoptive mother stated that he now uses a lot of things that he has learned in play therapy to help when he is upset (Grace. personal communication. December 9, 2016).

The introduction of these five participants serves to create a portrait of the children who comprised a portion the sample for the present study. Likewise, the introductions also served to gain a more detailed understanding of the lived experiences for children with disabilities who participate in play therapy services at The Child Protection Center of Ross County. Findings of this inquiry suggest the each of the children represented within the present study have experienced beneficial outcomes from the play therapy experiences. Although emerging themes will be discussed in the
following chapter, initial findings support prior research within the play therapy literature regarding the curative powers of play therapy.

The following section offers an overview of specific demographic information of the children for the present case study. The following table illustrates the specific similarities and differences within the sample. The table provides an examination of the participant’s age, race, type of disability or disabilities, specific categorization of the child’s traumatic experiences, educational status, duration of his/her play therapy experiences, and geographic region where the participant currently resides. All of the participants were identified as children with disabilities who have participated in play therapy, which is in accordance with the investigative requirements for the present case study. This information has been identified as an essential component because of the analysis of meaning for each participant as it serves to consider how these individual differences contribute to the uniqueness of their lived experiences.

The child participants who were selected for this study provided personal accounts of their lived experiences as children with disabilities who participated in play therapy through The Child Protection Center of Ross County. To obtain a more detail and thick description of the lived experiences of children with disabilities who participant in play therapy, the present case study also compares and contrasts the demographic information for each of the child participants who are represented in the present study. This examination explores the demographic information of participants of how these factors shaped their life experiences. In particular, five specific factors of the lived experiences of children with disabilities who participate in play therapy were examined.
These factors include 1) child’s age, 2) child’s race, 3) type of disability or disabilities, 4) categorization of traumatic experiences, and 5) duration of play therapy experiences.

Table 4. Provides an introductory overview for a critical analysis of how these factors have contributed to shaping the lived experiences of children with disabilities who participate in play therapy.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race</th>
<th>Type of Disability</th>
<th>Traumatic Experience</th>
<th>Play Experience</th>
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</thead>
<tbody>
<tr>
<td>Hope</td>
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<td>Caucasian</td>
<td>Speech &amp; Language</td>
<td>Sexual Abuse, PTSD, Neglect</td>
<td>24 sessions</td>
</tr>
<tr>
<td>Gunnar</td>
<td>10</td>
<td>Caucasian</td>
<td>IDD, Speech &amp; Language &amp; Anxiety</td>
<td>Physical Abuse, Neglect, Suspected Sexual Abuse</td>
<td>23 sessions</td>
</tr>
<tr>
<td>Rocky</td>
<td>8</td>
<td>Caucasian</td>
<td>IDD, Speech &amp; Language &amp; Anxiety</td>
<td>Physical Abuse, Neglect, Sexual Abuse</td>
<td>22 sessions</td>
</tr>
<tr>
<td>Ethan</td>
<td>6</td>
<td>Caucasian</td>
<td>Speech &amp; Language ASD</td>
<td>Physical Abuse, Neglect, Sexual Abuse</td>
<td>16 sessions</td>
</tr>
<tr>
<td>Ezekiel</td>
<td>5</td>
<td>Caucasian</td>
<td>Speech &amp; Language ADHD</td>
<td>Physical Abuse, Neglect, Sexual Abuse</td>
<td>16 sessions</td>
</tr>
</tbody>
</table>
Current Age

Through the examination of the demographic information a specific focus has been given to the age of participants at the time of the interviews. Analysis of the data finds that participants range from five to ten years of age. This age group represents children who are typical involved in elementary school. This sample and age classification illustrates the common occurrence of childhood disability within the earliest educational experiences. According to Drews (2001) a substantial percentage of children within the elementary years have mental and emotional disorders as well as other types of disabilities. As a result, children of this age range require specialized treatment approaches that are sensitive to the broad range of developmental competencies (Shen & Sink, 2002).

Race

All of the children who are represented in the current study are identified as Caucasian who reside in the Appalachian region of Ohio. This provides a necessity for the multicultural considerations with this population. Cultural competence is a complex process that requires sustained efforts on the part of professionals to understand truly and accurately the magnitude of individual’s cultural influences (Hendricks & Fong, 2006). Likewise, culturally competent clinicians must continuously explore his or her personal values and biases (Henderson & Thompson, 2011). As a result, professionals who work with children from specific cultures should ensure that they have knowledge and understanding of the cultural values familiar to the child. The Appalachian culture is no exception as professionals who work with this population also require multicultural
expertise (Sue & Sue, 2008). Russ (2010) asserted that clinicians who work with individuals of Appalachia must familiarize themselves with the cultural values and characteristics in order to deliver effective services.

**Type of Disability**

As a core requirement for participation in the present study, each of the children selected for the study were identified as having a disability. All of the five children who are represented within the sample were reported to have disabilities in speech and language. While speech and language disabilities were a shared commonality among the sample, all of the children also were noted to have additional diagnoses. Two of the child participants were diagnosed with Intellectual Developmental Disorder. One of the children was assigned a diagnosis of Post-Traumatic Stress Disorder. Likewise, another child had an additional diagnosis of Attention Deficit Hyper-Activity Disorder (ADHD). The remaining child included in the sample was reported to have a diagnosis of Autism Spectrum Disorder.

The identification of a child with a disability provides additional demographic considerations with the present study. Chapter One offered a brief discussion regarding disability as a culture. Children like all persons with disabilities encounter similar experiences that relate to having a disability. Therefore, children with disabilities share a unique perspective with one another as well as many other characteristics specific to their experiences. Consequently, individuals and children with disabilities are identified as a specific cultural group within our society (Smart, 2005).
**Traumatic Experience**

An addition demographic consideration comes from the children’s traumatic experiences. Each of the five children who were introduced are survivors of child maltreatment. Four of the children were reported to have experienced physical abuse, sexual abuse, and neglect prior to their participation in the study. One child was reported to be a survivor of sexual abuse and neglect prior to their participation in the study. There is a multitude of research that outlines the numerous effects of child abuse in the lives of children (Barfield, Donson, Gaskill, & Perry, 2012; Bethel, 2005). Orange and Brodwin (2005) asserted that abuse can have lifelong implications that thwart psychological, social, educational, vocational, and interpersonal development. These consequences of abuse are similar for children with disabilities. Children with disabilities affected by maltreatment frequently face challenges of negative behavioral, emotional, and social experiences (Shannon, 2006). Bethel (2005) asserted that children who are survivors of abuse commonly feel betrayed, overwhelmed, and helpless which may further complicate the child’s healing process.

**Play Therapy Experiences**

The remaining demographic factor is that of the children’s play therapy experience. This study identified selection criteria that included a child’s participation in play therapy for more than six sessions. In fact, a requirement for children to participate in the present study was their completion of at least six play therapy sessions. All of the children exceeded this minimal requirement with the sample having a range of sixteen play therapy sessions up to twenty-four play therapy sessions. The number of play
therapy sessions for the sample aligns with recommendations from the play therapy literature. Prior play therapy research has provided evidence that play therapy is effective with a few sessions, but the positive effect increases with the more play therapy sessions (Ray, Bratton, Rhine, & Jones, 2001).

The Voices of Registered Play Therapist Supervisors

In addition to the children with disabilities who are represented in the sample of this study, two Registered Play Therapist Supervisors (RPT-S) also participated and contributed significant information regarding their experiences of working with children with disabilities who participate in play therapy services at The Child Protection Center of Ross County. Both of the RPT-S who are part of the sample for the present case study are Licensed Clinical Counselors with Supervisory endorsement (LPCC-S) through the Ohio Counselor Social Worker Marriage and Family Therapist Board. Additionally, each of these clinicians have earned specialized training Registered Play Therapist Supervisors through the Association for Play Therapy.

The Association for Play Therapy was founded in 1982 by Charles Schaefer and Kevin O’Connor as a means of promoting the practice play therapy and advocating for increased education of play therapy services. Fortunately, the organization has witnessed significant growth and expansion since its earliest vision. The organization introduced the International Journal of Play Therapy in 1992 which further promoted research of play therapy practice. In 1993, The Association for Play Therapy initiated a credentialing process for registered play therapist (RPT) and registered play therapy supervisors (RPT-S). The Association for Play Therapy lists five areas of competencies in their
credentialing criteria. These include 1) licensure within the state clinician’s practice 2) relevant degree 3) clinical experience, 4) play therapy training, and 5) supervised play therapy experience (Association for Play Therapy, 2015).

**Joan.** Joan is a 45 year old Caucasian female who was born and raised in Chillicothe, Ohio. Joan is average height with short black hair. The pseudonym Joan was assigned to this participant because she has dedicated much of her professional career to advocating for child survivors of trauma. Similar to Joan of Arc, Joan has been a warrior towards advocating for the protection and treatment of children impacted by traumatic experiences. Joan has been employed with The Child Protection Center of Ross County since 2004. Initially she was hired as a child and family therapist but currently serves as the Executive Director of the agency. In addition to her administrative duties, Joan is a certified forensic interviewer and conducts interviews for children referred to the agency by law enforcement and/or child welfare agencies. As an independently licensed clinician and a Registered Play Therapist Supervisor, Joan also provides counseling and play therapy to a limited number of children identified through the agency. Joan has been practicing counseling since 2001 and is currently a Licensed Professional Clinical Counselor with Supervisory endorsement with the Ohio Counselor Social Worker Marriage and Family Therapist Board.

Joan presented herself for the interview with a large smile while sitting in a play room surrounded by toys. Her passion for children was evident from the excitement in her voice. When asked about working specifically with children with disabilities, Joan was quick to refer to her experience. She stated, “child advocacy center see a high
percentage of children with disabilities. It’s sad to think about but in terms of child abuse, children with disabilities are more vulnerable compared to other children. I’ve worked with this population for well over ten years.” Joan continued by reporting that, “I’m not sure that I would say working with children with disabilities is different, cause in play therapy you really meet where they are. However, there are obvious adaptations that must be made based upon a child’s disability, like their cognitive skills may not allow them to comprehend more advanced terminology so you do have to adapt in that manner (Joan. personal communication. December 2, 2016).”

Using her experience as both a clinical counselor and a Registered Play Therapist Supervisor, Joan stated that, “Children with disabilities often have a number of objectives when coming to play therapy. Because I work solely with traumatized children, we see kids with a lot of anxiety, fears, and trauma related symptoms. These are probably the most immediate objectives for all children who come through this agency. However, children with disabilities really have these reactions to trauma compounded. Not only do they face the common fears of trauma but many children with disabilities have issues related to self-esteem, depression, educational struggles and we certainly incorporate these objectives into play therapy (Joan. personal communication. December 2, 2016).”

As Joan sat surrounded by a sea of puppets, toys, and games she expanded upon her statement after being asked about making adaptations in the play room. Joan drew on one specific example, “I worked with a child years ago who due to her disability was in a wheelchair. As we explored play therapy techniques, I found that I did make adaptations. I placed the puppets stand on boxes to allow her more ease on using it, I lowered my sand
Anne. Anne is a 40 year old Caucasian female who provides counseling services to children from area school and children who are also referred from The Child Protection Center of Ross County. Anne stands approximately five feet eight inches in height and has shoulder length black hair. Like the well known educator of Helen Keller Anne Sullivan, Anne was a former educator who advocated for children with disabilities. She spent twelve years as a Middle School and High School teacher before returning to graduate school for a counseling degree. In fact, Anne credits her experience as an educator as a significant motivator for obtaining a counseling degree as she reported she always knew she wanted to have an even greater impact on children within her classroom.

As a Licensed Clinical Counselor with supervisory endorsement, Anne has been practicing counseling for approximately three and a half years. Her passion for working with children was evident as Anne reported that this was the population with which she knew she wanted to work with when she entered her graduate program. Anne began her play therapy education almost immediately following her graduate school curriculum and utilized numerous educational opportunities towards achieving her goal to become a Registered Play Therapist Supervisor. This goal became a reality approximately one year ago for Anne.

Although Anne describes herself as, “relatively new to the counseling profession” she brings a diversity of experience into her counseling and play therapy practice. Anne
pulled from her experiences as an educator and commented that, “I guess I have a profound sense of how children with disabilities feel in the educational environment. They need encouragement and opportunities to discover their skills and talents.” When asked if play therapy is different for children with disabilities, Anne provided an interested response. She stated,

That’s tough but I don’t think so, I mean in reality we all likely have some form of a disability. As a play therapist I also try to adapt and differentiate my treatment methods for any child that I work with regardless of whether they have a disability or not. Although it’s fundamental that counselors and play therapist understand the uniqueness of the specific child they are working with.

When talking about any adaptations within the playroom, Anne again relied upon her experience in the classroom. She stated,

It’s like working with children who have Individualized Education Plans, you are always making accommodations, but that is true for any child. So really I don’t feel that children with disabilities require any more adaptations than children without disabilities. We always want the child regardless of their specific disability to have a comfortable environment. I’ve worked with children and have had to change the language I use to accommodate for their cognitive disabilities, but this is like working with a person from another country. We don’t change our approach because of the disability; we change our approach because it provides a better opportunity for that therapeutic rapport (Anne. personal communication. December 12, 2016).
According to Anne, there are many common therapeutic objectives when working with children with disabilities. Anne was quick to assert that children with disabilities experience the same emotions as children without disabilities and stated, “When you work with children with a history of trauma you must address these feelings of vulnerability and insecurities.” However, Anne was very direct in sharing her opinion of social and environmental challenges for children with disabilities. She said,

As a former teacher I have seen children with disabilities being bullied, I’ve heard disparaging statements about children, and have witnessed how these experiences have devastated a child emotionally. So, addressing some of the issues of oppression and discrimination are also common objectives for play therapist who work with children with disabilities (Anne. personal communication. December 12, 2016).

**Demographic Trends of Play Therapist**

The play therapy professionals, who were selected to participate in the present study, shared their experiences of facilitating play therapy services for children with disabilities at The Child Protection Center of County. To further delineate a rich thick description of the play therapy experiences at The Child Protection Center of Ross County for children with disabilities the information obtained from these two play therapists was vital. The present study compares and contrasts demographic factors for each of the clinicians who are represented. The exploration of these demographic factors was instrumental in acquiring a more in-depth understanding of how these characteristics shaped and the experiences of these professionals. Three demographic factors were
examined. These include 1) race, 2) clinical experience, and 3) experience as play therapists. The following table offers a visual representation of these factors.

Table 5

*Registered Play Therapist Participant Demographics*

<table>
<thead>
<tr>
<th>Name</th>
<th>Race</th>
<th>Clinical Counseling Experience</th>
<th>Play Therapy Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joan</td>
<td>Caucasian</td>
<td>16 years</td>
<td>1 year</td>
</tr>
<tr>
<td>Anne</td>
<td>Caucasian</td>
<td>3 years</td>
<td>1 year</td>
</tr>
</tbody>
</table>

**Race**

The play therapy profession has continued to advocate for play therapists to enhance their knowledge of cultural sensitivity within play therapy practice (Gil & Drewes, 2005). In particular, The Association of Play Therapy (2009) has encouraged play therapists to be conscientious of specific interventions that are implemented in the play therapy sessions that might represent cultural bias or incongruence with the child’s cultural characteristics. Both of the play therapists who participated in the present study identified themselves as Caucasian. Likewise, each of the clinicians reported living in practicing within the Appalachian region of Ohio. These characteristics are consistent with the racial and geographic factors noted for the children who participated within this study. Equally as important, is that both therapists reported having experience of working with children with disabilities. The racial and cultural experiences of the two professionals represented within this sample appear to indicate that each of the clinicians
are likely to possess a good understanding of working with children with disabilities from this region of Ohio.

**Clinical Counseling Experience**

Additional consideration was given to the clinical experiences in each of the therapists who participated in the present study. One of the play therapists reported over sixteen years of clinical experience. The other play therapist reported three years of clinical practice. Both clinicians are licensed professional clinical counselors with the Ohio Counselors Social Work Marriage and Family Therapist Board. This information has provided evidence which supports the competence of each clinician within the counseling profession in clinical practice.

**Play Therapy Experience**

Play therapy experience and training was another important factor for consideration. Both of the clinicians identified within the study, report one year of experience as play therapists. Additionally, each of these clinicians reported participation and continual training to enhance their play therapy competence. These experiences validate the credibility of the two play therapists who participated in the current study. Although the play therapy literature has attempted to assess the relationship of play therapist training on treatment outcomes, these results remain difficult to ascertain. Specifically, a review of the literature has found that most studies do not report the training and experience a play therapist (Ray, Bratton, Rhine, & Jones, 2001).
Voices of Caregivers of Children with Disabilities

In addition to the voices of children with disabilities and play therapist who participated in the present study, three caregivers of the children with disabilities also contributed to the research. The following section will provide introductory information for each of these caregivers. Information obtained from semi-structured interview with these participants will be discussed in the following section. Data obtained from all of the participants provided a foundation for examining emerging themes in the following chapter. Similar to the introductions of the children and play therapist who participated in this study, each of the caregivers have been assigned a pseudonym for confidentiality purposes.

Angel. The first caregiver to participate in the present case study is Angel. Angel is a sixty-three year old Caucasian female who was born and raised in Circleville, Ohio. She is the paternal grandmother of Hope and has legal custody of the child. The pseudonym Angel was assigned to this participant due to her tireless advocacy for the protection and safety of her granddaughter. According to Angel, both of Hope’s biological parents were addicted to Heroin. Unfortunately, in the first three years of Hope’s life she became a survivor of sexual abuse that prompted Angel and her husband to intervene and seek custody of their granddaughter. Both of Hope’s biological parents were eventually incarcerated due to criminal charges of drug trafficking.

Angel presented herself for the interview casually dressed wearing blue jeans and a teal colored sweater. Her shoulder length blonde hair had loose curls on the top but hung straight on the sides. Angel stood at approximately five foot nine inches in height
and had a dark complexion. Her enthusiasm was evident when she presented for the interview. Angel stated, “This place has done wonders for my granddaughter, I am so happy that I can give information to help other kids.”

While this enthusiastic approach represented a high degree of comfort with Angel, she admitted she initially had some reservations about play therapy services for Hope. She reported, “It’s not that I didn’t buy into it, it was just that I didn’t know much about play therapy.” Angel had spent years advocating for the best interest of her granddaughter and admittedly wanted assurance that she was giving her the best services possible. She stated,

Hope had a lot of anxiety when she started coming to play therapy. I wanted her to be able to sleep through the night without nightmares, not be afraid of strangers in public, and not to go into major meltdowns. (Angel. personal communication. December 5, 2016).

Despite Angel’s initial reservations it is evident that she is very pleased with the progress that her granddaughter has made. Many of the therapeutic goals that Angel spoke of have been achieve. Angel describes her granddaughter as, “A different child since she started coming here. Hope was scared of everyone and that’s no surprise, but she has thrived this year in kindergarten (Angel. personal communication. December 5, 2016).”

According to Angel, Hope’s nightmares have reduced in frequency and she can independently practice calming strategies that she has learned in play therapy. In addition to the progress that has been made with Hope’s anxiety, her grandmother thinks
that the child enjoys coming to The Child Protection Center. Angel stated that many of these activities are more than simply playing, as she recognized the therapeutic value in the activities that occur within the playroom stated, “She has no difficulty talking about worries or staying safe when she is playing. “ It is frequent that Hope will talk about what she did in play therapy during our drive home.” Angel is appreciative of Hope’s excitement (Angel. personal communication. December 5, 2016).”

There has been a significant change in Angel’s confidence in play therapy compared to her initial feelings regarding these services. Angel had no difficulty sharing her present opinion of play therapy. She stated that she has witnessed, “Major improvements with Hope and I know this is due to her play therapy.” Angel also reported that she has explored research through the internet since Hope started coming to play therapy and strongly agrees with the therapeutic value of play. She said:

I would recommend play therapy to any parent. I tell my family, our friends and anyone who will listen about how far Hope has come (Angel. personal communication. December 5, 2016).”

**Grace.** The second caregiver to participate in the present study is Grace. Grace is the adopted mother of Gunnar and Rocky who were introduced earlier in this chapter. She identifies herself as a forty-seven year old Caucasian female. The pseudonym Grace was assigned to this participant to represent the ease for which Grace approaches her role as a foster and adoptive parent. As a native of Ross County, Ohio Grace was born and raised in Kingston, Ohio.
Grace reported that Gunnar and Rocky were initially placed in her home by children services as foster care children. However, Grace and her husband eventually adopted the two children when the children were placed in permanent custody status with children services. With over seven years of foster care experience, Grace is very familiar with the services offered through The Child Protection Center of Ross County. She reported that she has had many children who were served by the agency.

According to Grace, both Gunnar and Rocky had been victims of neglect, physical, and sexual abuse when they were placed in her home. She also discussed the challenges associated with each child. Grace shared that both boys had speech and language difficulties and were also challenged educationally. Although both children have disabilities associated with communication, Grace reported that each child independently verbalized abuse by their biological parents.

Grace had responded to the recruitment letter that was posted in the lobby of The Child Protection Center of Ross County. She presented for her interview wearing tan pants and a black sweater. Grace has wavy dark blonde hair that extends slightly beyond her shoulders. She is short in stature standing approximately five feet two inches in height. As a licensed foster parent Grace and her husband have worked with a number of children throughout the last several years and work with multiple child welfare agencies.

When Gunnar and Rocky were initially placed in Grace's home, they had a number of fears. The children were also unable to identify or talk about feelings according to Grace. Both children were reported to have extreme fear of their parents that was exacerbated by supervised visitation efforts through children's services. These
behaviors and symptoms were the primary objectives of play therapy services for the children. It was the goal of child welfare professionals and Grace that play therapy could assist Gunnar and Rocky in developing more adaptive coping strategies.

Grace reported that she and her husband had some familiarity with play therapy due to their foster care experience. The family has had four other foster children who been referred for play therapy services at The Child Protection Center of Ross County. In addition, Grace also shared that she had some prior knowledge of play therapy from educational classes that she attended as part of her educational requirements for foster care licensure.

It was also reported that both of Grace’s adoptive children often discuss their activities in the playroom. Gunnar and Rocky frequently come out of the playroom with pictures or stories of their activities according to Grace. Grace stated, “This is helpful because we can talk about these things at home too.” Gunnar and Rocky’s foster mother also shared that each of the children enjoys their play therapy sessions. She states, “They are all the time asking when they get to come to play (Grace. personal communication. December 9, 2016).”

While Grace has witnessed much success regarding her children’s participation, she does not feel that her views of play therapy have changed. Based upon previous experiences of other foster children who have participated in play therapy, Grace had confidence with these services when Gunnar and Rocky initiated services at The Child Protection Center of Ross County. However, Grace did report that Gunnar and Rocky’s
disabilities were more severe than most children and their response to play therapy exceeded her expectations (Grace. personal communication. December 9, 2016).

**Rose.** The third and final caregiver who participated in the present case study is Rose. Ross is the adoptive mother of Ethan and Ezekiel. The name Rose was given to the participant due to her efforts and dedication to the two children who she adopted. It has been Rose’s dedication that has allowed Ethan and Ezekiel to bloom. Rose is a fifty-two year old Caucasian female who along with her husband has been a licensed foster parent for three years. Ethan and Ezekiel were the couple’s first foster placement and this eventually led to a successful adoption of the two young children.

Rose has wavy black hair that is cut short but extends to cover her ears. She stands approximately five feet ten inches in height and was casually dressed. Rose presented herself for the interview wearing blue jeans and a beige colored sweater that was complimented with a blue and teal neck scarf. According to Rose, it was Ethan and Ezekiel’s play therapist who was responsible for referring the children for participation in the present study, but Rose reported that she was pleased to offer her insights as well. Rose stated, “Hopefully, other children can benefit from the experiences of Ethan and Ezekiel.”

As a licensed foster and adoptive parent, Rose and her husband have participated in educational opportunities as part of the state’s licensure requirements. However, Rose admittedly had no prior knowledge of play therapy before Ethan and Ezekiel were referred to The Child Protection Center of Ross County. Rose stated, “I honestly had never heard of play therapy until their caseworker mentioned it.” Yet, based upon the
history of trauma that Ethan and Ezekiel had experienced Rose indicated that the family was willing to explore any option to help the children. Over the course of the last year Rose says that she and her husband have, “learned a lot.”

Both of Rose’s adoptive children initiated play therapy services with a significant amount of anxieties. Rose reported that both of her children had difficulty with nightmares and were easily startled. According to Rose’s descriptions, both Ethan and Ezekiel were difficult to soothe when they became upset. After talking with the children’s caseworker and representatives of The Mayerson Clinic, it was proposed that play therapy services could provide benefit to the challenges listed above. Both Rose and her husband were hopeful based upon their discussions with medical and child welfare officials that play therapy could benefit the children.

Ethan and Ezekiel both have improved significantly according to Rose. There has been a decrease with the children’s anxiety and they appear less startled as Rose reported. As a result, Rose views the play therapy experiences of her children as positive. The children’s adoptive mother further reported that both children talk more about how they are feeling and exhibit more empathy for others. Although Rose had limited knowledge of play therapy prior to her children’s experience at The Child Protection Center, she reports that play therapy has helped tremendously over the last year.

According to Rose, Ethan and Ezekiel talk a lot about what they do in the play room. The children often share games they play or strategies they learned about self-soothing and relaxation. Rose indicated that many of these strategies they have used in the home per the suggestion of The Registered Play Therapist Supervisor. Moreover,
Rose detailed many incidents in which the children could not wait to share their experiences of using these strategies at home with their Registered Play Therapist Supervisor when they returned to the agency. The children’s adoptive mother shared that each of her sons love coming to The Child Protection Center.

**Demographic Trends of Caregivers**

While the primary objective of the present study is to acquire a more in-depth view of the experiences of children with disabilities who participated in play therapy services of The Child Protection Center of Ross County, data obtained from caregivers aided towards enhancement of the researched. As described with other participants of this study, there were also demographic considerations with the three caregivers who participated in the present case study. Examination of the characteristics was paramount to obtain a rich thick description of their experiences. Two particular factors were explored. These are the caregiver’s prior knowledge of play therapy and the length of time that the child had been placed within their home. The table below further highlights these characteristics.
Table 6

Caregiver Participant Demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Prior Knowledge of Play Therapy</th>
<th>Length of Caregiving for identified child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angel</td>
<td>None</td>
<td>2 ½ years</td>
</tr>
<tr>
<td>Grace</td>
<td>Some prior knowledge</td>
<td>2 years</td>
</tr>
<tr>
<td>Rose</td>
<td>None</td>
<td>1 year</td>
</tr>
</tbody>
</table>

Prior Knowledge of Play Therapy

The caregiver’s prior knowledge of play therapy is an important characteristic. Previous literature has concluded that parents and caregivers who have prior knowledge and training in play therapy contribute to a child’s significant improvement. Consequently, parental involvement remains a key factor in play therapy outcomes (Ray, Bratton, Rhine, & Jones, 2001). One of the five caregivers in the present case study reported having prior knowledge of play therapy before their children initiated the services at The Child Protection Center of Ross County. However, all of the caregivers provided information of their active involvement in play therapy services for their children.

Length of Caregiving with Children

Considering that four of the five children who participated in the present study were adopted, the length of time of placement with the children was considered a relevant factor. Angel, who is the guardian and paternal grandmother of Hope, has maintained a relationship with the child since her birth. By contrast, Grace who is the adoptive mother...
of Gunnar and Rocky, have had the children placed in her home for two years. Ethan and Ezekiel were adopted by Rose and her husband and have lived in their home for approximately one year. Both Grace and Rose also identified themselves as licensed foster and adoptive parents and as such have been required to participate in continuing education for maintenance of their licensure within the state of Ohio.

**Summary**

This chapter has provided information relevant to the site of the research and introductory information of ten participants who participated in the present study. Specifically, a rich thick description of The Child Protection County of Ross County was provided. Additionally, information was offered regarding five children with disabilities who participated in play therapy services at The Child Protection County of Ross County, three caregivers of these children, and two play therapists facilitated these services. The next chapter will utilize data obtained from the semi-structured interviews of these ten participants to identify and analyze emerging themes.
Chapter 5: Emerging Themes

This chapter will provide a detailed review of the responses recorded through interviews and observations of the ten participants who were introduced in Chapter Four. During in-depth interviews ten participants offered their experiences, perceptions, and philosophies regarding children with disabilities who participate in play therapy services. The analysis of this data will be used to highlight salient themes that emerged during this process. As discussed previously, the emerging themes will provide insight towards gaining a more thorough understanding of the lived experiences for children with disabilities who participate in play therapy services through The Child Protection Center of Ross County. In an attempt to address the research question of the present study the analysis of ten interviews will be delineated throughout this chapter.

Facilitation of interviews conducted with participants previously identified, yielded a fifty-two page transcript for interpretation and analysis. The research findings are based upon emergent themes that have been identified through semi-structured interviews and observations. The researcher obtained, explored, and analyzed the data in a detailed and purposeful approach. Specifically, Marshall and Rossman (2011) offered specific guidelines for the analysis and interpretation of qualitative data. These recommendations include, sorting the data, becoming immersed in the data, coding of the data line by line, generation of themes, offering interpretations, searching for alternative explanations, and drafting the final report.

The present case study has identified five broad emerging themes related to the lived experiences of children with disabilities who participated in play therapy sessions at
The Child Protection Center of Ross County. These five salient themes included, 1) play therapy provides an opportunity for problem solving, 2) play therapy offers an opportunity for abreaction, 3) play therapy promotes attachment, 4) play therapy promotes attachment, and 5) children gain confidence through play therapy. In addition to these broad emerging themes three sub-themes were also identified from the analysis of the data. These three sub-themes include, 1) play therapy offers opportunities for self-expression, 2) posttraumatic play, and 3) play therapy offers opportunities for rapport building.

Table 7 provides a summary of the emerging themes. This table identifies the themes, relevant quotations from participant accounts, and relevant research and literature.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Relevant Quotation</th>
<th>Brief Explanation</th>
<th>Literature Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving</td>
<td><em>I rub my worry rocks when I worry and take big breaths and I get better</em></td>
<td>Participants identified strategies to create coping mechanisms or solve</td>
<td>Schaefer &amp; Drewes, 2011</td>
</tr>
<tr>
<td>Abreaction</td>
<td><em>Sometimes we pretend that the alligator is the mean man and he hurts the little girl doll, don’t worry it’s not real, it’s fake but that’s how the mean man hurted me.</em></td>
<td>Participants are capable of discharging and releasing distressing thoughts and feelings through play</td>
<td>Schaefer &amp; Drewes, 2011</td>
</tr>
<tr>
<td>Self-Expression</td>
<td><em>With play therapy we use crayons and colors to identify and discuss difficult emotions</em></td>
<td>Participants can utilize play therapy as a method of communicating</td>
<td>Schaefer &amp; Drewes, 2011</td>
</tr>
<tr>
<td>Posttraumatic Play</td>
<td><em>It’s common that children will reenact traumatic experiences during play therapy</em></td>
<td>Participants will display themes of play associated with their trauma</td>
<td>Gil, 2017</td>
</tr>
<tr>
<td>Attachment</td>
<td><em>Her therapist told me to tell Hope what I thought she was feeling or just say out loud what the bonding got stronger</em></td>
<td>Play therapy can promote attachment through a child’s interaction with their caregiver</td>
<td>Schaefer &amp; Drewes, 2011</td>
</tr>
<tr>
<td>Rapport Building</td>
<td><em>Play therapy is all about the relationship and creating rapport.</em></td>
<td>Play therapy provides opportunities to build rapport</td>
<td>Homeyer &amp; Morrison, 2008</td>
</tr>
<tr>
<td>Gaining Confidence</td>
<td><em>I used to long time ago worry lots, but I don’t now only little</em></td>
<td>Play therapy provides opportunities for children to increase confidence in addressing challenges</td>
<td>Schaefer &amp; Drewes, 2011</td>
</tr>
<tr>
<td>Power &amp; Control</td>
<td><em>I can get my worry rocks and breathe and my worry goes away</em></td>
<td>Children gain a sense of mastery through play therapy experiences</td>
<td>Schaefer &amp; Drewes, 2011</td>
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**Theme 1: Play therapy as an opportunity for problem solving.** The most prominent theme that emerged from the interviews with each of the ten participants was
play therapy can serve as a catalyst for learning. Analysis of the data yielded findings that illustrate the importance of play therapy for educational purposes. Each of the five children who participated in this study provided information that supported the theme that play therapy provides opportunities for psychoeducation. The children reported learning new information that assisted them with individual challenges. Moreover, each child who is represented within the sample shared narratives to indicate frequent and practical applications of the educational material that was provided through their play therapy experiences.

The play therapy literature has highlighted the benefits of play therapy for children in acquiring creative problem solving abilities. Play therapy allows children the freedom to explore and test out different methods of coping without fear of negative consequences. As a result children often find discoveries of more adaptive coping mechanisms that assist them problem solving (Schaefer & Drewes, 2011). Analysis of the data from the present case study has found that these opportunities have been consistent with the five children who participated in play therapy services at The Child Protection Center of Ross County.

Specifically, Hope provided a detailed description of her use of “worry rocks” as a strategy for coping with her anxieties. Hope stated, “I rub my worry rocks when I worry and take big breaths and I get better (Hope. Personal communication December 5, 2016). The child also shared that she has placed these small gems under her pillow at night to assist with her frequency of bad dreams. During the interview Hope demonstrated by rubbing her fingers on the small blue stones and taking deep breaths. To
further validate the child’s benefit with this educational technique she offered a worry rock to this researcher during the interview process.

Gunnar also provided information that illustrated new strategies he gained from play therapy to cope with his fears. The child reported tightening and tensing his muscles in bed at night before he falls asleep. The child described this process as, “making my body uncooked spaghetti and cooked spaghetti.” Gunnar demonstrated this process during the interview making his body stiff and standing tall and calling this uncooked spaghetti. He then fell to the couch and curled up in a ball and referred to this as cooked spaghetti. Gunnar stated, “I not scared when I relax (Gunnar, personal communication. December 7, 2016).

Rocky also shared his experiences of acquiring new tools during his play therapy experiences. This child discussed an army of people who can keep him safe. Calling each individual a soldier or General, Rocky identified five people who he can tell if he is scared. The child helps up his hand and individually counted off people in his army of support. There was a great deal of confidence and pride that was projected from Rocky as he identified his social support system. He stated, “All these make me safe so I not scared (Rocky, personal communication. December 7, 2016).

When asked about what occurs in the playroom, Ethan offered an overview of his of drawing out pictures of monsters on paper and “making them silly.” With an elevated tone of voice Ethan shared drawing funny hats on the monsters or putting a big red nose on them. He stated, “I make the monsters in my dreams silly, and I not ‘fraid.” The child expanded with details of drawing pictures of monsters that have hurt him in the past
but exhibited visible relief when he shared that he could make them appear silly and not as frightening (Ethan, personal communication. December 9, 2016).

Lastly, Ezekiel also provided valuable insight into how play therapy can provide a child with new strategies for coping. As the other children have disclosed in this study, Ezekiel also presented with a great deal of anxiety when he initiated play therapy services. This child recounted his construction of a worry can. According to Ezekiel, he can draw a picture of anything that he worries about and place the picture in the can. He stated, “I don’t worry if it’s in the can (Ezekiel, personal communication. December 9, 2016).

These themes were apparent through the interviews of children with disabilities who participated in play therapy services with The Child Protection Center of Ross County. However, the caregivers of these children also contributed information that substantiated play therapy as an opportunity for learning. Each of the caregivers represented within the sample of this case study supplied data to support this assertion. The caregivers communicated through their interviews the benefits of their children acquiring and utilizing new skills introduced in the play therapy environment. Many of the caregiver participants also expressed that their children often transferred the skills acquired in the playroom to their home.

Like her granddaughter, Angel was eager to share the play therapy technique of worry rocks. Angel stated, “Hope tells everyone she see about worry rocks.” According to Angel, there has been a significant reduction of nightmares since the first child placed the worry rocks under her pillow at night. The child’s grandmother also discussed that
she had made many attempts to teach her child to breathe deeply when she became upset but had limited success prior to play therapy. Angel credits the worry rocks as being instrumental in reminding her granddaughter of the importance of deep breathing and relaxation (Angel, personal communication. December, 5, 2016).

Grace provided similar accounts of her children utilizing techniques that they gained during their play therapy experiences. According to Grace her adopted son Gunnar is often practicing blowing bubbles which she described as a deep breathing technique. Gunnar often request bubbles according to Grace and will tell her, “I gotta breath.” When specifically asked about what has changed since her children started play therapy, Grace shared that both of her children can independently use tools for relaxation or healthy coping. She detailed Rocky’s use of feeling thermometers, which is a technique the family has incorporated into their home. Using a handout of thermometers with feeling faces that is hung on the refrigerator Rocky often shares with his mother how he is feeling in the morning before school.

Rose reinforced the theme of play therapy being an opportunity for educational growth during her interview. According to Rose both Ethan and Ezekiel have communicated information and strategies learned in play therapy sessions. As reported by Ezekiel, Rose shared her child’s experience with the worry can and reported that he uses this can at home continually to cope with his anxieties. In fact, Rose attributes much of his improvements with reduced anxiety to the worry can strategy. Ethan also has demonstrated information acquired in play therapy according to his adoptive mother. Rose discussed Ethan’s awareness of his physical cues to anxiety and frequently
demonstrates various relaxation techniques that he has acquired during his play therapy experience.

Additional data from each of the two Registered Play Therapists who were interviewed further contributed to the theme of educational growth during play therapy. Both of the Registered Play Therapist offered information consistent with this theme. When asked if play therapy is different for children with disabilities compared to children without disabilities, Joan stated that every child can learn from the play therapy experience. She further expressed that modifications and adaptations are required with all children based upon their developmental need. However, Joan provided examples of some of the benefits of play therapy for the enhancement of learning. She stated; “When counseling adults we offer many tools of psychoeducation. Children may not have the developmental skills to comprehend techniques like guided imagery, deep breathing, or progressive relaxation. So, play therapy introduces these concept through play which children find enjoyable and can comprehend strategies better once they are introduced in a developmentally appropriate fashion (Joan, personal communication, December 2, 2016).

Anne offered similar views regarding a child’s ability to learn from the play therapy experience. According to Anne, children process and acquire information differently. As a former educator, Anne validated this assertion by referencing her experience in the classroom. However, in Anne’s opinion play therapy serves as an equalizing tool for all children. She stated, “Through play we can communicate on the child’s level in a manner that is nonthreatening and enjoyable. Children learn different
methods for coping, expressing themselves, and addressing their individual challenges (Anne, personal communication, December 12, 2016).

Although each of the ten participants within the present study validate the assertion that play therapy provides opportunities for educational acquisition, this theme is also supported through the play therapy literature. According to Schaefer and Drewes (2011), play therapy serves as a catalyst when providing direct or indirect instruction to children. The authors argued that important skills can be disseminated to children through activities like puppets, roleplay, and games. Homeyer and Morrison (2008) detailed the specific example of using a game play as a therapeutic tool as well as an opportunity for learning. Children learn by adherence to the rules of games, taking turns, and winning or losing.

Educational opportunities are also a fundamental component of the therapeutic process when counseling children who are affected by adverse events or traumatic experiences. The standardized counseling model of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) promotes psychoeducation as the initial objective for clinicians who provide counseling to children impacted by trauma. Although psychoeducation is the primary focus during initial contact with children following traumatic experiences, the model also emphasizes the importance of psychoeducation through the delivery of the model (Deblinger et al., 2006). Psychoeducation provide children with the opportunities to gain a better understanding of the traumatic event, normalization of symptoms they might be experiencing, and offer optimism towards recovery (Cohen & Mannarino, 2010).
Acquiring information and education via play therapy is an important theme that is likely to complement the psychosocial adaptation to disability for children. Smart (2001) identified many stages of the disability process in which new information may be critical for successful transition. Similarly, Power and Dell Orto (2007) cited a spectrum of emotions that are common for children with disabilities. The evidence offered in the current study have provided specific themes of children with disabilities gaining new information throughout their play therapy interventions. Therefore, it appears that play therapy could be implemented for children with disabilities in transitioning through various stages of the adaptation process.

**Theme 2: Abreaction during play therapy.** The second theme that emerged from the present study is abreaction. Abreaction is the re-experiencing and related emotions of prior events that are distressing to an individual (Homeyer & Morrison, 2001). Each of the five children who participated in the present study had histories of adverse childhood experiences. Although each child represents individualized traumatizing experiences, the data provides consistent similarities in how these traumatic experiences were addressed in play therapy services. Results from the interviews conducted with the five children with disabilities support the theme of abreaction during play therapy sessions. In addition two sub themes were identified through data analysis. These include play therapy as a form of self-expression and posttraumatic play.

All of the children who participated in this study acknowledged during the interview process the traumatic experiences that they had confronted. When asked why they stated coming to play therapy each of the children verbalized their individual
histories of trauma. Likewise, the children all provided examples of play activities that illustrate their sharing of these stories. All of these accounts reinforced the children’s comfort in discussing these abusive situations. The caregivers and play therapists of these children also provided information that further enhanced the children’s accounts. Two subthemes were identified under the salient them of Abreaction. These are self-expression and posttraumatic play.

Considering that all the children who participated in the present study had a history of abusive experiences, it is not surprising that each child provided information consistent with the theme of abreaction. According to the literature, Abreaction is a common occurrence in play therapy for traumatized children. Children who experienced traumatic events can acquire a sense of power in control and gain mastery over these challenging situations (Schaefer, 1999). In fact, Schaefer and Drewes (2011) stressed that children have an innate tendency to use play as a coping mechanism for external traumatic events. Kottman (2011) shared that the purpose of abreaction is to offer children a means to express some of the negative thoughts and feelings that are associated with the child’s trauma. Evidence-based literatures relative to children who have experienced trauma also support the concept of abreaction as well as the therapeutic benefit of children to create a trauma narrative. Specifically, allowing a child to establish a narrative representation of their trauma provides a reparative effect with symptoms of anxiety and fearfulness (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011).

The theme of abreaction also has important implications for the psychosocial stages of disability adjustment. The onset of a disability or chronic illness is initially met
with shock and devastation (Smart, 2001). The onset of a disability precipitates painful physical and psychological experiences that are challenging for children with disabilities. However, abreaction in play therapy affords children the opportunity to communicate these hurtful experiences in a nonthreatening environment. Considering that abreaction is common in the course of play therapy, it seems likely that the patterns could benefit children in the disability adaptation process

**Self-expression.** One sub theme that was identified in the present study is that play therapy offers children with disabilities and opportunity for self-expression. It is been well-documented that play therapy has a cathartic effect with children. The catharsis that is created with the reenactment of traumatic events helps to provide children with a sincere sense of mastery over their adverse event experiences (Schaefer & Drewes, 2011; Homeyer & Morrison, 2008). Evidence obtained from the present case study are congruent with these arguments. Specifically, the play therapists who were included in this study offered detailed accounts of their experiences in witnessing the catharsis that children exhibit during play therapy experience.

Joan offered her views regarding self-expression and play therapy. She stated:

Play therapy gives all children opportunities to communicate. But many children with disabilities who are traumatized may have language or speech disabilities. So play therapy provides a means for which these children can communicate. Many times my role as a play therapist is to simply reflect what the child is doing or what feeling they are trying to get across. As adults many people believe that you have to have certain rules in play and children should not be allowed to create
fights or distressing scenario supply. When we restrict us we restrict the child's ability to express themselves (Joan, personal communication, December 2, 2016). Anne identified many directive forms of self-expression in play therapy sessions. When asked about adaptation for children with disabilities in the playroom Anne offered the following:

There are many ways that children can communicate through play therapy. However it's common the children we see are reluctant to discuss the bad things that have occurred in their lives. Children with disabilities who have been abused are also hesitant. So with play therapy we can use crayons and colors to identify and discuss difficult emotions. Or a child can create a sand tray as a way of expression. It is much easier for a child to talk about small figures in the sand versus talking about personal details of their experiences. It helps children distance themselves from the bad stuff and gives them a way to express their thoughts and feelings (Anne, personal communication, December 12, 2016).

Schaefer (1999) identified self-expression is one of the numerous therapeutic power of play. Many children who present for play therapy services exhibit limitations in communication skills (Schafer & Drewes, 2011). The children who participated in the present study are no exception as all the children who are represented in this study had medical findings of regression in communication. However, play therapy offers all children the opportunity to express their thoughts and feelings without being dependent upon expressive or receptive language skills. In fact, children are naturally more comfortable with communication via play based interventions and materials
Consequently, children who have confronted traumatic events can acquire a greater awareness of their thoughts and emotions and utilize play as a form of expression (Schafer & Drewes, 2011). Analysis of the interviews conducted with the five children who participated in this study substantiated self-expression as one of the therapeutic powers of play. Each of the children who were interviewed openly communicated their recollections of abuse and feelings associated with these distressing events. However these narratives were commonly shared through descriptions of the children's play activities.

Hope not only disclosed her abuse during the interview process but provided some examples of how these abusive experiences were communicated during play therapy. When asked what she does in the play room Hope offered a number of examples of her play activities. However, in particular relevance to the theme of self-expression, Hope stated,

I drew a picture of me for Ms. Joan and then put band aids on all the hurts.

The child also stated, “Sometimes we pretend that the alligator is the mean man and he hurts the little girl doll, don’t worry it’s not real, it’s fake but that’s how the mean man hurted me (Hope, personal communication, December 5, 2016).” While these stories represent a painful reality for Hope, she exhibited a sense empowerment as she described play activities about these incidents.

Gunnar and Rocky also provided accounts of their abusive childhood with their biological parents. Each child provided narrative accounts of play activities that illustrated their communication of the abuse. During their discussion of what occurs in
the play room Gunnar talked about burying his old parents in the sand and his new parents rescuing him. His brother, Rocky, also shared his experiences through sand tray work. Rocky revealed that he made a castle in the sand where he could be locked away and protected from his old mom and dad. The child continued by describing all the people surrounding his castle in the sand which included his new parents, the police, and his play therapists.

Additional data was provided by Ethan and Ezekiel who were equally descriptive in their experiences of abuse. Considering that the brothers had no prior interaction with this researcher both were very forthcoming in sharing their experience of physical and sexual abuse as well as neglectful situations. After being asked to discuss what occurs in the play room Ethan responded by stating,

I make my dad monster puppet and he tries to tell me bad stuff but I put lots of tape and glue and stuff on his mouth (Ethan, personal communication, December 9, 2016). In addition, to the child’s verbal description direct observation from this researcher noted a sense of confidence of empowerment being display through the child’s body language.

Ezekiel shared his experiences in the play and described putting his mother and father in jail. The child stated:

I put them in jail for all the bad stuff and there really is a real jail in there with a lock and they can’t get out (Ezekiel, personal communication, December 9, 2016).
This phenomenon of self-expression in play therapy is likely to empower children with disabilities in the adaptation process. It is common that children with disabilities experience many intense emotions as the result of a disability or chronic illness (Power & Dell Orton, 2007). Therefore play therapy could serve as an optimal environment for children to communicate these experiences. The present study has offered various examples in which children with disabilities have utilized play therapy experiences to express difficult and challenging events that have occurred in her life. This theme provides practical evidence that can aid professionals towards assisting children with disabilities through the psychosocial stages of disability adjustment.

**Posttraumatic play.** Posttraumatic play was also identified as a sub theme under the broader theme of abreaction. Gil (2017) described posttraumatic play as a child’s play behavior that involves the methods of play, symbols, and/or metaphors as a means of expelling painful or traumatizing thoughts. Posttraumatic play is a term that was first used by Lenore Terr who has provided the greatest amount of insight into the posttraumatic play behaviors of children. According to Terr (1990), posttraumatic play differs from generic play in that posttraumatic play is a common occurrence for children who have experienced trauma that is often repetitive in nature, literal, and absent of pleasure (Gil, 2017).

Gil (2006) highlighted the benefits of posttraumatic play as she described this phenomenon as a means of gradual exposure that allows children a safe means of retelling and re-establishment of control over their traumatic experiences. Posttraumatic play allows children the opportunity to create a narrative that is accurate and meaningful
to their developmental interpretation of the trauma. Consequently, posttraumatic play becomes a natural and effective means of healing for children following trauma. Terr (1990) posited that posttraumatic play is the most powerful method to promote internal change in young children who have been traumatized. Gil (2017) shared this view of the healing powers of posttraumatic play as she also reported that posttraumatic play is an integral and paramount piece of a child’s recovery following traumatic experiences.

Eleven specific characteristics were offered by Terr (1990) to further define posttraumatic play. These include, a) play that is repetitive and compulsive, b) play that involves a link to the child’s traumatic experience(s), c) play that is literal, d) play that fails to immediately reduce anxiety, e) play that extends over a wide age range, f) play behaviors that may occur at various time intervals following traumatic experiences, g) play behaviors that can bring in non-traumatized children, h) play that has contagious qualities, i) posttraumatic play that can be dangerous, j) repetitive play that can involve doodling, talking, and audio recounts of the trauma, and k) play behavior that can be traced back to a child’s earlier traumatic experience(s) (Gil, 2017).

Although the children who are represented within this study did not provide any specific accounts of their play behavior that met the criteria of posttraumatic play, additional data supported the occurrence of such behavior with each child. In particular, each of the caregivers who participated in the study provided information related to their child(ren)’s play behavior that was consistent with the characteristics of posttraumatic play. All three of the caregivers of the children who participated in this study described repetitive play that often had some linkage to the child(ren)’s traumatic experiences.
Angel discussed various accounts of her granddaughter’s play with dolls in which the doll would be hit in face and hurt. At one point after the initiation of play therapy services Angel recounted a time where she specifically asked the child’s play therapist about the child’s play behavior. According to Angel, her granddaughter Hope was attempting to insert objects into the anal region of dolls. Angel stated that her granddaughter’s play therapist provided specific suggestions of how to address this behavior but also reported it to be common for children who are survivors of sexual trauma.

Additional information was reported by Grace that paralleled the themes of posttraumatic play with her adopted children. Grace shared that Gunnar had repeatedly used a small house in the family’s play area and verbalized that it was on fire as he manipulated figures running from the house. The child’s biological family had experienced a house fire prior to his placement in foster care. Rocky also has displayed play behavior that meets the criteria of posttraumatic play. Grace reported that Rocky also used the small play house in the family’s play room but, his play activity frequently involved fighting that included verbalizations of foul language and the manipulation of one miniature hitting another.

Ethan and Ezekiel were also reported to have engaged in similar play activities after their placement in foster care. Rose discussed Ethan’s use of a stuffed animal that he would often put in bed. However, Ethan would often yell that he was dreaming of monsters. Rose shared that Ethan would then take larger stuffed animals that he would describe as the mom and dad and physically use these animals to hit the smaller one.
Rose remembered that Ethan would even speak for the larger stuffed animals and would say, “Shut up, go to sleep.” Ezekiel displayed posttraumatic play through the re-enactment of police figures and people being shot with a gun. Unfortunately this was also consistent with the child’s history in his biological home. Although all of these episodes were challenging for Rose and her husband to witness, Rose reported that the child’s play therapist reported that these types of play behaviors are common with children following trauma.

The most comprehensive accounts to posttraumatic play for children with disabilities was provided by the register play therapist who participated in the present study. Each of the clinicians who were interviewed reported the post traumatic play was a common observation in their experiences of facilitating play therapy with children child survivors of trauma. As play therapist who specialize in serving children affected by trauma, each of the clinicians represented within the sample reported that this occurs with children with disabilities as well as with children without disabilities. There is also a consensus among the two therapists that posttraumatic play is beneficial to the therapeutic process. Although the therapist reported posttraumatic play with many traumatized children, each detailed examples of post dramatic play for children represented within this sample as well as other children with disabilities with whom they have worked.

Joan who is dedicated much of her professional career towards advocating and counseling abused and traumatized children describes posttraumatic play as the expectation and not the exception. However, when asked how the play therapy was
different for children with disabilities, Joan offered her professional insight in that many children with disabilities present in her practice with deficits in verbal and communication skills. However, Joan was quick to refer to the reality that children communicate through play and shared that this may be one of the few avenues that children with disabilities have towards sharing their dramatic histories. Joan stated,

It’s common that children will reenact traumatic experiences during play therapy. That is part of the recovery process. By allowing them to create these scenarios we give them permission to attempt to solve the underlying stress associated with the trauma (Joan, personal communication, December 2, 2016).

Anne also attributed a child’s history of trauma to the frequency of posttraumatic play. Anne provided various examples of posttraumatic play as she discussed the benefits of play therapy, but she did not report that these experiences were different for children with disabilities. Anne articulated the children with disabilities are frequently referred to services and as a result of trauma often exhibit postromantic play during play therapy sessions. Anne continued to offer her experiences of working with children with disabilities. After being asked if play therapy is different for children with disabilities, Anne reported that all children regardless of disability or functioning require tools and counseling. This clinician even discussed her selection of materials in her playroom. Anne described having miniatures that represent children of various cultural and ethnic groups as well as various disabilities.

Both of the clinicians reported that posttraumatic play is a beneficial process for most traumatized children. However, Joan and Anne have both witnessed the significant
benefits of children with disabilities as they engage in posttraumatic play. Joan shared an example in her work with Hope and referred to challenges that the child initially had with communication. Joan believes the posttraumatic play provided hope the opportunity to externalize distressing emotions that would be difficult for Hope to verbalize given her regression in speech and language.

The results of the present study illustrates the frequent occurrence of posttraumatic play during the play therapy interventions. While many of the children represented within the current inquiry were reported to have demonstrated posttraumatic play regarding their abusive experiences, this phenomenon could also be appropriate for children with disabilities as an outlet of communication throughout the adaptation process. In fact since play has this been described as a natural means of communication for children (Axline, 1947), it seems likely that children with disabilities might use this behavior to articulate painful and difficult experiences related to the adaptation process.

**Theme 3: Play therapy offers opportunities for attachment.** The third theme that emerged from the lived experience of children with disabilities who participate in play therapy service with The Child Protection Center of Ross County was the promotion of attachment through play therapy. Interpretation and analysis of the data found evidence to support prior literature in this area. However, one sub-theme was also encompassed with the salient theme of attachment. This included the increase of rapport building through play therapy.

Play therapy has been found to enhance and strengthen emotional connections between children and their caregivers (Schafer & Drewes, 2011). Evidence from the
interviews completed with five children who participate in this study, their caregivers, and the registered play therapist supervisors support this assertion. The most prominent evidence was provided by the caregivers who are identified within this study. Each of these caregivers reported gains in bonding and attachment with their children since the initiation of play therapy services at The Child Protection Center of Ross County. Moreover, two of the caregivers contributed specific examples of how the play activities their children acquired enhance bonding opportunities within their home.

When asked what has changed since play therapy services began Angel reported that her granddaughter is more comfortable and bonded in her home compared to two years ago. According to Angel, Hope verbalizes affection more and has no difficulty hugging and kissing her grandmother. These behaviors appear to be in contrast to the challenges that Hope exhibited when she was first placed with her grandmother. Angel associated these improvements to play therapy services. She stated:

Hope would always talk about what she did in play therapy and many times she would want me to play the same kinds of things. Her therapist told me to tell hope what I thought she was feeling or just say out loud what I saw her doing. When we started doing that and the bonding got stronger (Angel, personal communication, December 5, 2016).

Grace was also quick to report that both of her adopted children gain a sense of security within their home from their play therapy experiences. As Grace discussed the many changes she has observed since her children started play therapy, she referred to both children as passive, shy, and easily frightened when they started play therapy.
However, Gunnar and Rocky are now often telling their adoptive parents that they love them according to Grace. After hearing both boys talk about what they did in play therapy sessions, it became routine that the children would attempt to engage their adoptive parents in play therapy according to Grace. Grace cited a specific time when the boys handed each parent a stuffed animal. She reported that they would tell the parent what to do with the stuffed animal and what a stuffed animal should say. Grace believes that this type of interaction was instrumental in strengthening her bond with the adopted children.

Although Rose did not provide any specific examples of play activity that served to promote attachment, she did acknowledge that there has been an increase in the children’s bond since they initiated play therapy services. As Rose discussed what she had hoped her adoptive children would gain in play therapy she described Ethan and Ezekiel as timid, passive, and easily frightened. However, Rose reported that over the course of the last year both children are more outgoing and frequently are initiating hugs and affection with her and her husband. According to Rose, Ethan and Ezekiel have also made significant progress in bonding with extended family members.

Additional validation towards the strengthening of attachment via play therapy was also found through analysis of the interviews offered from the five children who participated in play therapy services. All of the children included in the present case study were reported to present with symptoms consistent with anxiety when they entered play therapy services. Many of the children were reported to be fearful of their caregivers and strangers. However, all of the children have made improvements as
reported by their caregivers. Likewise, none of the children who participated in this study exhibited distress when speaking with this researcher. Hope’s grandmother even remarked of how pleased she was that Hope could separate for the interview. Gunnar, Rocky, Ethan and Ezekiel provided statements during the interview that referenced their sense of safety with their adoptive parents. Each of these children verbalized a sense of safety associated with their adoptive families.

Both of the Registered Play Therapists provided professional opinions regarding the value of play therapy towards strengthen attachment through play therapy. When asked if play therapy was different for children with disabilities, Joan referenced the power of non-directive play therapy as an initial theoretic model to assist with developing rapport. Joan cited the establishment of a non-threatening environment as a fundamental task with non-directive play therapy. She stated:

This helps to establish and strengthen the therapeutic alliance with children. Often times we encourage the same actions with parents when they observe children playing at home. As play therapist we suggest that parents use non-judgmental statements and try to reflect what a child is feeling. This ultimately says to the child that they understand what I’m feeling. These tasks can greatly help in building secure attachment for children (Joan, personal communication, December 2, 2016).

Anne echoed these principles but specifically discussed the incorporation of parents and caregivers in her work with children. As Anne discussed providing play therapy to children with disabilities compared with children without disabilities she
underscored the inclusion of parents and caregivers in her work. She offered the following:

Children with disabilities are likely to be most secure with their caregiver. If I can introduce a play therapy strategy and encourage the caregiver to use these in the home that will only strengthen the bond between the child and the caregiver. Ultimately we view a caregiver as a substitute therapist where they can assist in implementing these strategies in the home, which is the natural environment that a child is likely to feel most comfortable. While we build rapport as therapist we want to increase reinforce and increase the attachment between the child and their parent (Anne, personal communication, December 12, 2016).

The current study has identified the benefits of play therapy and strengthening attachment with children and their caregivers. This theme is beneficial for children throughout the disability adaptation process. Smart (2001) describe common stages of the adaptation experience as anger and depression. Based upon analysis of the current study, play therapy can provide an avenue to assist children and caregivers towards the strengthening of relationships. As a result, children with disabilities are likely to progress with stronger familial relationships.

**Rapport building.** One sub themes was identified with the data that relate to the strengthening of attachment through play therapy. This was rapport building via play therapy. Although the sub theme is closely tied to attachment, results from the present case study found specific patterns associated with the benefits of play therapy towards rapport building. The two play therapists cited in this study provided information
Regarding attachment. However, each of these clinicians shared additional insights associated with play therapy being used for the strengthening of relationships.

During her discussion of common play therapy goals for children with disabilities, Joan stated:

Play therapy is all about the relationship and creating rapport. Although we can use play therapy tools with all children, playing games encourage children with disabilities to participate. We build trust with these children through play. Through play we send a message of understanding of acceptance regardless of their particular disability and that's what we also want for children with disabilities defined in their homes and schools (Joan, personal communication, December 2, 2016).

Anne offered a comparison of play therapy and traditional models of counseling. She stated:

Children with disabilities often find it challenging to come into a counseling office and share intimate details of their life, especially traumatize children with disabilities. But with play therapy the exchange of information is done in an enjoyable environment and this builds relationships (Anne, personal communication, December 12, 2016).

The caregivers who have adopted children in this present study also shared information that was characteristic of this experience. Grace recalled that she and her husband routinely played games with Gunnar and Rocky at home to strengthen rapport. According to Grace, the children often expressed excitement in describing their activities
during play therapy. Grace and her husband saw play as a natural way to encourage the children to communicate and connect with one another. Rose provided similar reports, and she shared that her children's play therapist provided the family with homework. The therapist according to Rose, assigned task and activities that were designed to help children feel more secure in their home.

Data was also obtained from the feedback of children who were interviewed for this present case study. While it is understandable, given the children's developmental capacities, that they did not provide verbal statements that cited the keywords of rapport or relationships, each child did offer information adhering to this subtheme. Statements from each of the children provided thematic patterns that reflect their view of their relationships with their play therapist. Specifically, Hope, in more than one instance, referred to her play therapist as a "friend." Gunnar and Rocky independent of each other referred to their play therapist as a "helper." By comparison, Ethan use the words "my Joan" when referring to his play therapist while his brother Ezekiel in one instance included his play therapist as he talked about his new adopted family. These descriptors reflect the strong rapport that has developed between the children and their play therapists. Furthermore, this information provides additional validation for the building of rapport through play therapy.

Previous literature has also identified play therapy as an instrumental tool for building rapport. The creation and maintenance of a therapeutic alliance is an essential component in play therapy. According to Schaefer and Drewes (2011) this often occurs naturally when a child interacts in a playful manner with a play therapist or caregiver
who responds appropriately to his/her behaviors. The building of rapport within play therapy sessions also assist children with development new attachments (Homeyer & Morrison, 2008).

Relationships are an influential part of the psychosocial adaptation process for individuals with disabilities. In fact, a family's reaction to a child's disability can have a positive or a negative effect on family functioning (Marinelli & Dell Orto, 1999). However, the present study has identified specific themes in which relationships can be built and strengthened through the play therapy process. These patterns illustrate the success of improved relationships with children with disabilities and their caregivers. It would appear that children with disabilities can utilize strong relationships in the adaptation process via play therapy.

**Theme 4: Gaining confidence through play therapy.** An addition theme and pattern noted for the present study was the emerging theme of confidence. The ten participants who served as the sample for this study all provided confirmation of this salient theme. Interpretation of the data has found all the children who participated in the study progressed during their play therapy experiences. Evidence has shown that the child has gained confidence in addressing the challenges that precipitated his/her play therapy sessions. Previous research has also provided justification for this salient theme. Schaefer (1999) projected the play therapy creates experiences for children through sand, drawing, and stories in which they can acquire confidence and self-efficacy. The use of toys and games are used in play therapy to promote skills for children and assist them towards a transference of these talents into other settings (Schaefer & Drewes, 2011).
Evidence obtained from interactions with children who participated in this study provided substantial information that revealed gains and competencies from the children's play therapy experiences. All of the children provided verbal statements that reflect skills they acquired from play therapy. Additional data was provided from the caregivers of these children. Each of the caregivers who were interviewed reported significant improvements with their child's identified goals during play therapy. Contributions consistent with this theme were also offered from the interviews with the two play therapists in the present study.

The adjustment to a disability is a complex and emotional process. However it is argued that it is a necessary process to achieve adaptation and integration to a new way of living. Specifically, the adaptation and integration stage requires a change in one's values, proles, and police following a disability (Smart, 2001). This study has demonstrated that children with disabilities acquire confidence through play therapy. As a result, it seems beneficial that play therapy can have benefits and the disability adaptation process.

Specific statements were coded from interview transcripts that found the children with disabilities who were provided play therapy services from The Child Protection Center of Ross County acquired confidence from their experiences. After being asked what had changed since she started play therapy, Hope responded, “I used to long time ago worry lots, but I don't worry now only little (Hope, personal communication, December 5, 2016).” Gunnar commented to this question by saying, “I no afraid now (Gunnar, personal communication, December 7, 2016).” Rocky and Ethan both cited a
decrease in their frequency of nightmares whereas Ezekiel simply responded by saying, "I better (Ezekiel, personal communication, December 9, 2016).

Although the statements referenced above reflect a sense of confidence that the children have acquired through play therapy, subsequent data was identified through analysis of the interviews with the caregivers of these children. As the primary caregivers of the children, it is not surprising each of the three participants have witnessed and reported the most success from their child's time in play therapy. Angel was very verbal about Hope's improvements in her ability to better manage her anxiety. Grace also shared the view that her children acquired new skills from their play therapy sessions. However, Grace provided one specific example of her son Gunnar using deep breathing strategies in his school setting and offered to teach the skills to his peers in his classroom teacher. Additional information to support the theme that children gain skills from play therapy came from Rose. According to Rose her adopted children have, “flourished since starting play therapy, they have learned so much from coming here (Rose, personal communication, December 9, 2016).

Interviews with the two play therapists identified in the present case study yielded further support for this notable theme. Both clinicians discussed their views of play therapy and referenced this therapeutic model as an educational tool for children. Joan stated:

One of the most rewarding things that comes from working with children with disabilities in play therapy is the experience of watching children learn new skills and this gives them confidence. Although we commonly see self-esteem issues
with many children who are abused, children with disabilities often present as being more passive and may not have an understanding of their internal strengths. Play therapy gives children with disabilities the opportunity to try out new skills in a fun and safe environment. This builds their confidence and gives them new skills (Joan, personal communication, December 2, 2016).

Anne shared her experiences of working with children with disabilities in play therapy. She stated:

It is amazing to watch children with disabilities grow and learn from play-based interactions (Anne, personal communication, December 12, 2016).

**Power and control.** The attainment of power and control through play therapy was a salient sub theme under the broader theme of acquiring confidence through play therapy. Three of the children who were identified as participants in the present study contributed evidence regarding a child’s achievement of a sense of power and control with their play therapy experiences. Hope described her perception of power and control when she offered an explanation of her worry rocks. Hope said:

I can grab my worry rocks and breathe and my worry goes away." She also discussed within the context of her interview her use of a night light and a dream catcher and said; "I can make my scary dreams go away. I can tell granny, I can draw picture, I can look at my dream thing (Hope, personal communication, December 5, 2016).

Ethan provided a similar view of his ability to master his disruptive sleeping patterns. He stated:
When I have monster dreams, I get to make a picture of them. She lets me make the monsters in my bad dreams silly. I give it a funny nose and hat (Ethan, personal communication, December 9, 2016).

Gunnar reported during his interview that:

I make bad stuff go away and make picture for worry can. I put it in can (Gunnar, personal communication, December 7, 2016).

Each of the play therapists who is part of the sample for the present study furnished additional support for a child's attainment of power and control via play therapy. Both clinicians reported that this is one of the many therapeutic factors of play therapy. Joan asserted:

Children can use play as a way to gain power over their environment. When you think about children who have been traumatized, they have lost a sense of control. Children with disabilities who have been traumatized feel very helpless. Play therapy allows children to manipulate toys or change play scenarios which can reestablish a sense of control. When you work with children in play therapy, you offer them safety, trust, and control (Joan, personal communication, December 2, 2016).

Anne shared similar views regarding her work with children in play therapy. She stated:

"I have witnessed so many children in the playroom move from a passive state to an assertive state. This is what we want for children who would been victimized. All children need to feel like they have power within their environment. But trauma impedes this and unfortunately sometimes the child's disability impedes
this. That is why play therapy is so helpful. Play therapy can be used with children across many developmental levels, and it helps to provide them with a feeling of control (Anne, personal communication, December 12, 2016).

**Answering the Research Question**

The above section offered a thick rich description of salient themes that emerged during the research investigation. These themes were obtained through exploration of the lived experience of children with disabilities who participated in play therapy through The Child Protection Center of Ross County. The following section of this chapter discusses the importance of each of these emerging themes in addressing the research question of the present case study. What are the lived experiences of children with disabilities to participate in play therapy at The Child Protection Center of Ross County? This research question was proposed to acquire as much information as possible regarding the experience of children who participated in play therapy services at the child advocacy in south central, Ohio.

The eight themes that were generated from the current study have provided important findings to address the research question. Based upon the evidence collected, this research has suggested that children with disabilities who participated in play therapy services with The Child Protection Center of Ross County found these experiences to be beneficial. The five children who participated in this study have all provided evidence of their enhancement of problem solving, self-expression, and the development of new skills from their play therapy experiences. Based upon the analysis of evidence collected from caregivers of these children, it is further suggested that the children increased their
emotional attachments and rapport building throughout their play therapy experiences. The two play therapists who participated in the present study provided further contributions regarding the therapeutic value of play for children with disabilities. Evidence provided by these clinicians suggest that children with disabilities can utilize the play therapy experiences for abreaction, demonstration of posttraumatic play, and to acquire a sense of power and control over their traumatic experience.

Although the findings of the present study are specific to the five children with disabilities who participated in play therapy services at The Child Protection Center of Ross County, these findings will contribute to existing research in this area. Results of the present case study appear to be consistent with prior studies. Schaefer (1999) was the first to offer an overview of the therapeutic powers of play. Through a comprehensive review of the research, he identified over twenty therapeutic factors in play therapy. These include 1) self-expression, 2) access to the unconscious, 3) direct and indirect teaching, 4) abreaction, 5) stress inoculation, 6) counterconditioning of negative affect, 7) catharsis, 8) positive affect, 9) sublimation, 10) attachment and relationship enhancement, 11) moral judgement, 12) empathy, 13) power and control, 14) competence and self-control, 15) sense of self, 16) accelerated development, 17) creative problem solving, 18) fantasy compensation, 19) reality testing, 20) behavioral rehearsal, and 21) rapport building. Evidenced from the current inquiry found that seven of the eight emerging themes identified in the present case study parallel factors cited by Schaefer (1999). While the emerging theme of posttraumatic play was not directly cited by Schaefer (1999), posttraumatic play is closely related to other factors from his research. Moreover,
posttraumatic play is well documented within the play therapy literature (Gil, 2017; Terr, 1990).

The current investigation has the play therapy experience of children with disability. In examining the experiences of children with disabilities this investigation further addresses one major assumption. Specifically, the assumption addressed from this inquiry is that play therapy can serve as a beneficial therapeutic strategy for children with disabilities. Evidenced obtained from participant interviews and examination of emerging themes have provided credibility for this assumption. While it has long been recognized that play therapy holds curative powers (Schaefer & Drewes, 2001), this inquiry utilized the framework of the psychosocial adaption to disability to gain a more detailed account of the benefit of play therapy outcomes for children with disabilities.

Although specific recommendations will be highlighted in the concluding chapter, it is important to highlight the value of play therapy intervention for children with disabilities based upon the present research findings. As previously discussed individuals with disabilities confront significant obstacles as the result of the onset of a disability. The emerging themes identified in the current investigation offer specific examples of how play therapy can be used to empower individuals with disabilities in the psychosocial adaptation process. A comparison of Stage-Phase Models of disability adaptation, and emerging themes from the present inquiry are offered in Table 8.
Table 8

Comparison of Stage Phase Models and Emerging Themes

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<thead>
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<th>Stage of Disability</th>
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<td>Adaptation (Smart, 2009)</td>
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<tr>
<td>Shock</td>
<td>Abreaction</td>
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<tr>
<td></td>
<td>Posttraumatic Play</td>
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<td>Self-Expression</td>
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<td>Rapport Building</td>
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<td>Problem Solving</td>
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<tr>
<td>Integration Acceptance</td>
<td>Power &amp; Control</td>
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Summary

In conclusion, this chapter has detailed emerging themes that was generated from analysis of the present study. The themes identified in the present study appear to be consistent with previous literature in the play therapy field (Schaeffer, 1999, Gil, 2017). The thick rich description of data that is summarized in the present chapter provides a foundation and rationale for play therapy in assisting children with disabilities in the disability adaptation process. This chapter has created a vivid portrayed of the lived experience of children with disabilities who have participated in play therapy services at The Child Protection Center of Ross County. Chapter Six will follow and offer recommendations and implications for professional practice as well as recommendations for future research.
Chapter 6: Lessons Learned

The goal of the present case study was to offer a rich thick description of children with disabilities who participated in play therapy services with The Child Protection Center of Ross County. The current study was designed to access and explore the real-life experiences of these children. Data was generated from individual interviews and observations of ten participants. Specifically, five children with disabilities who participated in play therapy services at The Child Protection Center of Ross County, their caregivers, and two Register Play Therapist Supervisors who facilitated these services. The result of this inquiry was utilized to answer a central research question. What are the lived experiences of children with disabilities who participate in play therapy services at the child protection Center of Ross County? As the concluding chapter of this case study, this section will offer lessons learned from the inquiry, implications for practice, and recommendations for future research.

Implications for Practice

Although the current case study focuses specifically on the experiences of children with disabilities who participated in play therapy services at a child advocacy center, the outcomes of the study contribute to many areas of professional practice. The descriptions of the experience of these participants in the current case study offer implications for practice. As reported in Chapter One, children with disabilities are often served by a variety of professional disciplines. These include but are not limited to physicians, hospital personnel, social workers, psychiatrists, physical therapists, occupational therapists, speech therapist, nutritionals, personal care assistance,
transportation professionals, clinical counselors, and rehabilitation counselors (Batshaw, Pellegrino, & Roizen, 2007). Therefore, the implications from the current study may be applicable to a diversity of professionals across many disciplines. The outcomes of this study are also likely to provide implications to child advocacy centers and agencies that offer services similar to that of The Child Protection Center of Ross County. Registered Play Therapists and Registered Play Therapist Supervisors may also benefit from implications of the current study. Additionally, information from the existing study is likely to provide implications to caregivers and family members with children with disabilities.

The first major implication from the existing study is offered for families and caregivers of children with disabilities. First, caregivers and family members must recognize the increased vulnerability of children with disabilities and child maltreatment. The present study highlighted the experiences of five children with disabilities who were survivors of childhood maltreatment. However, prior research has also identified the increased risk of child abuse for children with disabilities (Gore & Janssen, 2007; Henderson & Thompson, 2011; Sullivan & Knutson, 2000). As a result caregivers of children with disabilities should explore methods to educate their children and explore any preventive services to promote safety for their children. Likewise, caregivers and family members are encouraged to seek professional services in assessing and facilitating services for children with disabilities who are survivors of child maltreatment.

Caregivers and family members should also be conscientious of the impact that their child's disability has on the entire family system. As previously reported, a child's
disability can have a devastating impact on the entire family system (Powers & Del Orto, 2007). Consequently, caregivers and family members of children with disabilities commonly experience a multitude of emotional reactions (Tornasello, Manning, & Dulmus, 2000). Implications from the current studies offer caregivers and family members the additional strategies of play therapy services to assist children with disabilities. The current study has provided multiple examples of how play therapy can be incorporated to empower children with disabilities, their caregivers, and their families.

Additional implications from the present case study are for professionals and agencies that provide medical, therapeutic services, advocacy, and direct care for children with disabilities. Professionals are encouraged to explore referrals for children with disabilities to play therapy providers as they work to assist these children within their own area of specialization. Professionals who work with this population could also draw implications from this study and explore the possibility of implementing play-based interventions within their professional domains. These opportunities might include the incorporation of professional educational opportunities facilitated by play therapy specialists. Moreover, professionals could consider opportunities for collaboration or consultation with play therapy professionals to enhance existing services for children with disabilities.

Implications for Policy and Legislative Action

Historically individuals with disabilities have been victimized by vast amounts of stigma and oppression (Rubin & Roessler, 2008). Although there have been a number of legislative attempts to advocate and further protect individuals with disabilities, stigma
and discrimination remain for this vulnerable population. Legislative action similar to The Rehabilitation Act of 1973 and The Americans with Disabilities Act of 1990 have provided protection for individuals with disabilities (Marini, 2012). Similarly, The Individuals with Disabilities Act (IDEA, 2004) have provided protection for children with disabilities in the educational setting. While these advances in legislation and policy have established precedents, professionals cannot ignore the continual need to advocate for the rights of individuals with disabilities. All professionals who serve persons with disabilities have an ethical and moral duties to promote change through advocacy and policy development.

Despite the policies and legal mandate to protect children with disabilities, their vulnerability remains. Unfortunately, the abuse of children with disabilities has been identified as a critical public health issue (Hibbard & Desch, 2007). Shannon (2006) reported that child protective service agencies have greater difficulty in meeting the needs of children with developmental disabilities who are survivors of abuse. Although child protective services professionals are knowledgeable about the general nature of child abuse and neglect, children with disabilities have a complexity of behavioral, cognitive, social, and physical health care needs. These challenges often leave social service professionals ill-equipped to provide appropriate care to children with developmental disabilities who have a history of child maltreatment. Therefore, child welfare agencies, state and federal officials are encouraged to explore avenues to strengthen services to protect children with disabilities.
Recommendations for Counselor Education Programs

Considering the assertion that counselors are likely to serve children with disabilities (Carmichael, 2006; Henderson & Thompson, 2011), counselor education programs can have a foundational role in preparing future counselors for the complexities associated with working with children with disabilities and their families. Counselor education programs are encouraged to offer educational courses specific to children with disabilities. These educational opportunities should address the heightened risk of child maltreatment for children with disabilities. Moreover educational courses should incorporate curriculum that addresses the impact of the child's disability on his or her family system. Research has also underscored the importance of multicultural education in counseling curriculum. Sue and Sue (2008) highlighted the importance of knowledge acquisition for culturally competent counselors. Particularly, counseling professionals must be proficient with understanding the culture of those individuals whom they serve. Therefore, it is vital the multicultural counseling courses address the culture of disability to prepare future counseling in working with this population. Although play therapy is a specialization within the counseling, social work, and psychology professions, counselor education programs are encouraged to develop and increase specific educational opportunities dedicated to play therapy.

The findings from this investigation further support a more integrative approach among traditional counselor education programs and rehabilitation counseling education institutions. The collaborative merger of these two disciplines would only serve to enhance service delivery to children with disabilities and their families. As each
professional discipline explore more innovative approaches to work with children with disabilities, this investigation has highlighted a number of potential benefits of play therapy for counselors who work with children with disabilities.

**Recommendations for Clinical Counselors and Rehabilitation Counselors**

Clinical and Rehabilitation Counselors are some of the most common professionals who work with children with disabilities. The following recommendations are offered for Licensed Professional Counselors (LPCs) and Certified Rehabilitation Counselors (CRCs) who provide therapeutic, case management, and/or advocacy services to children with disabilities and their families.

**Recommendations for Clinical Counselors**

Among the various recommendations for counseling professionals who work with children with disabilities is the continual examination of one’s values, attitudes, and beliefs. Henderson and Thompson (2011) illuminated the importance of self-evaluation for professionals. These authors suggested that one of the greatest challenges associated with counseling children with disabilities is largely related to a clinician’s preconceived ideas regarding a child’s specific diagnosis. This categorization of children with disabilities has often led to professionals overlooking a child’s individual strengths. Counselors who view children with disabilities simply as a label or as a victim can greatly minimize a child’s strengths and capabilities (Henderson & Thompson, 2011). Regrettably, these further create therapeutic roadblocks for children with disabilities in their pursuit towards resilience. As this study has identified through analysis of emerging
themes, many beneficial experiences can be achieved through offering children play therapy in a non-threatening environment.

A limited number of counseling theories have been offered in the research to assist counselors who work with children with disabilities. Cognitive Behavioral Counseling has been reported as a beneficial model for exploring a child’s irrational ideations, negative self-perceptions, as well as behavior modification (Thurneck et al., 2007). Henderson and Thompson (2011) suggested group counseling as a means for children with disabilities to increase his or her relationship skills while simultaneously being offered a supportive and nurturing environment. Considering that many children with disabilities may have communication impairments, counselors should also explore non-traditional counseling paradigms. While traditional counseling theories have remained dependent upon the verbal exchanges between a child and clinician, creative therapies offers a unique approach that is not as dependent on a child’s communication skills. These can include play therapy, art therapy, bibliotherapy, and sand play (Bethel, 2005; Thurneck et al., 2007). The present case study has provided a rich thick description of the experience of five children who were provided play therapy intervention through The Child Protection Center that offers additional support for models of play therapy.

The ability to establish a therapeutic rapport is an essential skill for counseling professionals. However, when serving children with disabilities who are survivors of maltreatment, the importance of a strong therapeutic relationship cannot be overly emphasized. Children with disabilities frequently encounter feelings of anxiety, shame,
as well as other negative feelings surrounding his or her disability (Henderson & Thompson, 2011). The abuse experiences itself exacerbates these affective responses as it robs children of the basic ability to trust others. Therefore, clinicians must work diligently to foster a nurturing and supportive environment for children with disabilities who are impacted by the abuse experience. Once again support for the play therapy model is identified in the emerging themes of the present investigation. Play therapy offered children who participated in services through The Child Protection Center of Ross County opportunities for the building of rapport, self-expression, the development of problem solving skills and gaining a sense of power and control.

Collaboration is also an essential element for counselors who work with children with disabilities. A child’s disability may require specialized services from a diversity of health care professionals. Henderson and Thompson (2011) reported that it was paramount for counselors who work with children with disabilities to work closely with all agencies who serve the child as well as the child’s parents and family members. Hibbard and Dresch (2007) echoed this recommendation by stating that medical professionals need to collaborate with other treatment providers who work with children with disabilities. These collaboration efforts could include providing educational opportunities to other service providers regarding play based interventions and the value of play therapy when working with children with disabilities.

Counselors who serve children with disabilities may also find themselves in an advocacy role. Professional counselors are in a unique position to not only serve as a therapeutic agent of change but also be a support for the best interest of the child via
advocacy efforts. These responsibilities can include working to ensure that appropriate referrals are being initiated as well as recommendations are followed up on (Gore & Janssen, 2007). Similarly, it is estimated that nearly 14% of children 6 – 21 years of age receive special educational services (Henderson & Thompson, 2011). Therefore, educational advocacy is often another role for counseling professionals to explore in advocating for children with disabilities. Further collaboration can include working with educational professionals to incorporate play based interventions within the educational environment.

Parental or caregiver involvement is another significant area that counselors should consider when serving children with disabilities with abuse experiences. Professionals can often use counseling as an avenue to provide psycho-educational services to parents and care providers. These services can reinforce the positive behaviors of the child and assist caregivers in exploring disciplinary methods other than negative punishment. Professionals could also consider developing specialized parenting programs that can assist parents as a source of support (Gore & Janssen, 2007). Parental involvement has been shown to be one of the most significant predictor’s positive outcomes (LeBlanc & Ritchie, 2001). According to the Centers of Disease Control and Prevention (2009) parent training programs have been found to decrease a child’s aggressive behaviors, hyperactivity, and increase a child’s level of compliance. The voices of caregivers of children with disabilities who participated in the present inquiry provide several examples for the incorporation of caregivers in play therapy interventions.
Implications for Rehabilitation Counselors

Child maltreatment has been known to have a detrimental impact on the psychological and interpersonal development of an individual and specifically children with disabilities (Orange & Brodwin, 2005). In order to combat the negative effect of maltreatment and address other mental health needs, rehabilitation counselors must link children with disabilities to clinical counselors. This collaboration allows effective treatment strategies to be employed to mitigate the mental health challenges that may be encountered while focusing on the response the child may have to his/her disability. Moreover, rehabilitation counselors should educate clinical counselors and other professionals about disability adaptation and how to work with children with disabilities and their families regarding this process. These efforts can include referrals to play therapy professionals. As the current study has illustrated play therapy services can offer children a variety of benefits in gaining a sense of mastery.

Rehabilitation counselors assist individuals with disabilities achieve their psychosocial, vocational, educational, and personal goals. In helping them with this goal actualization, it is imperative that rehabilitation counselors understand the duplicity of disability and child maltreatment. It has been documented in the literature that children with disabilities have higher rates of child abuse and neglect (Mandell, et al., 2005; Shannon, 2006). However, the current qualitative study examined the impact of abuse on the lives of five children with disabilities. This information builds further credibility to the commonality of child abuse experiences for children with disabilities. Rehabilitation counselors must be able to recognize the signs and symptoms of child
maltreatment and be knowledgeable about the mandated reporting statutes within the state in which they practice. Rehabilitation professionals have an ethical and moral duties to not only adhere to these mandates but to familiarize themselves with the processes of child protection agencies.

Additionally, it is important that rehabilitation counselors know the indicators of abuse and be able to differentiate the symptoms of the disability from potential signs of abuse (Hibbard & Dresch, 2007). It has been found that professionals who serve children with disabilities often attribute cardinal signs of abuse to the child’s disability (ARCA, 1994). Hibbard and Dresch (2007) outlined specific disorders that mimic signs of abuse. Consequently, rehabilitation counselors should educate the child, family members, educators, mental health professionals and others about disabilities and key factors to distinguish between disability and characteristics of abuse. It is also necessary for rehabilitation counselors to educate families and school professionals about the risk factors associated with disability and abuse. Gaining a better understanding of these risk factors may aid professionals in delivering appropriate and quality services for children with disabilities.

Another concern that has been identified in the literature is that children with disabilities may not have the access to information about personal safety. According to ARCA (1994), prevention programs to educate children regarding the importance of personal safety exist, yet, these programs are seldom offered to children with disabilities and their families. In order to ameliorate child maltreatment, children with disabilities must be educated on safety strategies. Thus, rehabilitation counselors must provide
education about personal boundaries and practical body safety measures. This information is not only crucial for children with disabilities but rehabilitation counselors should also consider providing this educational material to families, educational systems, and other service providers. As indicated by the data analyses in the present inquiry play therapy afford children the opportunities to learn new information in the play therapy activities. Therefore, play therapy offers many potential opportunities to provide psychoeducation to children with disabilities.

As recommended for clinical counselors, rehabilitation counselors also have a responsibility to advocate for children with disabilities. Rehabilitation counselors often have optimal opportunities to advocate for children with disabilities. It should be the responsibility of all professionals to promote the well-being of all children, particularly, the most vulnerable population of children with disabilities who have been abused. All service providers, including rehabilitation counselors, should collaborate with one another to ensure that the needs of children with disabilities are being met. Rehabilitation counselors who serve in an advocacy role for children with disabilities can model effective strategies for encouraging and empowering this susceptible population of children.

**Recommendations for Future Research**

The current study has provided a rich thick description of the lived experiences of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County. A qualitative case study design was used to address one central research question. What are the lived experiences of children with disabilities
who participate in play therapy services at The Child Protection Center of Ross County?
The results and analysis of the data from the present study offered implications for
practice as listed above. In addition to the implications for practice, recommendations for
future research are also provided. These include:

1) Future qualitative case studies could further contribute to the
   established literature. These case studies would provide significant
   information by offering additional rich thick descriptions of the play
   therapy experiences of children with disabilities. Future qualitative
   case studies would only serve to strengthen existing literature and gain to
   provide a more in-depth understanding of the play therapy experiences of
   children with disabilities.

2) Future qualitative and quantitative studies could explore the outcomes
   and experiences of children with disabilities who participate in play therapy
   services. Such studies could aid in the increasing efforts to promote play
   therapy as a research-based effective paradigm.

3) Future qualitative and quantitative inquiries could assess the outcomes
   and experiences of play therapy interventions as a therapeutic model for
   empowering children with disabilities who are survivors of child
   maltreatment.

4) Future qualitative and quantitative research could explore the
   experiences and effectiveness of play therapy with caregivers and
   family members of children with disabilities.
Conclusion

The purpose of the present case study was to offer a rich description of the play therapy experiences of children with disabilities who participated in play therapy services at The Child Protection Center of Ross County. The results from participant interviews and observations have generated data to address one research question. The following section lists the research question and provides answers obtained from the data of the present study.

The research question in the current case study explores one central phenomenon. What are the lived experiences of children with disabilities to participate in play therapy services at The Child Protection Center of Ross County? Chapter Four provided introductions of each participant in this study and began to provide data to address the research question. A more detailed analysis was provided in Chapter Five which identified and discussed emerging themes with the present case study. Data analysis identified eight emerging themes. These themes were highlighted throughout direct quotations from the individual interviews with five children with disabilities who participated in play therapy services at The Child Protection Center of Ross County, their caregivers, and to play therapist who provided the specialized services.
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Appendix A: Approved IRB 16 X 263

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The Social/Behavioral IRB reviewed and approved by expedited review the above referenced research. The Board was able to provide expedited approval under 45 CFR 46.110(b)(1) because the research meets the applicability criteria and one or more categories of research eligible for expedited review, as indicated below.

| IRB Approved: | 11/14/2016 12:04:41 PM |
| Explication:  | 11/14/2017 |
| Review Category: | 7 |

Waivers: N/A

If applicable, informed consent (and HIPAA research authorization) must be obtained from subjects or their legally authorized representatives and documented prior to research involvement. In addition, FERPA, PPRA, and other authorizations must be obtained, if needed. The IRB-approved consent form and process must be used. Any changes in the research (e.g., recruitment procedures, advertisements, enrollment numbers, etc.) or informed consent process must be approved by the IRB before they are implemented (except where necessary to eliminate apparent immediate hazards to subjects).

The approval will no longer be in effect on the date listed above as the IRB expiration date. A Periodic Review application must be approved within this interval to avoid expiration of the IRB approval and cessation of all research activities. All records relating to the research (including signed consent forms) must be retained and available for audit for at least three (3) years after the research has ended.

It is the responsibility of all investigators and research staff to promptly report to the Office of Research Compliance / IRB any serious, unexpected and related adverse and potential unanticipated problems involving risks to subjects or others.

This approval is issued under the Ohio University OHRP Federalwide Assurance #00000095. Please feel free to contact the Office of Research Compliance staff contact listed above with any questions or concerns.
Appendix B: Recruitment Letter

A Qualitative Case Study: The voices of children with disabilities through play therapy.

Dear (Registered Play Therapist name)

My name is Brian L. Bethel and I am a doctoral student at Ohio University’s Patton College of Education. I am currently seeking to complete a research study that explores the play therapy experience of children with disabilities. This research will be utilized to complete my doctoral dissertation in counselor Education and Supervision. My dissertation is “A Qualitative Case Study: The voices of children with disabilities through play therapy.
Currently, I am looking for children to participate in my study. If you know a child between the ages of five and eleven years of age who has a disability (as defined by The Americans with Disabilities Act) and participates in play therapy sessions please contact the researcher for participation in this study. Participation will included an interview lasting approximately sixty minutes. The research would also ask the child’s parent/caregiver to participate in an interview also approximately sixty minutes. The child’s Registered Play Therapist will also be asked to participate in an interview. The purpose of the study is to gain an increased understanding into the play therapy experience of children with disabilities. It is the goal of the researcher that this proposed study will contribute to the existing literature and provide mental health clinicians with a more in-depth understanding of the play therapy experience for children with disabilities. For details, please contact bribethel@gmail.com or at (740) 701-3509.
Sincerely,

Brian L. Bethel, M.Ed., LPCC-S, LCDC III, RPT-S
Doctoral Student at Ohio University Patton College of Education
Counselor Education and Supervision

Revised 10/17/16
Appendix C: Interview Questions

Individual Interviews (Individuals with Disabilities and Play Therapy)

1. Basic Demographic Information
   a. What is your first name?
   b. How old are you?
   c. Where are you from?
   d. How long have you been coming to play therapy sessions?

2. Interview Questions for Children with Disabilities:
   a. Do you like coming to the play room? Tell me about it…?
   b. Tell me about being in the play room?
   c. Why did you start coming to play therapy?
   d. What has changed since you started coming to play therapy?
   e. What are your favorite things about coming to play therapy?

3. Interview questions for Registered Play Therapist:
   a. Do you think play therapy is different for children with disabilities? If so how?
   b. Do you make any adaptations in the playroom for children with disabilities?
   c. Is your theoretical model different for children with disabilities? If so how?
   d. Do you see differences in the playroom between children with disabilities and children without disabilities? If so how?
   e. How long have you been licensed as a mental health professional?
   f. How long have you been certified as a Registered Play Therapist-Supervisor?
   g. In your practice, what do you see as the therapeutic objectives for children with disabilities?

4. Interview questions for parents/caregivers:
   a. Is there anything different since your child started play therapy?
   b. Does your child share what went on in the playroom?
   c. What did you hope your child would get out of play therapy?
   d. Does your child look forward to coming to play therapy?
   e. Were you familiar with play therapy prior to your child starting play therapy? If so tell me about your knowledge.
   f. Have your views of play therapy changed?

Revised
10/17/16
Appendix D: Approved Informed Consent

Ohio University Parental Consent Form
Adult Consent Form

Title of Research: A Qualitative Case Study: The voices of children with disabilities through play therapy

Researchers: Brian L. Bethel

You are being asked permission for your child to participate in research. In addition to your child’s participation you will also be invited to participate in the proposed study.

The following information is provided to assist you in making the decision about your child’s participation and your participation in this proposed study. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your child’s personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow both you and your child’s participation in this study. You should receive a copy of this document to take with you.

Explanation of the Study:

My name is Brian Bethel and I am conducting a research study that explores children with disabilities and their experiences in play therapy. The goal of this research is to acquire information about the experiences that children with disabilities have in play therapy sessions.
I will interview children with disabilities for this study so others can understand more about the topic. In addition, I will be conducting interviews of parent/caregivers of children with disabilities who participate in play therapy services, and interview Registered Play Therapist. If you agree to allow your child to participate, he or she will be asked to participate in one interview lasting approximately one hour. Your child should not participate in this study if he or she does not have a disability or if they have not participated in play therapy sessions.

Your child will be asked to participate in an interview lasting no more than sixty minutes.

As a parent/caregiver you will also be asked to participate in an interview lasting no more than one hour for this proposed study.

Risks and Discomforts
Risks or discomforts that your son or daughter might experience are feelings of sadness, shame, or anger when talking about topics related his or her disability. Your child may stop the interview at any time and his or her decision will not impact the services that he
or she receives from this agency. If your son or daughter discloses any information related to past or current sexual abuse or victimization, I am legally mandated to report this information to the appropriate authorities.

Risks or discomforts that you might experience are feelings of sadness, shame, or anger when talking about topics related to your child’s disability. You may choose to stop the interview at any time and this will not impact the services that your child receives from this agency. If you disclose any information related to past or current sexual abuse or victimization of your child, I am legally mandated to report this information to the appropriate authorities.

The local community mental health center’s Crisis Center is available should you or your child express discomfort or disclose information that may warrant additional mental health services. The Crisis Center’s contact number is (740) 773-4357. The Crisis Center has the availability to contact staff at The Child Protection Center.

Benefits
This study is important because children with disabilities experience many challenges that often require mental health services. While you son or daughter may not benefit from participation in this study directly, the goal is for the study to contribute to the existing researcher for mental health professionals.

Confidentiality and Records

The information that you and your child provides for this study will be kept confidential. Only first names will be used during the interview and all names will be changed before reporting results. All interviews will be audio-recorded electronically and transferred to DVD. The DVDs will be locked in 138 Marietta Rd. Chillicothe, Ohio beginning November 2016, the DVDs will remain in my possession and will be destroyed after 1 year (November 2017).

Additionally, while every effort will be made to keep the information provided by you and your child confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;
Contact Information
If you have any questions regarding this study, please contact Brian Bethel (doctoral student) at 740-701-35089 or bribethel@gmail.com or Mona Robinson (faculty advisor) at 740-593-4461 or robinsoh@ohio.edu

If you have any questions regarding your child’s rights as a research participant, please contact Dr. Chris Hayhow, Director of Research Compliance, Ohio University, (740)593-0664 or hayhow@ohio.edu.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks to your child and they have been explained to your satisfaction;
- you have been informed of potential risks that you may experience as a result of your participation in this proposed study;
- you understand Ohio University has no funds set aside for any injuries your child might receive as a result of participating in this study;
- you are 18 years of age or older;
- both you and your child’s participation in this research is completely voluntary;
- you and your child may leave the study at any time; if you and/or your child decides to stop participating in the study, there will be no penalty to your child and he/she will not lose any benefits to which he/she is otherwise entitled.

Parent Signature_________________________________________ Date __________

Printed Name____________________________________________

Child’s Name____________________________________________
Registered Play Therapist Consent Form

Title of Research: A Qualitative Case Study: The voices of children with disabilities through play therapy

Researchers: Brian L. Bethel

You are being asked to participate in research. As a play therapy profession who serves children with disabilities, your participation is likely to provide benefits to the proposed study. In order to make an informed decision about your participation in the study, you should understand what this project is about, as well as the possible risks and benefits of your participation. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of the Study:

My name is Brian Bethel and I am conducting a research study that explores children with disabilities and their experiences in play therapy. The goal of this research is to acquire information about the experiences that children with disabilities have in play therapy sessions.

I will interview children with disabilities for this study so others can understand more about the topic. In addition, I will be interviewing parents/caregivers of children with disabilities who participate in play therapy and Registered Play Therapist-Supervisors. As a professional who serves children with disabilities, you can offer unique insight into this population. If you agree to participate, you will be asked to participate in one interview lasting approximately one hour. You should not participate in this study if you are not serving children with disability and are not registered as a play therapist.

Your participation in the study will include a one hour interview.

Risks and Discomforts

As a Registered Play Therapist who serves children with disabilities, it is possible that you might experience some risk or discomforts. Risks or discomforts that you might experience are feelings of sadness, shame, or anger when talking about topics related to children whom you provide play therapy services. You may choose to stop the interview at any time.

The local community mental health center’s Crisis Center is available should you express discomfort or disclose information that may warrant additional mental health services. The Crisis Center’s contact number is (740) 773-4357. The Crisis Center has the availability to contact staff at The Child Protection Center.
Benefits
This study is important because children with disabilities experience many challenges that often require mental health services. While you may not benefit from participation in this study directly, the goal is for the study to contribute to the existing researcher for mental health professionals who might use play therapy as a treatment paradigm when serving children with disabilities.

Confidentiality and Records
Your interview and personal information for this study information will be kept confidential. Only first names will be used during the interview and all names will be changed before reporting results. Interviews will be audio-recorded electronically and transferred to DVD. The DVDs will be locked in 138 Marietta Rd. Chillicothe, Ohio beginning November 2016, the DVDs will remain in my possession and will be destroyed after 1 year (November 2017).

Additionally, while every effort will be made to keep your information confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

Contact Information
If you have any questions regarding this study, please contact Brian Bethel (doctoral student) at 740-701-35089 or bribethel@gmail.com or Mona Robinson (faculty advisor) at 740-593-4461 or robinsoh@ohio.edu
If you have any questions regarding your child’s rights as a research participant, please contact Dr. Chris Hayhow, Director of Research Compliance, Ohio University, (740)593-0664 or hayhow@ohio.edu.

By signing below, you are agreeing that:
- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks to you may experience and they have been explained to your satisfaction;
- you understand Ohio University has no funds set aside for any injuries your child might receive as a result of participating in this study;
- you are 18 years of age or older;
- you are a Registered Play Therapist-Supervisor
- you may choose to leave the study at any time.